DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495353	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSTONE	900 S MAIN ST BLACKSTONE, VA 23824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/15/2021 through 11/17/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/15/2021 through 11/17/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey (VA00053137-Substantiated without deficiency). The census in this 180 certified bed facility was 134 at the time of the survey. The survey sample consisted of 44 resident reviews.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(l)(1)-(7) §483.10(l) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584	**F584** **Corrective Action(s):** Resident #21's wheelchair has been inspected and repairs to the armrests completed. **Identification of Deficient Practice(s) and Corrective Action(s):** All other resident wheelchairs may have potentially been affected. A complete documented inspection of all resident wheelchairs has been completed. Work orders for identified negative findings have been completed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda Crumpler | TITLE: LNHA | (X6) DATE: 12/1/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a comfortable, homelike environment for one of 44 residents in the survey sample, Resident #21. The facility staff failed to maintain Resident #21's wheelchair armrests in good repair. The plastic covering on the armrests was torn and cloth was exposed. The findings include:	F 584		

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F 584	Continued From page 2 Resident #21 was admitted to the facility on 6/30/10. Resident #21's diagnoses included but were not limited to diabetes, major depressive disorder and convulsions. Resident #21's annual minimum data set with an assessment reference date of 8/23/21, coded the resident's cognition as moderately impaired. On 11/15/21 at 2:01 p.m. and 11/16/21 at 7:59 a.m., observation of Resident #21 was conducted. The resident was sitting in a wheelchair. The plastic covering on both wheelchair armrests was torn with cloth exposed. On 11/16/21 at 2:07 p.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 stated the 11:00 p.m. to 7:00 a.m. CNAs are responsible for washing wheelchairs so she thought they would report torn wheelchair armrests. CNA #2 further stated if staff sees torn areas on wheelchair armrests then staff is supposed to notify maintenance with a work order in the computer system. On 11/16/21 at 4:42 p.m., an interview was conducted with OSM #3 (other staff member) #3 (the maintenance director). OSM #3 stated the maintenance staff inspects all resident wheelchairs including armrests every quarter and staff is supposed to report torn wheelchair armrests any other time via a work order in the computer system. OSM #3 stated he had previously ordered wheelchair armrests but had difficulty with getting the supply and the supply only recently came in. On 11/16/21 at 5:36 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2	F 584	**Systemic Change(s):** The facility's policy & procedure for providing a safe, sanitary, and comfortable environment has been reviewed. No changes are warranted at this time. The Maintenance Director will provide inservices to all staff on facility policy and procedure on the maintenance notification system to use when facility equipment (including wheelchairs) and repairs are noted and needed throughout the facility. **Monitoring:** The Maintenance Director and the administrator are responsible for maintaining compliance. Documented wheelchair inspections will be completed weekly to monitor compliance. The administrator will review the findings of the audits weekly to ensure negative findings are being corrected. Cumulative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice **Completion Date:** 12/27/21	

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F 584	Continued From page 3 (the assistant administrator) and ASM #3 (the director of nursing) were made aware of the above concern. On 11/17/21 at 7:54 a.m., OSM #3 provided an invoice that documented wheelchair armrests were received at the facility on 10/15/21. OSM #3 also provided documentation to evidence Resident #21's wheelchair was inspected by the maintenance staff on 8/27/21 and stated he had not received any work orders from other staff regarding Resident #21's wheelchair armrests. On 11/17/21 at 9:42 a.m., ASM #1 and ASM #2 was made aware that the above findings remained a concern. The facility policy titled, "Homelike Environment" documented, "Residents are provided with a safe, clean, comfortable, homelike environment and encouraged to use their personal belongings to the extent possible." The facility policy titled, "Wheelchair Cleaning and Maintenance Inspection" documented, "It is the policy of this facility to conduct regular cleaning and inspections of all wheelchairs and resident transportation equipment to ensure that they are cleaned and safe. Repairs and cleaning shall not be limited to the routine cleaning and inspection procedures. Any observation of an uncleaned device or device that needs repair should be cleaned and/or reported for repairs through the Tels work-order system (computerized work order system for the Maintenance department)." No further information was presented prior to exit.	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge	F 623		

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F 623	Continued From page 4 CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs,	F 623	**F623** **Corrective Action(s):** The state ombudsman office has been notified that the facility failed to provide a discharge/transfer notice for the resident's transfer to the hospital on 7/17/21. **Identification of Deficient Practices/Corrective Action(s):** All other residents discharged and/or transferred from the facility may have been affected. The Social Services Director and/or Admissions Director will conduct a 100% audit of all residents who have been discharged and/or transferred in the past 60 days. Residents identified at risk will be corrected at time of discovery and the required notifications to the residents' responsible party and the state ombudsman will be made. **Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The Administrator and/or Regional Nurse Consultant will inservice the facility's social worker(s) and nursing administration on the requirement that a resident's responsible party and the state ombudsman be notified of resident discharges/transfers.	

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F 623	Continued From page 5 under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 623	**Monitoring:** The Social Services Director will be responsible for maintaining compliance. The Social worker/designee will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 12/27/21	

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F 623	Continued From page 6 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide written notification of a transfer to the ombudsman for one of 44 residents in the survey sample, Resident #76. The facility failed to notify the ombudsman of Resident #76's transfer to the hospital on 7/27/21. The findings include: Resident #76 was admitted to the facility on 9/6/18, and most recently readmitted on 8/6/21, with diagnoses including a history of a stroke and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/7/21, Resident #76 was coded as being severely cognitively impaired for making daily decisions, having	F 623		

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F 623	Continued From page 7 scored six out of 15 on the BIMS (brief interview for mental status). A review of Resident #76's clinical record revealed the following progress note written on 7/27/21 at 1:20 p.m.: "CNA (certified nursing assistant) came to this nurse to report resident coughing up blood. CNA was making rounds when resident yelled out 'someone help me.' Upon entering resident's room, nurse witnessed resident coughing up copious amounts of bright red blood and mucus mixture...Vital signs were taken...Resident nodded yes as to rationale for being sent out to hospital. RP (responsible party) made aware. Resident was transported via stretcher...RP was offered bed hold, which she refused." The resident did not return to the facility until 8/6/21. Further review of Resident #76's clinical record failed to reveal evidence that the ombudsman was notified of the resident's discharge to the hospital on 7/27/21. On 11/16/21 at 5:19 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the administrator of a sister facility, ASM #5, the nurse consultant, and ASM #3, the director of nursing, were informed of these concerns. On 11/17/21 at 8:36 a.m., ASM #1 was interviewed. When asked who is responsible for notifying the ombudsman when a resident is discharged to the hospital, he stated the social worker is responsible for this. ASM #1 stated the social worker at the time of Resident #76's discharge is no longer employed at the facility. ASM #1 stated the social worker ordinarily keeps a binder with all the ombudsman notifications in it,	F 623		

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F 623	Continued From page 8 but the paper for Resident #76's discharge on 7/27/21 could not be located. A review of the facility policy, "Transfer or Discharge Notice," revealed, in part: "A resident and/or his or her representative (sponsor) will be given a thirty (30)-day advance notice of an impending transfer or discharge from the facility. Under the following circumstances, the notice will be given as soon as it is practicable but before the transfer or discharge...The resident and/or representative (sponsor) will be notified in writing...a copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman." No further information was provided prior to exit.	F 623		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 44 residents in the survey sample, Resident # 106. The facility staff failed to ensure timely transcription of a an order for the use of a negative wound vac [vacuum]. The physician ordered the wound Vac on 11/12/21 and the order was not transcribed until 11/15/21.	F 658	**F658** **Corrective Action(s):** Resident #106's attending physician has been notified that the facility staff failed to transcribe an order for the use of negative pressure wound vac given on 11/12/21 until 11/15/21. **Identification of Deficient Practices/Corrective Action(s):** All other residents with newly received verbal orders may have potentially been affected. The DON/designee will conduct a 100% review of all resident's orders to identify any residents at risk for not having orders transcribed timely. All residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each error.	

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F 658	Continued From page 9 The findings include: Resident # 106's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/25/2021, coded Resident # 106 as scoring a 3 [three] on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 [three] - being severely impaired of cognition for making daily decisions. The "Wound Evaluation & Management Summary" for Resident # 106 dated 11/12/2021 documented in part, "Dressing Treatment Plan: Negative pressure wound therapy." The "Physician's Telephone Order" for Resident # 106 dated "11/15/21" documented, "Cleanse wound to R [right] hip with hibiscus wipe with dampened 4x4 [four by four] gauze, pack wound with black foam. Apply negative pressure therapy run continuous at 120 mmHg [millimeters of mercury]. Change dressing Tues [Tuesday], Friday and PRN [as needed]." The comprehensive care plan for Resident # 106 dated 07/02/2021 documented in part, "Problem/Need: Infection/Wound to R [right] Hip. At risk for pain, odor, and infection due to right hip wound and comorbidities." Under "Approaches" it documented in part, "11/15/21 New wound care order Negative pressure therapy continuously @ [at] 120 mmHg [millimeter of mercury] per order." On 11/17/2021 at 8:09 a.m., an interview was conducted with LPN [licensed practical nurse] # 2, wound nurse. LPN #2 was asked when the wound vac treatment was started for Resident # 106. LPN # 2 stated that Resident # 106 had the	F 658	**Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcribing and administering physician ordered medications per physician order. Licensed staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for transcribing orders. **Monitoring:** The DON is responsible for maintaining compliance. The DON/designee will review new orders weekly coinciding with the care plan calendar in order to maintain compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 12-27-21	

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F 658	Continued From page 10	F 658		

negative wound vac on 11/12/2021 and had discontinued the PICO vac [3] on the 11/12/2021. After reviewing the physician's telephone order for Resident # 106's use of the wound vac as listed above, LPN # 2 was asked why the order was dated 11/15/2021 when they stated that the wound vac started on 11/12/2021. LPN # 2 stated, "The order was not written until 11/15/2021." When asked who was responsible for transcribing the order, LPN # 2 stated, "I was responsible for obtaining the order." When asked to describe the procedure for obtaining the physician's order for Resident # 106's use of the wound vac, LPN # 2 stated, "I print the recommendation from the wound doctor, scan it to the physician, the facility's medical director, write the telephone order, document it in the nurse's notes, notify the family all in the same day." When asked if the order for Resident # 106's wound vac was transcribed timely, LPN # 2 stated no. When asked about the date of the "Approach" on Resident # 106 comprehensive care plan, LPN # 2 stated that the care plan is updated when the order is written.

On 11/15/2021 at approximately 12:00 p.m., during the entrance conference with ASM [administrative staff member] # 2, assistant administrator and ASM # 3, director of nursing, ASM # 3 stated that the facility's nursing staff follow Lippincott's standard of nursing.

On 11/17/2021 at approximately 10:22 a.m. a request was made to ASM # 1, administrator for facility policies and the Lippincott standard of nursing for transcribing physician's orders. At approximately 11:00 a.m., RN [registered nurse] # 2, assistant director of nursing, provided the survey team with requested policies. The facility

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F 658	Continued From page 11 was unable to provide the Lippincott standard of nursing for transcribing physician's orders. On 11/17/2021 at approximately 5:00 p.m., ASM [administrative staff member] # 1, administrator, ASM # 2, assistant administrator, ASM # 3, director of nursing, ASM # 4, administrator of sister facility and ASM # 5, nurse consultant, were made aware of the above findings. No further information was provided prior to exit. References: [1] Vacuum-assisted closure of a wound is a type of therapy to help wounds heal. It's also known as wound VAC. During the treatment, a device decreases air pressure on the wound. This can help the wound heal more quickly. The gases in the air around us put pressure on the surface of our bodies. https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/vacuumassisted-closure-of-a-wound#:~:text=Vacuum%2Dassisted%20closure%20of%20a%20wound%20is%20a%20type%20of,the%20surface%20of%20our%20bodies. [2] A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. [3] The PICO* patient/population, intervention, comparison and outcomes] Single Use Negative Pressure Wound Therapy System is indicated for acute and chronic wounds and closed surgical incisions with low to moderate levels of exudate. This single use system is canister-free with a wear time of 7 to 14 days. Approved for both	F 658		

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	495353	A. BUILDING _____ B. WING _____	C 11/17/2021

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F 658	Continued From page 12 hospital and home care settings. This information was obtained from the website: https://www.woundsource.com/product/pico-single-use-negative-pressure-wound-therapy-system.	F 658		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review it was determined the facility staff failed to secure Medications in a safe and secure manner according to professional	F 761	**F761** **Corrective Action(s):** Wing One Med Cart Two, Wing Two Med Cart One, and Wing Two Med Cart Two have been cleaned by nursing staff. The medical director has been notified that facility staff failed to secure medications in a safe and secure manner on the 3 identified medication carts. **Identification of Deficient Practices & Corrective Action(s):** All other unit medication carts may have been potentially affected. The DON and/or designee will conduct a 100% review of medication carts to identify any improperly secured medications Any/all negative findings will be corrected at time of discovery. **Systemic Change(s):** Facility policy and procedure for medication and biological storage have been reviewed and no changes are warranted at this time. All licensed nurses will be inserviced by the DON on the facility policy and procedure for storing and securing medications and biologicals.	

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F 761	Continued From page 13 standards in three of three medication carts, (Wing 100-medication cart-two, Wing 200-medication cart-one and Wing 200-medication cart-two). The findings include: One whole pill and two half-loose unidentified pills were observed in the second drawer of the Wing 100-medication cart-two. Three half unidentified pills were observed in the second drawer of the left side of Wing 200-medication cart-one and an opened bottle of pills without a cap was observed in the third drawer on the right side of Wing 200-medication cart-one. One whole unidentified pill was observed in the second drawer of Wing 200-medication cart-two. On 11/16/21 at approximately 2:50 PM, an observation of Wing-200 medication cart-one was conducted with LPN (licensed practical nurse) #3. Observation inside the drawers of Wing-200 medication cart-one revealed the following: In drawer two on the left side of cart: three half loose unidentified pills. In drawer three on the right side of cart: One large bottle (capacity to hold 1000 tablets) of Docusate (laxative) (1) opened with no cap. On 11/16/21 at approximately 3:00 PM, an observation of Wing-200 medication cart-two was conducted with LPN #4. Observation inside the drawer of Wing-200 medication cart-two revealed in drawer two on the left side of cart: one whole loose unidentified pill. On 11/16/21 at approximately 3:10 PM, an observation of Wing-100 medication cart-two was conducted with LPN #5. Observation inside the	F 761	**Monitoring:** The DON is responsible for maintaining compliance. The DON/designee will perform weekly medication cart audits to monitor for compliance. All negative findings found in these audits will be corrected at the time of discovery and disciplinary action taken as appropriate. Results of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 12-27-21	

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F 761	Continued From page 14 drawer of Wing 100-medication cart-two revealed in drawer two on the left side of cart: two half loose unidentified pills. The loose pills in each drawer above were observed located behind the medication cards stored in each drawer. When asked about the loose medications in the drawers, LPN #3 stated, "There are so many cards in the drawer that sometimes the pills pop out of the medication cards, that is the problem with the cards." An interview was conducted on 11/16/21 at 2:50 PM with LPN #3. When asked about the opened bottle of pills in the drawer, LPN #3 stated, "Well I know the cap was here. I just took it off when I was giving the medications." LPN #3 was observed placing the cap that was in the drawer back on the open bottle of Docusate. An interview was conducted on 11/16/21 at 3:15 PM with LPN #5. When asked about the loose unidentified pills in the drawer, LPN #5 stated, "We give a lot of meds here on the skilled side and there is a lot of medication cards for each resident. The drawer gets full, we are constantly pushing the cards back and forth, and we administer medications. That is why the pills sometimes pop out. I will dispose of those pills." On 11/16/21 at 5:15 PM, when asked what the standard of practice the facility followed, ASM (administrative staff member) #3, the director of nursing stated, "We follow Lippincott." On 11/16/21 at 5:18 PM, ASM #1, the administrator, ASM #2, the assistant administrator, ASM #3, the director of nursing, ASM #4, the administrator of a sister facility and	F 761		

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F 761	Continued From page 15 ASM #5, the regional nurse consultant were informed of the above findings. According to the facility's "Storage of Medications" policy, dated November 2020, which documents in part, "The facility stores all drugs and biologicals in a safe, secure and orderly manner. Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner." No further information was provided prior to exit. References: (1) 2019 Lippincott Pocket Drug Guide for Nurses, Wolters, Kluwer, page 444. (2) Lippincott Nursing Procedures, 8th edition, Wolters, Kluwer, page 556.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812	**F 812** **Corrective Action(s):** The fan located in the dietary department has been cleaned by maintenance. All facility dietary staff have been re-educated on the proper procedure for drying dishes and on the procedure to notify maintenance of needed repairs or cleaning of the fan.	

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F 812	Continued From page 16 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that facility staff failed to store, and prepare food in in accordance with professional standards for food service safety. Facility staff were observed drying clean dishes using a cloth and paper towels and a fan with coated with gray dust and lint on the front and back blade guards was found blowing air over the area where dishes were washed and racked to dry. The findings include: On 11/16/2021 at approximately 9:35 a.m., an observation of the facility's dish room revealed OSM [other staff member] # 2, dietary aide removing and wiping dry clean trays, plates from the dishwashing racks on the clean dish line. OSM #2 then stacked the trays on top of each other on a ladder rack and stacked the dishes together, placing them in the dish storage rack. Observation of the wall behind the clean dish line revealed an 18 inch fan mounted on the wall, above and blowing on the clean trays, plates and silverware. On 11/16/2021 at approximately 9:45 a.m., an observation of the procedure described above was conducted with OSM # 1, dietary director. When asked about the drying procedure OSM #	F 812	**Identification of Deficient Practices & Corrective Action(s):** All residents may have been potentially affected. The Food Service Manager, and/or Registered Dietician will complete monitoring each member of the dietary staff as they complete the dishwashing process to identify any negative findings. Negative findings will be addressed at the time of discovery and disciplinary action taken as indicated. **Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician will inservice the Food Service Manager and dietary staff on the proper procedure for washing dishes and checking of the fan in the washroom for cleanliness. **Monitoring:** The Food Service Manager is responsible for maintaining compliance. The Food Service manager/designee will complete weekly monitoring of the dishwashing area and process to monitor and maintain compliance. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 12-27-21	

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F 812	Continued From page 17 1, stopped OSM # 2 from drying, provided them with a roll of paper toweling and informed them to use the "One towel" procedure. When asked to describe the "One towel" procedure OSM # 1 stated that they were to use one piece of paper towel for one piece of dish ware each. OSM # 1 was then asked to turn off the fan above the clean dish line. Observation of the fan when it stopped, revealed the fan blades, and the front and back blade guards coated with grey dust and lint. When asked about the fan, OSM # 1 stated that it helped dry the dishes. When asked who was responsible for cleaning the fan and how often it was done OSM # 1 stated that maintenance cleaned the fan. On 11/16/2021 at 10:15 an interview was conducted with OSM # 2, dietary aide. When asked how long they had been working in the dish room and who trained them, OSM # 2 stated that they had started two months ago and was trained by other staff members who worked in the dish room. When informed of the observation of them drying plates and trays with a cloth when the dishes came out dish washer, OSM # 2 stated, "I use one cloth for the dishes and another one to dry the trays." When asked about the "One towel" procedure OSM # 2 stated that they did not know about it until OSM # 1 showed them. When asked about the fan, OSM # 2 stated that it helped dry off the excess water from the dishes and trays. On 11/16/2021 at approximately 2:10 p.m., an interview was conducted with OSM # 3, maintenance director. When asked if they were responsible for cleaning the wall mounted fan in the facility's dish room, OSM # 3 stated that it was not a part of the routine maintenance schedule	F 812		

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F 812	Continued From page 18 but that they [maintenance department] would clean the fan when the kitchen asked. OSM # 3 further stated that if they did repairs on the fan they would clean it at that time. On 11/16/2021 at approximately 3:00 p.m., an interview was conducted with OSM # 1. When asked to describe the correct procedure for drying food trays and dishes after being washed, OSM # 1 stated, "They should be air dried." When asked why they needed to be air dried, OSM # 1 stated, "It doesn't harbor bacteria." When asked to describe the procedure for cleaning the wall mounted fan located in the dish room, OSM # 1 stated, "We don't have a regular schedule. Maintenance will come in and clean when we call them." The facility's policy "American Healthcare Dietary Policy and Procedural Manual" documented in part, "XII. Dishwashing. Procedure: 7. Allow clean dishes to air dry completely before storing." FDA Food Code (U.S. Food and Drug Administartion -2017): Drying 4-901.11 Equipment and Utensils, Air-Drying Required: Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils. 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT	F 812		

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F 812	Continued From page 19 and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 (B) May not be cloth dried except that UTENSILS that have been air-dried may be polished with cloths that are maintained clean and dry. On 11/16/2021 at approximately 5:00 p.m., ASM [administrative staff member] # 1, administrator, ASM # 2, assistant administrator, ASM # 3, director of nursing, ASM # 4, administrator of sister facility and ASM # 5, nurse consultant, were made aware of the above findings. No further information was provided prior to exit.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842	**F842** **Corrective Action(s):** Resident #106's physician has been notified that the resident's clinical record did not accurately reflect the use of a PICO wound vac which was discontinued on 11/12/21. Resident #106's clinical record has been updated with a late entry regarding the incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. The DON and Unit Manager will conduct a 100% review of all resident records to identify residents in the past 30 days who have had inaccurate documentation. All negative findings will be corrected at the time of discovery.	

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F 842	Continued From page 20 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON or regional nurse consultant on clinical documentation standards and maintaining complete and accurate clinical records. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will audit medical records weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 12-27-21	

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F 842	Continued From page 21 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain an accurate clinical record for one of 44 residents in the survey sample, Resident # 106. The facility staff documented on Resident # 106's November 2021 eTAR [electronic treatment administration record] the use of a PICO wound vac [vacuum] [1] that was discontinued on 11/12/2021. The findings include: Resident # 106 was admitted to the facility with diagnoses that included but were not limited to: dementia without complications [2], heart failure, artificial right hip joint. Resident # 106's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/25/2021, coded Resident # 106 as scoring a 3 [three] on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 [three] - being severely impaired of cognition for making daily decisions. The "Wound Evaluation & Management Summary" for Resident # 106 dated, 11/12/2021 documented in part, "Dressing Treatment Plan: Negative pressure wound therapy."	F 842		

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F 842	Continued From page 22 The "Physician's Telephone Order" for Resident # 106 dated "11/15/21" documented, "Cleanse wound to R [right] hip with hibiscus wipe with dampened 4x4 [four by four] gauze, pack wound with black foam. Apply negative pressure therapy run continuous at 120 mmHg [millimeters of mercury]. Change dressing Tues [Tuesday], Friday and PRN [as needed]." The comprehensive care plan for Resident # 106 dated 07/02/2021 documented in part, "Problem/Need: Infection/Wound to R [right] Hip. At risk for pain, odor, and infection due to right hip wound and comorbidities." Under "Approaches" it documented in part, "11/15/21 New wound care order Negative pressure therapy continuously @ [at] 120 mmHg [millimeter of mercury] per order." The eTAR [electronic treatment administration record] dated November 2021 documented, "Check function of PICO vac [vacuum] to R [right] hip. If you have Any concerns or questions please reach out to wound nurse for assistance. Discontinue Date: 11/15/2021." Further review of the eTAR revealed check marks on 11/12/21 at 6:30 a.m., 2:30 p.m. and at 10:30 p.m., on 11/13/21 at at 6:30 a.m., 2:30 p.m. and at 10:30 p.m., on 11/14/21 at 6:30 a.m., 2:30 p.m. and at 10:30 p.m. and on 11/15/21 at 6:30 a.m., 2:30 p.m. and at 10:30 p.m.. On 11/17/2021 at 8:09 a.m., an interview was conducted with LPN [licensed practical nurse] # 2, wound nurse. When asked when the wound vac was started for Resident # 106, LPN # 2 stated that Resident # 106 had the negative wound vac on 11/12/2021. LPN #2 stated the PICO vac [3] was discontinued on the	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495353	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSTONE	900 S MAIN ST BLACKSTONE, VA 23824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 23 11/12/2021. After reviewing the physician's telephone order for Resident # 106's use of the wound vac as listed above, LPN # 2 was asked why the order was dated 11/15/2021 when they stated that the wound vac started on 11/12/2021. LPN # 2 stated, "The order was not written until 11/15/2021." When asked who was responsible for transcribing the order LPN # 2 stated, "I responsible for obtaining the order." After reviewing Resident # 106's eTAR dated November 2021 for the dates list above, LPN # 2 was asked if the documentation was correct or accurate. LPN # 2 stated that the eTAR was not accurate for the dates listed above due to the fact that the PICO was not in use on those dates. On 11/17/2021 at approximately 5:00 p.m., ASM [administrative staff member] # 1, administrator, ASM # 2, assistant administrator, ASM # 3, director of nursing, ASM # 4, administrator of sister facility and ASM # 5, nurse consultant, were made aware of the above findings. No further information was provided prior to exit. References: [1] The PICO* patient/population, intervention, comparison and outcomes] Single Use Negative Pressure Wound Therapy System is indicated for acute and chronic wounds and closed surgical incisions with low to moderate levels of exudate. This single use system is canister-free with a wear time of 7 to 14 days. Approved for both hospital and home care settings. This information was obtained from the website: https://www.woundsource.com/product/pico-single-use-negative-pressure-wound-therapy-system. [2] A loss of brain function that occurs with certain	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495353	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSTONE	900 S MAIN ST BLACKSTONE, VA 23824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 24 diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.	F 842		