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
	495356	A. BUILDING ______ B. WING ______	C 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSBURG	3610 SOUTH MAIN STREET BLACKSBURG, VA 24060

(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 1/16/2023 through 1/19/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Two complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 1/17/23 through 1/19/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two (2) complaints were investigated during the survey: 1. VA00051252 - substantiated with no deficiencies 2. VA00055163 - unsubstantiated The Life Safety Code survey/report will follow. The census in this 179 certified bed facility was 129 at the time of the survey. The survey sample consisted of 26 current resident reviews and 4 closed record reviews.	F 000		
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.	F 812	**F812** **Corrective Action(s):** The facility threw away all out of date milk at time of discovery in Bistro refrigerator, center unit pantry, and Villa unit pantry. Additionally, all other pantry refrigerators were checked and no additional out of date milk was found.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alyma Hamilton	Administrator	2/3/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495356	A. BUILDING ____ B. WING ____	C 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSBURG	3610 SOUTH MAIN STREET BLACKSBURG, VA 24060

(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 812	Continued From page 1 (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 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 and staff interview, the facility staff failed to prepare, distribute, and serve food in a manner that would prevent foodborne illnesses. The Bistro refrigerator and 2 of 3 pantry refrigerators (Center and Villa) contained out of date milk. The findings included: The Bistro refrigerator and the pantry refrigerators on the Center and Villa units were observed to contain out of date milk. 01/17/23, during the initial tour of the facility, the surveyor observed a tray of milk in the Bistro refrigerator with an expiration date of 01/16/23. The Assistant Dietary Manager (ADM) removed the tray of milk from the refrigerator and stated they would dispose of the milk. 01/18/23 3:39 p.m., the pantry refrigerator on the Center unit was observed by the surveyor to contain one carton of frozen milk with an expiration date of 01/16/23. The Villa unit pantry refrigerator contained two cartons of milk with an expiration date of 01/16/23.	F 812	**Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected. The Dietary Manager, and/or Assistant Dietary Manager will complete a 100% audit of all pantry and Bistro refrigerators. Any negative findings will be corrected at the time of discovery and disciplinary action will be taken as needed. **Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The Dietary Manager and/or Dietary Assistant Manager will in-service all dietary staff on the rotation and storage of milk. **Monitoring:** The Dietary Manager is responsible for maintaining compliance. The Dietary manager/designee will complete twice weekly audits of all pantry and bistro refrigerators. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. 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:** **02/22/2023**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495356	A. BUILDING ____ B. WING ____	C 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSBURG	3610 SOUTH MAIN STREET BLACKSBURG, VA 24060

(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 812	Continued From page 2 01/18/23 3:40 p.m., the Director of Nursing (DON) was shown the outdated milk from the pantry refrigerators. 01/18/23 3:41 p.m., rechecked the Bistro refrigerator with the ADM. No out-of-date milk was observed, and the ADM stated if there was outdated milk in the pantry refrigerators the staff were not rotating the milk. 01/18/23 4:33 p.m., the Nurse Consultant, DON, Administrator, and Assistant Administrator, were notified of the expired milk. No further information was provided to the survey team prior to the exit conference.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880	**F880** **Corrective Action(s):** LPN #3 involved in the Treatment Observation for Resident #11 has received one-on-one in-service training on changing gloves and performing hand hygiene after cleaning an open wound and prior to applying a new dressing. A Facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents who receive a dressing change may have potentially been affected. The DON/designee will conduct a 100% audit of all licensed nursing staff to ensure proper infection control practices during a treatment administration procedure. Any negative findings will be addressed immediately and disciplinary action taken as needed. A facility Incident and Accident form will be completed for each negative finding.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495356	A. BUILDING _____ B. WING _____	C 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSBURG	3610 SOUTH MAIN STREET BLACKSBURG, VA 24060

(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 880	Continued From page 3 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880	**Systemic Change(s):** The facility policy and procedures have been reviewed and no changes are warranted at this time. All licensed nurses will be in-serviced on the facility policy and procedure for proper infection control practices during treatment procedures by the DON and/or Regional Nurse Consultant. **Monitoring:** The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will perform 2 random weekly Treatment Pass audits to monitor nursing staff for compliance. Findings of the audits will be reported to the QA Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** **02/22/2023**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495356	A. BUILDING ______ B. WING ______	C 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSBURG	3610 SOUTH MAIN STREET BLACKSBURG, VA 24060

(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 880	Continued From page 4 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and documentation review, the facility staff failed to consistently perform hand hygiene during wound care for one (1) of 26 sampled current residents, Resident #11. The findings include: Licensed Practical Nurse (LPN) #3 failed to change gloves and perform hand hygiene after cleaning an open wound and prior to applying a new dressing/bandage to one of Resident #11's pressure wounds/areas. Resident #11's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/31/22, was dated as completed on 1/3/23. Resident #11 was assessed as able to make self understood and as able to understand others. Resident #11's Brief Interview for Mental Status (BIMS) summary score was documented as a 14 out of 15 (this indicated intact and/or borderline cognition). Resident #11 was assessed as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #11 was assessed as having Stage 2 pressure ulcers present on admission to the facility. The facility's policy titled "Handwashing/Hand Hygiene" (with a revised date of August 2015)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495356	A. BUILDING ______ B. WING ______	C 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSBURG	**3610 SOUTH MAIN STREET BLACKSBURG, VA 24060**

(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 880	Continued From page 5 included the following situations which would indicate the need for hand hygiene/hand washing: - "Before handling clean or soiled dressings, gauze pads, etc." and - "Before moving from a contaminated body site to a clean body site during resident care". On the afternoon of 1/17/23 at approximately 3:00 p.m., a surveyor observed LPN #3 providing wound care to Resident #11's stage 2 pressure ulcer/wound. LPN #3 was observed to clean the open wound/ulcer with gauze and wound cleaner; LPN #3 preceded to apply a new bandage/dressing to the open wound/ulcer. LPN #3 did not change gloves or perform hand hygiene between cleaning the wound/ulcer and applying the new dressing bandage. During an interview on 1/19/23 at 9:36 a.m., LPN #3 reported they should have changed gloves and performed hand hygiene between cleaning Resident #11's open ulcer/wound and applying the new dressing/bandage. On 1/19/23 at 2:08 p.m., the survey team met with the facility's Administrator, Assistant Administrator, Regional Director of Clinical Services, and the Director of Nursing. The observation of LPN #3 failing to change gloves and perform hand hygiene after cleaning an open wound but prior to applying a new dressing/bandage was discussed. The Regional Director of Clinical Services acknowledged that a glove change and hand hygiene should have occurred between cleaning an open wound and applying a new bandage/dressing.	F 880		