STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 02/26/2023 through 02/28/2023. Corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The facility was determined to be in compliance with related regulatory requirements. The census in this 120 certified bed facility was 118 at the time of the survey. The survey sample consisted of 24 current Resident reviews and 3 closed record reviews.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to follow physicians orders regarding oxygen therapy for 1 of 24 residents, Resident #34.	F 695	**F695** **Corrective Action(s):** Resident #34's attending physician was notified that the facility failed to follow physician orders regarding oxygen therapy. Resident #34's attending physician assessed and clarified resident's oxygen order. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All residents receiving oxygen therapy may have potentially been affected. A 100% review of all resident's oxygen orders will be conducted by the DON, ADON and/or Unit Manager to identify residents at risk. Residents found to be at risk will be corrected at the time of discovery. A facility Incident & Accident form will be completed for each item discovered.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Derrick B. Ratliff — TITLE: Administrator — (X6) DATE: 3/21/23

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.

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F 695	Continued From page 1 The findings included: Resident #34's clinical record included a physician order for oxygen at 3 liters per minute. The surveyor observed the oxygen to be set at 6 liters per minute. Resident #34's diagnoses included, but were not limited to, obstructive sleep apnea, chronic obstructive pulmonary disease, and anxiety disorder. Section C (cognitive patterns) of Resident #34's significant change minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/09/22 included a brief interview for mental status (BIMS) score of 9 out of a possible 15 points. Section O (special treatments/procedures/programs) was coded to indicate Resident #34 was receiving oxygen therapy. Resident #34's comprehensive care plan included the intervention provide oxygen as ordered. Resident #34's physician orders included an order for oxygen at 3 liters per minute via nasal cannula diagnosis shortness of breath. The order date for the oxygen was documented as 01/09/23. 02/27/23 10:50 a.m., surveyor in room and observed oxygen to be set at 6 liters a minute. Resident stated oxygen should be set at 3 liters a minute. LPN (licensed practical nurse) #2 in room, checked oxygen and stated, they were not aware it was at 6 liters and adjusted the setting to 3 liters a minute.	F 695	**Systemic Change(s):** The facility policy and procedure for Oxygen administration has been reviewed and no changes were warranted at this time. All licensed nursing staff will be in-serviced on the facility policy and procedure for accurate oxygen administration and monitoring per physician order. In-services will include the delivery of oxygen per physician order and the monitoring oxygen flow rates throughout the shift. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or Unit manager will perform daily audits of all residents using oxygen to monitor for compliance. All negative findings will be corrected at time of discovery and appropriate disciplinary action will be taken as needed. All negative findings will reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 4-12-23**	

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F 695	Continued From page 2 02/27/23 4:15 p.m., the Administrator, Director of Nursing, Nurse Consultant #1 and #2, and the Assistant Administrator were made aware of the issue regarding Resident #34's oxygen. 02/28/23 11:05 a.m., Nurse Consultant #1 provided the surveyor with copies of in-service logs and stated they had inserviced 100% of the nursing staff regarding Resident #34's oxygen. No further information was provided to the survey team prior to the exit conference.	F 695		
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 §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	F 842	F842 **Corrective Action(s):** Resident #34's attending physician was notified that facility staff inaccurately documented that they had administered resident #34's medications while resident #34 was in the hospital and not at the facility. A facility Incident & Accident form has been completed for this incident. Resident #118's attending physician was notified that facility staff failed to document a post fall assessment. A facility Incident & Accident form has been 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' medication administration records and residents with falls will be conducted for the last three months by the DON, ADON, and or designee to identify residents at risk. All negative findings will be clarified and/or corrected as applicable at time of discovery. A facility Incident & Accident form will be completed for each negative finding.	

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F 842	Continued From page 3 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 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and	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, Social Services director, Activity Director and dietary manager will be in-serviced by the Regional Nurse Consultant or DON on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include Physician Orders, MAR's, TAR's and departmental notes according to the acceptable professional standards and practices. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or designee will conduct weekly chart audits coinciding with the Care Plan schedule 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: 4-12-23**	

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F 842	Continued From page 4 (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, the facility staff failed to maintain complete and accurate clinical records for 2 of 24 residents, Residents #34 and #118. The findings included: 1. For Resident #34, the facility staff documented they had administered Resident #34's medications. When in fact Resident #34 was in the hospital and not at the facility. Resident #34's diagnoses included, but were not limited to, obstructive sleep apnea, chronic obstructive pulmonary disease, and anxiety disorder. Section C (cognitive patterns) of Resident #34's significant change minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/09/22 included a brief interview for mental status (BIMS) summary score of 9 out of a possible 15 points. Section O (special treatments/procedures/programs) was coded to indicate Resident #34 was receiving oxygen therapy. The clinical record review revealed that Resident #34 had been admitted to the hospital on 11/24/22-12/02/22. Licensed Practical nurses (LPN) #6, #7, and #8 documented they had administered Resident #34's medications on 11/26/22. Registered Nurse (RN) #3, LPN #6, #8, and #9 documented they had administered Resident #34's oxygen after	F 842		

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F 842	Continued From page 5 they had been discharged to the hospital and before returning to the facility. 02/27/23 4:15 p.m., the Administrator, Director of Nursing, Nurse Consultant #1 and #2, and the Assistant Administrator were made aware of the issue regarding Resident #34's clinical record. Nurse Consultant #1 stated the Resident #34's admission was over a weekend, and they were not taken out of the system. No further information was provided to the survey team prior to the exit conference. 2. The facility staff failed to document a post-fall assessment for Resident #118. Resident #118's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 2/9/23, was dated as completed on 2/14/23. Resident #118 was documented as usually able to make self understood and as usually able to understand others. Resident #118's Brief Interview for Mental Status (BIMS) summary score of 12 out of 15; this indicated moderate cognitive impairment. Resident #118 was assessed as requiring limited assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #118 was assessed as having a history of falls without injuries. Resident #118 was care planned for being at risk for falls. The following information was found in a facility document titled "Charting and Documentation" (revised on July 2017): - "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or	F 842		

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F 842	Continued From page 6 psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." - "The following information is to be documented in the resident medical record: a. Objective observations...e. Events, incidents or accidents involving the resident ..." - "Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate." On 2/26/23 at 3:50 p.m., Resident #118 was observed to be setting in the corridor near their room. Facility staff members were observed to be assessing Resident #118 and assisting the resident into a wheelchair via a lifting device. Resident #118 was heard to say they were not having pain after the fall. Review of Resident #118's medical documentation failed to reveal documentation of the resident's aforementioned fall. On 2/28/23 at 8:47 a.m., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) was asked about the absence of documentation of Resident #118's fall which occurred on 2/26/23; the surveyor requested copies of any documentation of the fall. On 2/28/23 at approximated 10:00 a.m., the surveyor interviewed Licensed Practical Nurse (LPN) #18 about Resident #118's fall. LPN #18 stated, at the time they were starting to document the fall, they were called away to care for another resident. LPN #18 confirmed they had not documented the fall. The surveyor was provided a copy of a "LATE ENTRY" note for the 2/26/23	F 842		

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F 842	Continued From page 7 fall; this "LATE ENTRY" note was documented on 2/28/23 at 10:39 a.m. On 2/28/23 at 1:50 p.m., the survey team met with the facility's Administrator, DON, ADON, Infection Preventionist, and Regional Nurse Consultant; the failure of facility staff to document Resident #118's fall and/or post-fall assessment in the clinical record was discussed for a final time.	F 842		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident review, and family interview, the facility staff failed to maintain a clean and homelike environment on 2 of 2 wings. The findings included: 02/26/23 during initial tour of the facility the surveyors identified a pervasive smell of urine throughout the facility. 02/26/23 at approximately 2:50 p.m., during an interview with a family member of a resident of the facility the family member stated the facility always had an odor. 02/27/23 08:45 a.m., Licensed Practical Nurse (LPN) #1 stated the facility had an odor at times. The surveyor again identified a strong odor on the	F 921	F921 **Corrective Action(s):** A 100% review of all residents for incontinence was completed at the time of the report. All residents in need of incontinence care were cleaned and changed at that time. The rooms identified on both wings to have a pervasive smell of urine were deep cleaned by environmental services. The medical director was notified. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residential, and common areas have the potential to be affected. The Environmental Services Director will perform a documented walkthrough inspection of the facility to identify any areas of pervasive odor. The DON, ADON, and/or designee will conduct a 100% audit of all residents to identify residents with incontinence. The residents identified to be incontinent will have their care plan updated to reflect their status. Any/All negative findings will be corrected at the time of the discovery and will be reviewed with the administrator to prioritize areas that are in need, of deep cleaning.	

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F 921	Continued From page 8 C hall of the building. 02/27/23 4:15 p.m., the Administrator, Director of Nursing, Nurse Consultant #1 and #2, and the Assistant Administrator were made aware of the issue regarding odors in the building. 02/28/23 8:35 a.m., Resident Council President stated the facility had an odor occasionally and if it did have one it seemed to be more likely to happen in the evening. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 921	**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 Environmental Services Director will provide inservices to all staff on the procedure for proper notification to use when pervasive odors are noted throughout the facility. The DON, ADON, and/or designee will in-service all licensed nursing staff on addressing episodes of incontinence promptly. **Monitoring:** The DON and Environmental Services Director is responsible for maintaining compliance. The QA Program includes facility audit tools for monitoring compliance. The Environmental Services Director will complete the audit weekly to monitor for 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: 4-12-23**	