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	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hall Front Royal	400 West Strasburg Road Front Royal, VA 22630

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 29125 Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide all required documentation to the receiving facility upon a hospital transfer for one of 20 residents in the survey sample; Resident #11. The findings include: A review of the clinical record revealed a nurse's note dated 3/1/24 documented, Resident voiced increased fatigue, started SQ (subcutaneous) normal saline 0.9% fluids 1000ml (1000 milliliters) bag at 80ml/hr (80 milliliters per hour) in RUQ (right upper quadrant) without difficulties Called NP (nurse practitioner) N/O (new order) Send to ED (emergency department) for further evaluation d/t (due to) hyperkalemia. Voicemail left for emergency contact. No return call at this time. Reported called to (hospital physician). 9-1-1 telephoned EMS (emergency medical services) arrived x2 EMTs (emergency medical technicians) resident transported to (hospital) in stable condition. A physician's progress note dated 3/6/24 documented, Resident seen today for hospital follow up. Resident sent to ED (emergency department) 3/1/24 for Hyperkalemia and acute CKD (chronic kidney disease). Kayexalate (1) given. Resident then transferred to (hospital) ICU (intensive care unit) due to resident becoming lethargic, dizziness and chills Resident stabilized and returned to facility in stable condition Further review of the progress notes failed to reveal any evidence that the comprehensive care plan goals were sent to the hospital with this hospital transfer. A review of the hospital transfer form failed to reveal any evidence that the comprehensive care plan goals were sent. A review of the discharge summary failed to reveal any evidence that the comprehensive care plan goals were sent. A review of the hospital transfer checklist failed to reveal any evidence that the comprehensive care plan goals were sent. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 8:39 AM, an interview was conducted with LPN #1 (Licensed Practical Nurse), who completed the hospital transfer documents. She stated that she did not send the care plan goals. She stated that she does not know if she is supposed to. On 5/15/24 at 8:46 AM, LPN #1 followed up and stated I did not send it and I was supposed to. It will be added to the checklist. The facility policy Transfer or Discharge, Facility-Initiated documented, Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy Information Conveyed to Receiving Provider: 1. Should a resident be transferred or discharged for any reason, the following information is communicated to the receiving facility or provider: .f. Comprehensive care plan goals On 5/15/24 at 1:05 PM, ASM #1 (Administrative Staff Member) the Administrator and ASM #4 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. References: (1) Kayexalate is used to treat hyperkalemia (elevated levels of potassium in the body). Information obtained from https://medlineplus.gov/druginfo/meds/a682108.html

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 29843 Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to develop and/or follow the comprehensive care plan for three of 20 residents in the survey sample, Residents #42 (R42), R14 and R7. The findings include: 1. For R42 the facility staff failed to develop the comprehensive care plan for the use of bed rails. R42 was admitted to the facility with diagnosis that included but was not limited to muscle weakness. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/10/2024, the resident scored two out of 15 on the BIMS (brief interview for mental status), indicating R42 was severely impaired of cognition for making daily decisions. On 05/13/2024 at approximately 7:00 p.m., an observation revealed R42 lying in bed with right and left upper bed rail raised. On 05/14/2024 at approximately 10:14 a.m., an observation revealed R42 lying in bed with right and left upper bed rail raised. The physician's order for R42 dated 07/12/2023 documented in part, May use 1/2 (half) Siderail x 2 (times two) at HOB (head of bed) with bed controls on rails for positioning and support and to promote independence and to assist with defining parameter of the bed for safety awareness. The facility's bed rail assessment for R42 dated 05/07/2024 documented in part, 3. Side rail placement recommendations: b. Left. C. Right. 3a. Side rail placement: a. Side Rail/Assist Bar are indicated and serve as an enabler to promote independence. B. The resident has expressed a desire to have Side Rail/Assist Bar. The facility's Baseline Care Plan for R42 dated 05/26/2023 documented in part, 1/4 (quarter) SIDE RAILS: Yes, 1/2 SR (side rails) x2. Review of the facility's comprehensive care plan for R42 dated 11/11/2023 failed to evidence the use of side rails. On 05/15/2024 at approximately 11:12 a.m., an interview was conducted with LPN (licensed practical nurse) #3, MDS coordinator. After reviewing the comprehensive care plan for R42 dated 11/11/2023 LPN #3 stated that the use of R42's bed rails were not documented on the comprehensive care plan. When asked to describe the process for developing the comprehensive care plan LPN #3 stated that she transfers the information from the baseline care plan to the comprehensive care plan. She further stated that the bed rails were overlooked. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy Care Plans, Comprehensive Person-Centered documented in part, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation. 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. On 05/15/2024 at approximately 1:00 p.m., ASM (administrative staff member) # 1, administrator, ASM #2, administrator-in-training, ASM # 3, regional nurse consultant and ASM #4, director of nursing, were made aware of the above findings. No further information was provided prior to exit. 27660 2. a. For Resident #14, the facility staff failed to implement the comprehensive care plan for monitoring for side effects for the use of Coumadin (Warfarin) (1). The comprehensive care plan dated, 2/13/24, documented, At risk for bleeding/bruising d/t (due to) Anticoagulation Therapy r/t (related to) Chronic AFIB (atrial fibrillation). The Interventions documented, Evaluate for blood in stools. Evaluate for bruising. Evaluate for hematuria. Evaluate for signs and symptoms of bleeding. Mediation per MD (medical doctor) order. Monitor laboratory results per MD order. Notify MD prn (as needed). The physician order dated, 3/11/24, documented, Warfarin Sodium Oral Tablet 2.5 mg; Give 2.5 mg (milligrams) by mouth in evening for AFIB. Review of the nurse's notes failed to evidence documentation of monitoring for side effects of the Coumadin. An interview was conducted with LPN (licensed practical nurse) #2, on 5/15/24 at 10:13 a.m. When asked the purpose of the care plan, LPN #2 stated, it gives the staff guidance as to the history of the resident. It gives them a guideline to their orientation, fall history, their preferences, diet. Basically, it's how we take care of them. When asked if a resident is on an anticoagulant, is there anything the nurse should be doing, LPN #2 stated, they have to observe for skin issues related to bleeding, check the MD orders, when laboratory test results come back, notify the doctor. When asked where you evidence the no monitoring of the resident for side effects of the anticoagulant, LPN #2 stated, that she was aware of there isn't a specific area to document it. If there is a bruise, they make a note of it, notify the nurse practitioner, and monitor the area. LPN #2 stated the CNAs (certified nursing assistants) report to us if the resident has any changes in the stool or urine. LPN #2 stated, I guess we need to have one of the orders that should monitor so we can document it. ASM (administrative staff member) #1, the administrator, ASM #2, the administrator in training, ASM #3, the regional nurse consultant, ASM #4, the director of nursing, and LPN #4, the assistant director of nursing, were made aware of the above concern on 5/15/24 at 12:57 p.m. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit. (1) Warfarin is used to prevent blood clots from forming or growing larger in your blood and blood vessels. It is prescribed for people with certain types of irregular heartbeat, people with prosthetic (replacement or mechanical) heart valves, and people who have suffered a heart attack. Warfarin is also used to treat or prevent venous thrombosis (swelling and blood clot in a vein) and pulmonary embolism (a blood clot in the lung). Warfarin is in a class of medications called anticoagulants ('blood thinners'). It works by decreasing the clotting ability of the blood. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682277.html. 2 b. For Resident #14, the facility staff failed to develop a care plan for antibiotic use for an upper respiratory infection (URI). The physician order dated, 5/9/24, documented, Doxycycline Mono 100 mg cap (capsule)(an antibiotic): Give 1 capsule orally two times a day for URI for 10 days. The CXR (chest x-ray) completed 5/7/24 - Impression: Very mild bilateral lower lung airspace disease, possible atelectasis, though concerning for pneumonia in the clinical setting of infection. The comprehensive care plan, last updated 4/26/24, was reviewed. There was no documentation related to the respiratory illness and the use of an antibiotic. An interview was conducted with LPN #3 on 5/15/24 at 11:07 a.m. When asked who updates the care plans, LPN #3 stated she was responsible for that. LPN #3 was asked if a resident was on an antibiotic for an upper respiratory infection, should there be a care plan for that, LPN #3 stated, there should be. She stated she had made herself a note to develop one for Resident #14 but thought she had care planned it but didn't. ASM (administrative staff member) #1, the administrator, ASM #2, the administrator in training, ASM #3, the regional nurse consultant, ASM #4, the director of nursing, and LPN #4, the assistant director of nursing, were made aware of the above concern on 5/15/24 at 12:57 p.m. No further information was provided prior to exit.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 27660 Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to evidence the monitoring of side effects for the use of an anticoagulant for two of 20 residents in the survey sample, Residents #7 and #14. The findings include: 1. For Resident #7, the facility staff failed to evidence the monitoring of side effects for the use of Xarelto (Rivaroxaban) (1) On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/29/24, the resident scored a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired for making daily decisions. In Section N - Medications, the resident was coded as receiving an anticoagulant while a resident at the facility. The physician orders dated, 2/3/24, documented, Xarelto Oral Tablet (Rivaroxaban) 15 mg (milligrams); Give 1 tablet my mouth one time a day for afib (atrial fibrillation). The comprehensive care plan dated, 2/13/24, documented, At risk for bleeding/bruising d/t (due to) Anticoagulation Therapy r/t (related to) Chronic AFIB. The Interventions documented, Evaluate for blood in stools. Evaluate for bruising. Evaluate for hematuria. Evaluate for signs and symptoms of bleeding. Mediation per MD (medical doctor) order. Monitor laboratory results per MD order. Notify MD prn (as needed). An interview was conducted with LPN (licensed practical nurse) #2, on 5/15/24 at 10:13 a.m. When asked if a resident is on an anticoagulant, is there anything the nurse should be doing, LPN #2 stated, they must observe for skin issues related to bleeding, check the MD orders, when laboratory test results come back, notify the doctor. When asked where you evidence the no monitoring of the resident for side effects of the anticoagulant, LPN #2 stated, that she was aware of there isn't a specific area to document it. If there is a bruise, they make a note of it, notify the nurse practitioner, and monitor the area. LPN #2 stated the CNAs (certified nursing assistants) report to us if the resident has any changes in the stool or urine. LPN #2 stated, I guess we need to have one of the orders that should monitor so we can document it. The facility policy, Medication Therapy documented in part, 3. All medication orders will be supported by appropriate care processes and practices. ASM (administrative staff member) #1, the administrator, ASM #2, the administrator in training, ASM #3, the regional nurse consultant, ASM #4, the director of nursing, and LPN #4, the assistant director of nursing, were made aware of the above concern on 5/15/24 at 12:57 p.m. No further information was provided prior to exit. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) Rivaroxaban is used to treat deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in adults. Rivaroxaban is also used to prevent DVT and PE from happening again after initial treatment is completed in adults. It is also used to help prevent strokes or serious blood clots in adults who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body, and possibly causing strokes) that is not caused by heart valve disease. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a611049.html. 2. For Resident #14, the facility staff failed to evidence the monitoring of side effects for the use of Coumadin (Warfarin) (2). On the most recent MDS assessment, a end of therapy assessment, with an assessment reference date of 4/25/24, the resident scored a 15 out of 15 on the BIMS score, indicating the resident was not cognitively impaired for making daily decisions. In Section N - Medications, the resident was coded as receiving an anticoagulant while a resident at the facility. The physician order dated, 3/11/24, documented, Warfarin Sodium Oral Tablet 2.5 mg; Give 2.5 mg by mouth in evening for AFIB. Review of the nurse's notes failed to evidence documentation of monitoring for side effects of the Coumadin. The comprehensive care plan dated, 2/13/24, documented, At risk for bleeding/bruising d/t (due to) Anticoagulation Therapy r/t (related to) Chronic AFIB. The Interventions documented, Evaluate for blood in stools. Evaluate for bruising. Evaluate for hematuria. Evaluate for signs and symptoms of bleeding. Mediation per MD (medical doctor) order. Monitor laboratory results per MD order. Notify MD prn (as needed). An interview was conducted with LPN (licensed practical nurse) #2, on 5/15/24 at 10:13 a.m. When asked if a resident is on an anticoagulant, is there anything the nurse should be doing, LPN #2 stated, they have to observe for skin issues related to bleeding, check the MD orders, when laboratory test results come back, notify the doctor. When asked where you evidence the no monitoring of the resident for side effects of the anticoagulant, LPN #2 stated, that she was aware of there isn't a specific area to document it. If there is a bruise, they make a note of it, notify the nurse practitioner, and monitor the area. LPN #2 stated the CNAs (certified nursing assistants) report to us if the resident has any changes in the stool or urine. LPN #2 stated, I guess we need to have one of the orders that should monitor so we can document it. ASM (administrative staff member) #1, the administrator, ASM #2, the administrator in training, ASM #3, the regional nurse consultant, ASM #4, the director of nursing, and LPN #4, the assistant director of nursing, were made aware of the above concern on 5/15/24 at 12:57 p.m. No further information was provided prior to exit. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(2) Warfarin is used to prevent blood clots from forming or growing larger in your blood and blood vessels. It is prescribed for people with certain types of irregular heartbeat, people with prosthetic (replacement or mechanical) heart valves, and people who have suffered a heart attack. Warfarin is also used to treat or prevent venous thrombosis (swelling and blood clot in a vein) and pulmonary embolism (a blood clot in the lung). Warfarin is in a class of medications called anticoagulants ('blood thinners'). It works by decreasing the clotting ability of the blood. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682277.html.