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
	495301	A. BUILDING _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL FRONT ROYAL	400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630

(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 9/7/22 through 9/8/22. 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 9/7/22 through 9/8/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 60 bed certified facility was 55 at the time of the survey. The survey sample included 22 current resident reviews and 4 closed record reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain an accurate MDS (minimum data set) assessment for one of 26 residents in the survey sample, Resident # 31. The findings include: The facility staff inaccurately coded two MDS assessments that Resident #31 was receiving	F 641	**F641** **Corrective Action(s):** Resident #31 has had their MDS's (comprehensive with ARD of 7/6//22 & Quarterly with ARD of 4/4/22) corrected to accurately reflect the resident's injection status during the lookback period in Section N – Medications.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Canby, LNHA
TITLE: Administrator
(X6) DATE: 9/21/22

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 641	Continued From page 1 insulin when in fact the resident was not receiving insulin. On the most recent MDS assessment, an annual assessment, with an ARD (assessment reference date) of 7/6/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status), indicting the resident was not cognitively impaired for making daily decisions. In Section N - Medications, Resident #31 was coded as receiving one injection during the last seven days of the look back period. In Section N035- Insulin, the resident was coded as receiving one insulin injection in the past seven days of the look back period. Review of the physician orders dated, 7/23/2021, documented the resident was receiving Trulicity 0.75 mg (milligram) injected once a week on Tuesdays. (Trulicity is used with a diet and exercise program to control blood sugar levels in adults with type 2 diabetes [condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood]. Trulicity is also used to reduce the risk of a heart attack, stroke, or death in adults with type 2 diabetes mellitus who also have heart disease or who are at risk of developing heart disease) (1). The previous MDS assessment, a quarterly assessment, with an ARD of 4/4/2022, Resident #31 was coded in Section N - Medications as having received receiving one injection during the last seven days of the look back period. In Section N035- Insulin, the resident was coded as receiving one insulin injection in the past seven days of the look back period. An interview was conducted with LPN (licensed	F 641	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of all current resident MDS assessments in Section N-Medications will be completed by the MDS Coordinator and/or designee to identify residents at risk. All negative findings will be reported to the MDS department for immediate correction. A correction will be completed for each discrepancy identified on the most current MDS. **Systemic Change(s):** The MDS Coordinator has been inserviced by the Regional Nurse consultant on the proper assessment and coding of all areas of the MDS to include section N – Medications. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of the data in section N. **Monitoring:** The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings 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: 10/20/2022**	

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F 641	Continued From page 2 practical nurse) #3, the MDS coordinator, on 9/8/2022 at 12:52 p.m. The two MDS assessments above were reviewed with LPN #3. When asked if Trulicity is coded as an insulin, LPN #3 stated it was not insulin. LPN #3 stated it is used to treat diabetes but it is not insulin. LPN #3 wanted to review the MDS assessments and the RAI (resident assessment instrument) manual and get back with the survey team. On 9/8/2022 at 1:12 p.m. LPN #3 returned and stated that Trulicity was not insulin and she could not find it in the RAI manual that you can code it as insulin. When asked which reference she uses to complete the MDS assessments, LPN #3 stated she uses the RAI manual. ASM #1 was made aware of the above concern on 9/8/2022 at 2:41 p.m. On 9/8/2022 at 3:06 p.m. ASM (administrative staff member) #1, the administrator, stated Trulicity is not an insulin and should not have been coded as insulin on the MDS. ASM #1 presented a copy from the RAI manual for coding Section N - Medications, Insulin. Trulicity was not referred to in the RAI manual. No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a614047.html	F 641		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		

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F 698	Continued From page 3 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to ensure ongoing communication with the dialysis center for one of 26 residents in the survey sample, Resident #112. The findings include: The facility staff failed to review the dialysis communication book upon return to the facility and failed to ensure the dialysis center documented in the communication book post dialysis for Resident #112. There was no completed MDS (minimum data set) assessment completed for Resident #112 at the time of the survey. The physician orders dated, 9/2/2022, documented in part, "Pre dialysis vitals (blood pressure, temperature, pulse and respirations) Q (every) T - Th - Sat (Tuesday, Thursday, Saturday), complete in dialysis book. Post dialysis vitals Q T-Th-Sat, complete in dialysis book." The baseline care plan dated 9/2/2022, documented in part, "Special Treatments/Procedures: Dialysis Tues (Tuesday) Thurs (Thursday) Sat (Saturday) at 6am (6:00 a.m.) and husband to transport."	F 698	**F698** **Corrective Action(s):** Resident #112's attending physician was notified that the facility failed to ensure ongoing communication with the dialysis center by failing to complete the dialysis communication book. **Identification of Deficient Practices/Corrective Action(s):** All other residents on dialysis may have potentially beenaffected. The DON, and/or Unit Managers will conduct a 100% audit of all residents on dialysis to identify residents at risk. Residents identified at risk will be corrected at time of discovery. **Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The DON will inservice all licensed staff on the policy and procedure for dialysis communication. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will conduct chart audits weekly coinciding with the Care Plan calendar in order to maintain compliance. 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: 10/20/2022**	

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F 698	Continued From page 4	F 698		

On 9/7/2022, a Wednesday, at 3:42 p.m. a request for Resident #112's dialysis communication book was made to LPN (licensed practical nurse) #4. LPN #4 and ASM (administrative staff member) #2, the director of nursing, began looking for the book throughout the nurse's station. LPN #4 asked LPN #5 to call the resident's husband since he transports her to dialysis. LPN #5 found the book in Resident #112's room, in the back of the wheelchair.

The dialysis communication book contained two pieces of paper. One was dated 9/3/2022 and the other dated 9/6/2022. The only documentation on the forms were vital signs taken prior to the resident leaving the facility for dialysis. There was no documentation from the dialysis center.

An interview was conducted with LPN #5 on 9/7/2022 at 3:47 p.m. When asked the process for the nurse when a resident returns from dialysis, LPN #5 stated we check the resident's vital signs, alertness, orientation and see if they have any nausea. LPN #4, who was sitting at the nurse's station, stated "When the resident returns from dialysis we have to see if there are any notes from the dialysis center."

An interview was conducted with LPN #1 on 9/8/2022 at 1:21 p.m. When asked the nurse's responsibilities when a resident returns from dialysis, LPN #1 stated the nurse should get a set of vital signs, check the folder for notes, make sure the resident is stable. When asked if they don't see the communication book, LPN #1 stated they should call the dialysis center.

An interview was conducted with LPN #2, the assistant director of nursing, on 9/8/2022 at 1:29

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F 698	Continued From page 5 p.m. When asked the purpose of the communication book, LPN #2 stated it's to communicate with the dialysis regarding the resident's condition. The facility policy, "Dialysis Protocol" documented in part, "Communication between the dialysis center and nursing staff at (Name of corporation) will be maintained by phone calls and in written form to ensure the most accurate information exchange possible each time a resident goes for treatment. A progress not will be sent with the resident to the dialysis center. The nurse/doctor at the dialysis center will write a progress notes to include the resident's eight pre and post, any blood transfusions, medications given, and any other information that would be necessary for the nursing staff at (name of corporation) to provide safe, quality care of the resident." ASM #1, the administrator, was made aware of the above concern on 9/8/2022 at 2:41 p.m. No further information was obtained prior to exit.	F 698		