STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495135	A. BUILDING ______ B. WING ______	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219

(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 1/25/2023 through 2/1/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Five complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard and abbreviated survey was conducted 1/25/23 through 2/1/23. Five complaints (VA00056322 -Unsubstantiated without deficiency;VA00054878 -Unsubstantiated without deficiency;VA00054786 -Unsubstantiated without deficiency;VA00050852 -Substantiated without deficiency;VA00054373 -Substantiated without deficiency) were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 certified bed facility was 152 at the time of the survey. The survey sample consisted of 31 current resident reviews and 6 closed record reviews.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656	**F 656** **Corrective Action(s):** Resident #43's comprehensive care plan was reviewed and revised to reflect that the resident was receiving Hospice care services. Resident #43 has since passed away.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 02/23/23

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
	495135	A. BUILDING ______ B. WING ______	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219

(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 656	Continued From page 1 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to develop a comprehensive care plan for 1 of 31 residents,	F 656	**Identification of Deficient Practices & Corrective Action(s):** All residents receiving hospice /comfort care may have potentially been affected. A 100% review of comprehensive care plans for all residents receiving hospice/comfort care will be conducted by the DON/designee to identify residents with care plans which may not be up to date. Residents identified without hospice or comfort care, care planned will have their care plan reviewed and updated to reflect their current status. A Facility Incident & Accident Form will be completed for each incident identified. **Systemic Changes:** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development, revision and implementation process of individualized care plans.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495135	A. BUILDING ______ B. WING ______	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219

(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 656	Continued From page 2 Resident #43. The findings included: For Resident #43, the facility staff failed to develop a care plan for hospice services. Resident #43's face sheet listed diagnoses which included but not limited to mood disorder, type 2 diabetes mellitus, chronic obstructive pulmonary disease, and chronic kidney disease. The most recent minimum data set with an assessment reference date of 11/09/22 coded the resident as having both long- and short-term memory problems with severely impaired cognitive skills for daily decision making, in section C, cognitive patterns. Section O, special treatment, procedures and programs, coded the resident as receiving hospice care while a resident at the facility. This is a significant change assessment. Resident #43's comprehensive care plan was reviewed. Surveyor could not locate a hospice care plan. Resident #43's clinical record was reviewed and contained a physician's order summary for January 2023, which read in part "11/04/22 Do Not Transport-Resident admitted to ... (name omitted) hospice services. Surveyor spoke with the registered nurse (RN) #1 on 01/26/23 at 10:40 am. Surveyor asked RN #1 if Resident #43's hospice services should be included on the comprehensive care plan, and RN #1 stated that it should be, and that they thought it was handwritten on the care plan.	F 656	**Monitoring:** The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON / RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 03/16/23**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495135	A. BUILDING ______ B. WING ______	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219

(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 656	Continued From page 3 Surveyor requested and was provided with a copy of the resident's comprehensive care plan. Hospice services were not handwritten onto the care plan. The concern of not developing a hospice care plan was discussed with the administrator, director of nursing and regional nurse consultant on 01/31/23 at 4:30 pm. No further information provided prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657	**F657** **Corrective Action(s):** Resident #79's comprehensive care plan has been reviewed and revised to reflect the resident's stage 4 pressure ulcer. **Identification of Deficient Practices & Corrective Action(s):** All residents with wounds may have potentially been affected. A 100% review of all comprehensive care plans for all residents with wounds will be conducted by the DON /designee to identify residents with inaccurate or incomplete comprehensive care plans. Resident identified at risk will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495135	A. BUILDING ______ B. WING ______	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219

(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 657 Continued From page 4

team after each assessment, including both the comprehensive and quarterly review assessments.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review the facility staff failed to review and revise a care plan for 1 of 31 residents, Resident #79.

The findings included:

For Resident #79 the facility staff failed to review and revise the care plan to include a pressure ulcer.

Resident #79's face sheet listed diagnoses which included but not limited to chronic obstructive pulmonary disease, peripheral vascular disease and atherosclerotic heart disease.

The most recent minimum data set with an assessment reference date of 01/23/23 assigned the resident a brief interview for mental status score of 13 out of 15 in section C, cognitive patterns. Section M, skin conditions, coded the resident as a stage 4 pressure ulcer. Section M of the minimum data set with an assessment reference date of 10/24/22 coded the resident as having a stage 4 pressure ulcer.

Resident #79's comprehensive care plan was reviewed and contained a care plan for "Skin Condition" This care plan has a goal of "will have not skin breakdown noted thru the next 90 days" and has a start date of 10/05/22. The care plan did not include that the resident currently has a stage 4 pressure ulcer.

Surveyor spoke with registered nurse (RN) #1 on 01/26/23 at 10:40 am. Surveyor asked RN #1 is

F 657

Systemic Changes:
The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC, IDT and the DON will be in-serviced by the regional nurse consultant on the development, revision and implementation process of individualized care plans and also on offering resident representatives the opportunity to participate in the care planning process.

Monitoring:
The RCC/DON is responsible for maintaining compliance. The RCC/designee will perform care plan audits weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the RCC for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.

Completion Date: 03/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495135	A. BUILDING ______ B. WING ______	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219

(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 657

Continued From page 5

Resident #79's pressure ulcer should have been included on the care plan, and RN #1 stated "He/she has a pressure ulcer? When did that happen?" Surveyor referred RN #1 to Section M of the minimum data set, and then asked RN #1 if the pressure ulcer should have been included on the care plan, and RN #1 stated that it should have.

The concern of not reviewing and revising the resident's care plan was discussed with the adminstrator, director of nursing, and regional nurse consultant on 01/31/23 at 4:30 pm.

No further information was provided prior to exit.

F 684 SS=D

Quality of Care
CFR(s): 483.25

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review the facility staff failed to provide care and services to meet the needs of the residents for 1 of 31 residents, Resident #43.

The findings included:

For Resident #43, the facility staff failed to follow physician's orders for the administration of the

F684

Corrective Action(s):
Resident #43's attending physician was notified that the facility staff failed to administer the scheduled pain medication Norco as ordered by the physician. A facility Medication Error form was completed for this incident.

Identification of Deficient Practices/Corrective Action(s):
All other residents receiving scheduled pain medication may have potentially been affected. The DON, ADON, and Unit Managers will conduct a 100% audit of all resident's physician ordered scheduled pain medications and MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their attending physicians will be notified of each negative finding and a facility Incident & 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
	495135	A. BUILDING ______ B. WING ______	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219

(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 684	Continued From page 6 pain medication hydrocodone. Resident #43's face sheet listed diagnoses which included but not limited to osteoarthritis, intervertebral disc degeneration, low back pain, and right hip pain. The most recent minimum data set with an assessment reference date of 11/09/22 coded the resident as having both long- and short-term memory problems with severely impaired cognitive skills for daily decision making, in section C, cognitive patterns. Resident #43's comprehensive care plan was reviewed and contained a care plan for " ... is at risk for alteration in comfort r/t (related to) dx (diagnosis): Chronic pain, low back pain, DDD (degenerative disc disease), osteoarthritis, diabetic neuropathy" Resident #43's clinical record was reviewed and contained a physician's order summary for January 2023, which read in part "hydrocodone-acetamin 5-325 mg. Give 1 tablet po (by mouth) q (every) 4 hours. Dx: pain" Resident #43's medication administration record (MAR) for January 2023 was reviewed and contained an entry which read in part, "Hydrocodone-acetamin 5-325 mg. Give 1 tablet po q4 hours. Dx: pain" This entry was coded "N" on 01/21/23 for all scheduled administration times. The notes section on the MAR contained entries, which read in part "11:16 PM, 1/20/23 (Scheduled: 12: 00 AM, 1/21/23; Hydrocodone-acetamin 5-325 mg) Hydrocodone-acetamin 5-325 mg. Give 1 tab ...schedules for 01/21/2023 12:00 AM. On hold	F 684	**Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24-Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and administering physician ordered medications and treatments. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders as ordered by the physician. **Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform weekly MAR to Cart audits coinciding with the care plan calendar to monitor for 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: 3/16/23**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495135	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 02/01/2023
NAME OF PROVIDER OR SUPPLIER: HERITAGE HALL BIG STONE GAP		STREET ADDRESS, CITY, STATE, ZIP CODE: 2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219	

(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 684	Continued From page 7 until available//01/20/2023 11:16 PM", "5:11 AM, 1/21/23 ... Hydrocodone-acetamin 5-325 mg. give 1 tab ...scheduled for 01/21/2023 4:00 AM on hold until available // 01/21/2023 5:11 AM", "10:04 AM ...Hydrocodone-acetamin 5-325 mg ... scheduled for 01/21/2023 8:00 AM was held. On hold as per NP (nurse practitioner) order. Resident denies any c/o (complaints of) at this time. No s/s (signs/symptoms) of distress observed. //01/21/2023 10:04 AM", "12:49 PM, 1/21/23 ...Hydrocodone-acetamin 5-325 mg ... scheduled for 01/21/2023 12:00 PM was held. Held per NP order, awaiting arrival of med from pharmacy. // 01/21/2023 12:49 PM", "5:44 PM, 1/21/23 ...Hydrocodone-acetamin 5-325 mg ... scheduled for 01/21/2023 4:00 PM was held. Held per NP order. // 01/21/2023 5:44 PM", and "10:21 PM 1/21/23 ... Hydrocodone-acetamin 5-325 mg ... was held. Waiting on clarification from pharmacy" Surveyor requested and was provided with a list of medications available in the facility stat supply. This list contained the medication hydrocodone-acetamin 5-325 mg and indicated that 30 tablets were available. Surveyor requested and was provided with a facility policy entitled "Unavailable Medications", which read in part "2. A STAT supply of commonly used medication is maintained in-house for timely initiation of medications" Surveyor spoke with the director of nursing (DON) on 01/31/23 at 2:00 pm. Surveyor asked the DON what "N" on the MAR indicated, and DON stated it meant the medication had not been administered. Surveyor then asked the DON to confirm that hydrocodone was available in the	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495135	A. BUILDING ______ B. WING ______	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219

(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 684	Continued From page 8 facility stat box. DON stated that it was. Surveyor then asked the DON what should have been done in this instance, and DON stated the medication should have been pulled from the stat box and administered as ordered. The concern of not administering Resident #43's medication per the physician's order was discussed with the administrator, director of nursing, and regional nurse consultant on 01/31/23 at 4:30 pm. No further information was provided prior to exit.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced	F 692	**F692** **Corrective Action(s):** Residents #32's attending physician was notified that the facility failed to obtain a diet order targeted to address the clinical condition of the resident. Clarification order for Renal/Carbohydrate Consistent diet Regular texture thin liquids was obtained. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% review of all residents diet orders will be conducted by the DON/Dietary Manager to verify all diet orders address the clinical condition of the resident in conjunction with resident preferences. All negative findings will be corrected at the time of discovery and an Incident & Accident form will be completed for each incident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495135	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219

(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 692	Continued From page 9 by: Based on staff interview, clinical record review and facility document review the facility staff failed to to obtain a diet order targeted to address the clinical condition of the resident for 1 of 31 current residents in the survey sample (Resident #32). Resident #32 was admitted to the facility with diagnoses including hepatorenal syndrome, type 2 diabetes mellitus with diabetic neuropathy, morbid obesity, spinal stenosis without neurogenic caudication, chronic obstructive pulmonary disease. The resident received hemodialysis three times per week. The resident had orders for insulin per sliding scale before meals and at hour of sleep. The surveyor was unable to interview the resident who was out of the facility for hemodialysis three days per week and attended group activities, scheduled smoking opportunities, and a leave of absence. On 1/30/23 the surveyor reviewed the clinical record. Monthly weights documented in the electronic record indicated weights were stable: 10/26/22=250; 11/4/22=250; 12/5/22= 248; 1/5/23= 244. A nursing note dated 12/15/22, documented: consistency of diet to change to regular and leave other mods in place. The surveyor was unable to locate the prior diet order. On 1/30/23 at approximately 2 PM, the unit manager stated there was no diet order in chart(electronic or paper). Admission orders were not in the paper chart.	F 692	**Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. All licensed nurses will be in-serviced by the Register Dictician/DON. The licensed nurses will be in-serviced on all available diets to address the clinical condition of the residents and preferences. **Monitoring:** The DON/Dietary Manager is responsible for maintaining compliance. The Dietary Manager print all diet orders weekly and compare with tray card to verify all ordered diets address the clinical condition of the resident and preferences. Any/all negative findings will be reported to the DON at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: 3/16/23**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495135	A. BUILDING ____ B. WING ____	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219

(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 692	Continued From page 10 The registered dietician (RD) admission nutrition assessment dated 1/9/23 listed Diet: renal mechanical soft and noted that the diet was appropriate. On 1/30/23, the dietary manager told the surveyor the resident was on a regular diet. The director of nursing told the surveyor that the regular diet is the default diet in the facility. In the absence of an order for another diet, the resident's diet would default to regular. On 1/30/23, the surveyor reported to the director of nursing that the resident had no diet order in the record and stated that there was a concern that a resident with renal failure requiring hemodialysis and insulin dependent diabetes mellitus did not have a therapeutic diet order or an assessment that indicated that a therapeutic diet was not beneficial to the resident. The surveyor reported the ongoing concern during a summary meeting that included the administrator and director of nursing on 1/30/23.	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. 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, clinical record review	F 698	F698 **Corrective Action(s):** Residents #32's attending physician was notified that the facility failed to provide ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments. A facility Incident & Accident form was completed for this incident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495135	A. BUILDING ______ B. WING ______	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219

(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 698	Continued From page 11	F 698		

and facility document review the facility staff failed to provide ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility for 1 of 31 current residents in the survey sample (resident 32).

Resident #32 was admitted to the facility with diagnoses including hepatorenal syndrome, type 2 diabetes mellitus wit diabetic neuropathy, morbid obesity, spinal stenosis without neurogenic caudication, chronic obstructive pulmonary disease.

The surveyor was unable to interview the resident who was out of the facility for hemodialysis three days per week and attended group activities, scheduled smoking opportunities, and a leave of absence.

On 1/26/23 the surveyor reviewed the clinical record. Found no evidence in the electronic clinical record or paper record of communication with the hemodialysis center. Nursing notes document the resident leaving and returning from dialysis. There were no notes about condition on leaving and returning. Vital signs were not documented. The surveyor asked the unit manager if there was a record of the resident's condition after dialysis. The unit manager stated there was not a record and remarked that it was difficult to get staff at the dialysis center to give routine condition information to facility nurses.

Monthly weights documented in the electronic record indicated weights were stable:
10/26/22=250; 11/4/22=250; 12/5/22= 248; 1/5/23= 244.

Identification of Deficient Practices & Corrective Action(s):
All other residents receiving dialysis may have potential been affected. 100 % review of residents receiving dialysis will be conducted for assessment prior to and following dialysis treatment. The attending physician will be notified of all negative findings at time of discovery. Incident & Accident form will be completed for each incident.

Systemic Change(s):
The facility Policy and Procedure has been reviewed and no changes are warranted at this time. All licensed nurses will be in-serviced by the DON on the documentation of the residents condition and monitoring for complications before and after dialysis treatments.

Monitoring:
The DON is responsible for maintaining compliance. The DON/designee will review pre and post dialysis documentation weekly. Any/all negative findings will be reported to the DON for corrective action. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice.

Completion Date: 3/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495135	A. BUILDING ______ B. WING ______	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219

(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 698	Continued From page 12 The surveyor discussed the concern with the director of nursing (DON) on 1/26/23. The DON acknowledged the dialysis center staff did not communicate the resident's status after dialysis with facility staff. The concern was reported as a continuing concern during a summary conference that included the director of nursing and administrator on 1/31/23.	F 698		