PRINTED: 04/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				0.0938-039	
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#### F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid standard survey was conducted 4/12/16 through 4/14/16. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 97 certified bed facility was 84 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents #1-14) and 3 closed record reviews (Residents #15-17).

F 242 483.15(b) SELF-DETERMINATION - RIGHT TO SS=D MAKE CHOICES

The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview and clinical record review, it was determined the facility staff failed to provide 1 of 17 residents with their preference in food choices (Resident # 7.)

Findings;

Resident #7 was admitted to the facility on 8/14/15. Her diagnoses included anemia, congestive heart failure, hypertension and

# F242

### F 242 Corrective Action(s):

Resident #7's current Dietary Orders have been reviewed by the dietician to determine her current dietary needs. The Dietary Manager has met with resident #7 and her RP to determine the resident's individual food preferences. The comprehensive care plan has been revised and updated to reflect the current resident specific needs and approaches to meet her medical and dietary needs.

#### Identification of Deficient Practice(s):

All other residents may have potentially been affected. The Dietary Manager will review 100% of resident diet orders to ensure they contain the individual food preferences for each resident. Any/all negative findings identified will be corrected and time of discovery by the dietary manager Risk Management Incident Accident Forms will be completed for each.

#### Systemic Change(s):

Review of current policy and procedure. No changes warranted at this time. All staff will be inserviced by the Social service director and/or Director of Nursing on Residents Rights and Accommodation of Needs to include the resident's right to choose and direct their routine care. Specifically the right to make individual choices regarding their food preferences at all meals.

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

any deficiency statement ending with an asterisk (\*) benotes 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 242 Continued From page 1

dementia. The resident's clinical record was reviewed on 4/13/16 at 9:00 AM.

The latest MDS (minimum data set assessment) dated 2/2/16 coded the resident with significant cognitive impairment. She relied on staff assistance for all the ADLs (activities of daily living) but was observed to feed herself with encouragement from staff.

The resident's CCP (comprehensive care plan) updated on 2/3/16 documented nutritional requirements as "needs assistance with meal.....diet supplements as ordered, consults as needed, substitute food of equal value for foods refused or uneaten, learn preferences, assist with meals as needed.....restorative dining as ordered."

Weight records were reviewed. Between 8/14/15 and 11/4/15 the resident lost 45.5 lbs., or 29% of her body weight. Diet supplements and other interventions were provided and the resident has since regained 14.9 lbs.

On 4/13/14 at 8:15 AM the resident was observed eating breakfast in her bed unassisted. The resident was positioned badly and slumped nearly under the bed tray so it was just at the level of her mouth. She was still getting Rice Krispies to her mouth, but could not reach her milk--which was on the far side of the tray.

The surveyor stepped out of the room and spoke to RN I about the resident's positioning and her ability to eat independently. RN I stated, "She needs help to eat."

CNA I came into the room to reposition the

### F 242 Monitoring:

The Dietary Manager is responsible for maintaining compliance. The Dietary manager will audit each resident's dietary orders and dietary card weekly to ensure it is accurate and contains like and dislikes weekly coinciding with the care plan schedule. All negative findings will be corrected at time of discovery and reported to the Risk Management Committee for review. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice.

Completion Date: May 20, 2016

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F 242	appropriate position	her to eat. Once in the n, upright and comfortable the peat more of her food with the	F 24	42	
		riewed for the resident's likes sident did not have any coffee			

on her tray, but had a biscuit drenched with gravy on her plate and a creamsicle magic cup on the tray. The CNA assisted the resident to eat her food—the resident turned down the biscuit and gravy, wrinkling up her nose and had the same reaction to the magic cup.

CNA I was asked how often she fed the resident

CNA I was asked how often she fed the resident and she said, "Pretty much every day." She doesn't like those magic cups- she prefers the butter-pecan kind. She doesn't like gravy much any more either—when she first got here, that's all she would eat. I guess she is sick of it."

The CNA never noticed the resident did not have coffee on her tray.

On 4/13/16 3:20 PM the surveyor spoke to the DM I (dietary manager) about Resident #7's food choices and preferences. The DM I stated, "She should get coffee. I'll have the gravy put on the side of her tray so she can eat it or not." The DM also said she would change the magic cup to butter pecan immediately.

DM I stated, "We change these things immediately when we're told of them. This is the first I've heard of this. I will take care of it."

The DON and administrator were informed of the findings on 4/14/16 at 12:45 PM.

Facility ID: VA0119

If continuation sheet Page 3 of 4D

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F 280 Continued From page 3

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO

SS=D PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs. and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced bγ:

Based on staff interview and clinical record review, facility staff failed to update the resident's comprehensive care plan to reflect significant weight loss for 1 of 17 residents in the survey sample (Resident #8).

Resident #8 was admitted to the facility 11/27/15 with diagnoses including cardiopulmonary disease, dementia, cerebrovascular accident. anxiety, and depression. On the minimum data set assessment(MDS) dated 3/10/16, the resident was assessed with short- and long-term memory

F 280 Corrective Action(s):

F 280 Resident 8's comprehensive care plan has been revised to reflect the resident's significant weight loss and the current needs and interventions to be used to prevent further weight loss. A Facility Incident & Accident Form was completed for this incident.

#### Identification of Deficient Practices & Corrective Action(s):

All other residents with significant weight loss may have potentially been affected. A 100% review of all comprehensive care plans for residents with significant weight loss will be conducted by the RCC's and/or designee to identify residents at risk. Residents identified at risk will have their comprehensive care plans updated and revised to reflect their currents needs and interventions to meet their resident specific care needs to prevent or minimize any further weight loss. A facility Incident & Accident Form will be completed for each incident identified.

#### Systemic Changes:

The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process and the interdisciplinary team is responsible for managing the process. 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 Regional Nurse Consultant will provide in-services to the RCC and care plan team on the mandate to develop individualized care plans within 7 days of the completion and/or revisions to the comprehensive assessment and as indicated with any changes in condition.

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### F 280 Continued From page 4

deficits and impaired ability in daily decision-making. The resident was assessed wilh inattention, and occasional rejection of care. The resident was coded at K0300 Weight Loss with loss of 5% or more in the last month or 10% or more in the last 6 months 2=yes, not on physician prescribed weight-loss regimen.

The comprehensive care plan updated 3/11/16 documented: Problem onset 3/11/16 Nutritional status: (Resident #8) feeds self with staff assist at limes, he has no teeth or dentures, no chewing or swallowing problems noted at this time, Dx GERD (gastroesophageal reflux disease); Goal & Target date \*(Resident #8) will have adequate nutrition/hydration and maintain his weight thru the next 90 days. These were the same problem/ need and goal documented on the admission care plan. The approaches and interventions were unchanged from approaches on the admission assessment. On 4/13/16, the MDS nurse, asked about the care plan not addressing significant weight loss, stated that it might have been updated the day before in "weight meeting". A handwritten addition to the 3/11 care plan-3/2016 WT(down) 14.6 (pounds) 90 d (days) MD (medical doctor) and RP (responsible party) notified- indicated that weight loss had been noled on an undocumented date in March 2016,

Dietary progress notes documented significant weight loss on 1/12/16, 2/16/16, 3/15/16, and 4/12/16. The resident's "Nutrition Care Quarterly Follow-Up 3.0" dated 3/8/16 documented, under weight loss K0300 "no or unknown".

On 4/13/16 at a around 10:30 AM, the surveyor observed the resident and a CNA discussing lunch. The CNA stated that there would be

#### Monitoring:

F 280 The RCC and DON will be responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization coinciding with the care plan schedule. Any/all negative findings will be reported to the DON and 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.

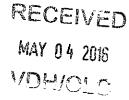
Completion Date: May 20, 2016

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: 93CB11

Facility IO: VA0119

If continuation sheet Page 5 of 40



### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 280	eat hamburgers. Thim something else surveyor observed meal tray that include surveyor asked if he and he stated he did resident's nurse state of snacks".  The resident's Meal lunch %eaten docur The surveyor did no	ch. The resident said he didn't he CNA said they could get. At approximately 12 PM, the the resident in his room with a ded a hamburger. The e was going to eat his lunch dh't like hamburgers. The ted that the resident "ate a lot.  Intake Roster for 4/13/16 mented Refused- notify nurse.	F 28	30	
SS=D	notified of the concer concern was discuss 4/14/16. 483.25 PROVIDE C. HIGHEST WELL BE Each resident must provide the necessar or maintain the higher mental, and psychos accordance with the and plan of care.  This REQUIREMENT by: Based on staff interview, it was determined to follow physicials.	receive and the facility must ry care and services to attain est practicable physical,	F <sup>-</sup> 30	Corrective Action(s): Resident #4's attending physicia facility failed to notify the attending ain of 2 pounds or more in a da pounds or more in a week. A factorm was completed for this incidentification of Deficient Practical All other residents with physicial monitoring may have been potent ADON, and Unit Managers will resident's physician orders and Mordered weight monitoring to ide Residents identified at risk will be discovery and their comprehensing reflect their resident specific need physicians will be notified of each	ding physician of a weight ay or a weight gain of 5 cility Incident and Accident ident.  ctices/Corrective Action(s): an ordered weight intially affected. The DON, conduct a 100% audit of all MAR's that have physician entify resident at risk, be corrected at time of ive plans of care updated to eds. The attending

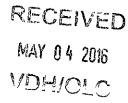
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NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL WISE  (A) ID PREFIX (A) DESCRIPTION MIST BE PRECEDED BY FULL REGULATORY OR I.S.C (IDENTIFYING INFORMATION)  F 309 Continued From page 6  The Findings Included: For Resident #4 the facility staff failed to follow the physician order for the facility staff to notify the physician if Resident #4's weight was greater than 2 pounds in a day or 5 pounds in a week. Resident #4's weight was greater than 2 pounds in a day or 5 pounds in a week. Resident #4's seniculed, but were not limited to: weakness, myocardial infarction, fall with nib fractures, congestive heart failure, anxiety, osteoprosis, chronic obstructive pulmonary disease, diabetes mellitus and atrial fibrillation.  The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment reference Date (ARD) of 3/22/18. The facility staff also coded that Resident #4's cognitive with a staff coded that Resident #4 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #4's cognitive and a 12-25 pm. the surveyor reviewed Resident #4's cognitive and physician orders included, but were not limited to: "Daily keight. Notify MD if > (greater than) 2 lbs (pounds) in one day of 5 bis in 1 week." (sic) Continued review of the clinical record. The weight record documented the following weights: 2/20/16 133.0 pounds  2/21/16 133.0 pounds  2/21/16 133.0 pounds  2/21/16 133.0 pounds						
HERITAGE HALL WISE  (X41 ID SUMMARY STATEMENT OF BEFICIENCIES PREFERENCE OF STREET ADDRESS, CITY, STATE, ZIP CODE 9434 COEBURN MOUNTAIN ROAD WISE, VA 24293  F 309 Continued From page 6 The Findings Included: For Resident #4 the facility staff failed to follow the physician order for the facility staff to notify the physician if Resident #4 is weight was greater than 2 pounds in a day or 5 pounds in a week. Resident #4 was an 80 year old female who was originally admitted on 12/fs/15 and readmitted on 2/g/16. Admitting diagnoses included, but were not limited to: weakness, mycardial infarction, fall with rib fractures, congestive heart failure, anxiety, osteoporosis, chronic obstructive pulmonary disease, diabetes mellitus and attral fibrillation.  The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment reference Date (ARD) of 3/22/16. The facility staff coded that Resident #4 and a Cognitive Summary Score of 15. The facility staff also coded that Resident #4 are quired extensive (3/3) to total nursing care (4/3) with Activities of Daily Living (ADL's).  On April 13, 2016 at 12:25 p.m. the surveyor reviewed Resident #4 significant fecord. Review of the clinical record revealed signed physician orders included, but were not limited to: "Daily weight. Notify MD if > (greater than) 2 los (pounds) in one day or 5 lbs in 1 week." (sic)  Continued review of the clinical record. The weight record documented the following weights: 2/20/16 133.0 pounds  2/21/16 133.0 pounds				B. WING		04/14/2016
WISE, VA 24293  (X4 ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX FAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 309 Continued From page 6  The Findings Included: For Resident #4 the facility staff failed to follow the physicians order for the facility staff to notify the physician in a day or 5 pounds in a week. Resident #4 was an 80 year old female who was originally admitted on 12/16/15 and readmitted on 2/9/16. Admitting diagnoses included, but were not limited to: weakness, myocardial infarction, fall with in fractures, congestive heart failure, anxiety, osteoporosis, chronic obstructive pulmonary disease, diabetes mellitus and atrial fibrillation.  The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment reference Date (ARD) of 30/21/6. The facility staff cload that Resident #4 required extensive (3/3) to total nursing care (4/3) with Activities of Daily Living (ADL's).  On April 13, 2016 at 12:25 p.m. the surveyor reviewed Resident #4's slinical record. Review of the clinical record revealed signed physician orders included, but were not limited to: "Daily weight. Notify MD if 's (greater than) 2 bis (pounds) in one day or 5 bis in 1 week." (sic) Continued review of the clinical record produced Resident #4's weight record. The weight record documented the following weights: 2/20/16 133.0 pounds 2/2/1/6 130.0 pounds 2/2/16 131.0 pounds	NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
(XA) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY OF LIST DEFICIENCY.  F 309  Systemic Change(s): Facility policy and procedures have been reviewed. No revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record and policy of the provision of early which includes, obtaining, transcribing, and completing physician orders are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record and physician orders are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record and physician orders to the development and documentation in the medical record and physician orders to consult the process as eviden	HERITA	CE HALL WISE		-	9434 COEBURN MOUNTAIN ROAD	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION!  F 309 Continued From page 6 The Findings Included: For Resident #4 the facility staff failed to follow the physicians order for the facility staff to notify the physician if Resident #4's weight was greater than 2 pounds in a day or 5 pounds in a week. Resident #4 was an 80 year old female who was originally admitted on 12/16/15 and readmitted on 2/9/16. Admitting diagnoses included, but were not limited to: weakness, myocardial infarction, fall with rib fractures, congestive heart failure, anxiety, osteoporosis, chronic obstructive pulmonary disease, diabetes mellitus and atrial fibrillation.  The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment reference Date (ARD) of 3/22/16. The facility staff coded that Resident #4 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #4 required extensive (3/3) to total nursing care (4/3) with Activities of Dally Living (ADL's).  On April 13, 20/16 at 12/25 p.m. the surveyor reviewed Resident #4's clinical record. Review of the clinical record revealed signed physician orders included, but were not limited to: "Dally weight Notify MD if 2 (greater than) 2 lbs (pounds) in one day or 5 lbs in 1 week." (sic) Continued review of the clinical record. The weight record documented the following weights: 22/2/16 133.0 pounds 2/2/2/16 133.0 pounds	I I LIVITOS	3E NALL 1110L			WISE, VA 24293	
The Findings Included: For Resident #4 the facility staff failed to follow the physicians order for the facility staff to notify the physician if Resident #4's weight was greater than 2 pounds in a week. Resident #4 was an 80 year pld female who was originally admitted on 12/16/15 and readmitted on 2/9/16. Admitting diagnoses included, but were not limited to: weakness, myocardial infarction, fall with rib fractures, congestive heart failure, anxiety, osteoporosis, chronic obstructive pulmonary disease, diabetes mellitus and atrial fibrillation.  The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment reference Date (ARD) of 3/22/16. The facility staff coded that Resident #4 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #4 required extensive (3/3) to total nursing care (4/3) with Activities of Daily Living (ADL's). On April 13, 2016 at 12:25 p.m. the surveyor reviewed Resident #4's clinical record. Review of the clinical record revealed signed physician orders included, but were not limited to: "Daily weight Notify MD if > (greater than) 2 lbs (pounds) in one day or 5 lbs in 1 week." (sic) Continued review of the clinical record produced Resident #4's weight record. The weight record documented the following weights: 2/20/16 133.0 pounds 2/22/16 130, pounds	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLÉTION
		The Findings Include For Resident #4 the the physicians order the physician if Resistan 2 pounds in a congression of Resident #4 was an originally admitted on 2/9/16. Admitting dia not limited to: weaker fall with rib fractures anxiety, osteoporosis pulmonary disease, of fibrillation. The most current Millocated in the clinical assessment with an acceptable (ARD) of 3/22/16. The Resident #4 had a Constant of Daily On April 13, 2016 at reviewed Resident #4 the clinical record revorders dated 3/21/16 included, but were not Notify MD if > (greated day or 5 lbs in 1 weeld Continued review of the Resident #4's weight documented the follow 2/20/16 133.0 pounds 2/21/16 130.0 pounds 2/21/16 120.0 pounds 2/21/16 130.0 pounds 2/21/16 130.0 pounds 2/21/16 120.0 pounds 2/21/21/20 120.0 pounds 2/21/21/20 2/21/20 2/21/20 2/21/20 2	ded: e facility staff failed to follow er for the facility staff to notify sident #4's weight was greater day or 5 pounds in a week. In 80 year old female who was on 12/16/15 and readmitted on iagnoses included, but were ness, myocardial infarction, is, congestive heart failure, is, chronic obstructive diabetes mellitus and atrial inimum Data Set (MDS) al record was a Quarterly MDS Assessment reference Date The facility staff coded that Cognitive Summary Score of falso coded that Resident #4 3/3) to total nursing care (4/3) by Living (ADL's). 12:25 p.m. the surveyor 4's clinical record. Review of evealed signed physician of Signed physician orders of limited to: "Daily weight. er than) 2 lbs (pounds) in one ek." (sic) the clinical record produced the record. The weight record owing weights: ls ls ls ls	F 30	Systemic Change(s): Facility policy and procedures have been revisions are warranted at this time. The process as evidenced by the 24 Hour Rep documentation in the medical record and remains the source document for the deve monitoring of the provision of care, whice obtaining, transcribing and completing plainclude weight monitoring. The DON and consultant will inservice all licensed staff for obtaining, transcribing, and completing ordered medication and treatment orders.  Monitoring: The DON is responsible for maintaining and DON and/or Unit Managers will audit/recorders and MAR's & TAR's weekly to maintain to compliance. Any all negative findings and corrected at time of discovery and discipling taken as needed. Aggregate findings of the reported to the Quality Assurance Committee, analysis, and recommendations for policy, procedure, and/or practice.	nursing assessment port and physician orders elopment and the includes, hysician orders to d/or Regional nurse on the procedure ag physician compliance. The view all physician monitor for d or errors will be linary action will be hese audits will be elittee quarterly for

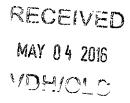
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Continued review of the clinical record produced the nurses' notes and February and March 2016

Event ID:93CBtt

Facility ID: VA0119

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		495350	B. WING			0.	4/14/2016
NAME OF	PROVIDER OR SUPPLIER		·	ST	REET ADDRESS. CITY, STATE, ZIP CODE		171472010
HERITA	GE HALL WISE				34 COEBURN MOUNTAIN ROAD ISE, VA 24293		
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F 309	Continued From pa	ge 7	F:	309			
	Medication Adminis	tration Records (MAR's). The					
		h 2016 MAR's documented nts. Review of the nursing					
	notes and February	and March 2016 MAR's failed					
		e physician was notified of and weight gain from 2/20/16					
	through 2/21/16, the	e 8 pound weight loss from					
	2/22/16 through 2/2 gain from 2/27/16 th	7/16 and the 8 pound weight rough 3/8/16.					
		: 2:05 p.m. the surveyor					
		rse, who was a Licensed N), that the physician had not					
		ered regarding Resident #4's					ļ
		ght loss. The surveyor I record with the MDS Nurse					
		or reviewed the signed					
		ets, weight record, nursing and March 2016 MAR's with					
	the MDS Nurse (LPI	N). The surveyor pointed out					
		n order for the nursing staff to of a greater than 2 pound					
	weight gain in a day	or 5 pounds in a week. The					
		t that documentation could clinical record that the facility					
	staff notified the phy-	sician regarding Resident					
		he MDS Nurse (LPN) record and was unable to					
	locate documentatio	n that the facility staff notified					
	the physician of Res	ident #4's weight gains.					j
	On April 14, 2016 at	12:30 p.m. the survey team					

met with the Administrator (Adm), Director of Nursing (DON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to follow physician orders for Resident #4. The surveyor notified the AT Resident #4 had a physician order for daily weights and to notify the physician of a

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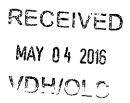
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		495350	B. WING		04/14/2016
	PROVIDER OR SUPPLIER GE HALL WISE			STREET ADDRESS, CITY, STATE, ZIP CO 9434 COEBURN MOUNTAIN ROAD WISE, VA 24293	DDE
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	greater than 2 pound 5 pound weight gair notified the AT that I weight gain from 2/2 surveyor notified the not notified as order  No additional inform exiting the facility as to follow physician of 483.25(a)(2) TREAT IMPROVE/MAINTAL A resident is given the services to maintain	d weight gain in a day or of a in a week. The surveyor Resident #4 had an 8 pound 27/16 through 3/8/16. The AT that the physician was red by the physician.  Tation was provided prior to a to why the facility staff failed orders for Resident #4.	F 3		
	This REQUIREMEN' by: Based on observation record review it was failed to provide physicare for 4 of 17 resident.)  Findings:  1. Resident #2 was a	T is not met as evidenced on, staff interview and clinical determined the facility staff sician ordered, restorative lents (Residents #2, 7,14 and admitted to the facility on		Corrective Action(s): Residents #2, #7, #11 and #14 have nursing and therapy department and programs have been reviewed and/current ADL and ROM status and needed to maintain or improve the abilities. Their comprehensive care to reflect their current ADL and Roman restorative nursing programs.  Identification of Deficient Practical Action(s):	d their restorative nursing /or revised to reflect their any current interventions ir current functional e plans have been revised OM status to include any
-	6/19/13. Her diagnos failure, hypertension, diabetes, anxiety, chr disease and muscle value resident's MDS (3/17/16 coded the resunimpaired. She requ	es included congestive heart peripheral vascular disease, conic obstructive pulmonary wasting and atrophy.  minimum data set) dated		Action(s): All other residents receiving restormay have potentially been affected Program manager and/or designee on a restorative nursing program to interventions are in place to meet the needs and that the program is being order. The residents comprehensive revised to reflect their current need their current ADL and ROM level	d. The DON, Therapy will review each resident o ensure that appropriate their resident specific g delivered per physician re care plans will be ds to promote or maintain

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Facility ID: VA0119

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### F 311 Continued From page 9

exception of eating--which required only set-up assistance.

The CCP, updated 3/18/16, presented the problem, "requires assist with ADL's and transfers......She has diagnosis: muscle disuse atrophy and lack of coordination." The interventions included PT/OT/ST/Restorative nursing as ordered.

The physician's orders, signed 3/17/15, contained an order for "Restorative nursing 6 x wk for UE (upper extremity) & LE (lower extremities) exercises - 2 x 15 rep(ititions.)

The restorative records were reviewed from January 1st until present. Restorative exercises had been provided by the RCNA (restorative certified nursing assistant) on 16 occasions in three and a half months.

On 4/13/16 at 10:50 AM RCNA was asked why the restorative wasn't being done per the physician's order. She stated, "I am supposed to do all the restorative, but I get pulled to the floor to work as a CNA a lot and don't get to do it.

On 4/14/16 at 12:45 PM the DON and administrator responded to the surveyor's requests about resident restorative care. The DON said they had pulled her when we need CNA help on the hall.

The administrator said they had their priorities for care when they're short of help. "We must address the quality of care issues first."

(\*\*\*Restorative range of motion exercises are a "Quality of Care" issue.)

#### F 311 Systemic Change(s):

The facility policy and procedure has been reviewed and no changes are warranted at this time. The DON and/or Therapy Program manager will provide inservice training to the licensed staff and CNA staff to address the importance of providing assistance to residents and accurately following and maintaining a restorative nursing program. The administrator, DON, and/or designee will conduct daily resident care rounds at differing times throughout the day to monitor residents on restorative programs to ensure delivery. Any/all negative findings will be addressed at time of discovery and the CNA staff assigned to the resident will receive additional training and/or disciplinary action as appropriate.

#### Monitoring:

The DON is responsible for maintaining compliance. The DON and/or designee will perform weekly audits of restorative documentation to insure that restorative programs are being delivered timely and per physicians order. Any/all negative findings will be reported to the DON for immediate correction. Detail findings of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in facility policy, procedure, and/or practice.

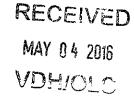
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EvenIID: 93CB11

Facility ID: VA0119

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PRINTED: 04/21/2016 FORM APPROVED OMB NO. 0938-0391

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		495350	B. WING		04	/14/2016
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HERITAGE	HALL WISE			9434 COEBURN MOUNTAIN ROAD WISE, VA 24293	<b>-</b>	
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### F 311 Continued From page 10

F 311

No additional info was forthcoming from the administration.

2. Resident #7 was admitted on 8/14/15. She had diagnoses which included congestive heart failure, hypertension, dementia and depression.

The latest MDS assessment, dated 2/2/16, coded the resident with severely impaired cognitive function. She required staff assistance with all the ADL functions.

The resident's CCP, updated on 2/3/16, Noted the resident required assistance with all ADL care. The interventions included PT/OT/ST/Restorative nursing as ordered.

The current physician's orders, signed 9/28/15, included: RNP (restorative nurse practice) BLE (bilateral lower extremities) and ROM (range of motion) and transfers. BUE (AROM-range of motion) and placement of right hand palm protector for 6-8 hours 6 X/wk."

The restorative records were reviewed from January 1st until present. Restorative exercises had been provided by the RCNA (restorative certified nursing assistant) on 43 occasions in three and a half months. That was not done six times a week.

On 4/13/16 at 10:50 AM RCNA was asked why the restorative wasn't being done per the physician's order. She stated, "I am supposed to do all the restorative, but I get pulled to the floor to work as a CNA a lot and don't get to do it.

On 4/14/16 at 12:45 PM the DON and

Facility ID: VA0119

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NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO		
HERITA	GE HALL WISE				9434 COEBURN MOUNTAIN ROAD WISE, VA 24293		
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	requests about reside DON said they had CNA help on the had The administrator sacare when they're standardess the quality of 3. Resident #14 w 2/8/16. Her diagnost brain cancer, myocal The latest MDS (2-6 moderately impaired required staff to according to the CCP, updated of required help with all included: PT/OT/ST/prdered.  Resident #14's curred orders, signed and did this order: D/C from restorative nursing for RLE and exercises.	nded to the surveyor's dent restorative care. The pulled her when we need II.  aid they had their priorities for nort of help. "We must of care issues first."  as admitted to the facility on es included hypertension, ardial infarction.  -16) coded the resident with I cognitive function. She complish all the ADL activities.  on 2/16/16, noted the resident I her ADLs. The interventions (Restorative nursing as ent telephoned physician's lated on 3/31/16, included PT/ST/OT. Refer to or transfers up to w/c. ROM, ogram to LLE by wk (week)	FS	311	1		
		ordered by the physician.					

On 4/13/16 at 10:50 AM RCNA was asked why the restorative wasn't being done per the physician's order. She stated, "I am supposed to do all the restorative, but I get pulled to the floor to work as a CNA a lot and don't get to do it.

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GE HALL WISE			l		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOUL)	D BE COMPLETION
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administrator response requests about reside DON said they had CNA help on the half The administrator sacare when they're shaddress the quality of Nothing additional wexited.  4. For Resident #1' provide physician or Program (RNP). Resident #11 was a admitted on 10/3/15. included, but were not status, urinary tract in anxiety. The most current Mirlocated in the clinical assessment with an A(ARD) of 3/23/16. The Resident #11 had show impairment (1/1) and with daily decision madily Living (ADL's). That Resident #11 requited the clinical record proders dated 3/18/16. included, but were not required to the clinical record proders dated 3/18/16. included, but were not required to the clinical record proders dated 3/18/16. included, but were not required to the clinical record proders dated 3/18/16. included, but were not required to the clinical record proders dated 3/18/16. included, but were not required to the clinical record proders dated 3/18/16. included, but were not required to the clinical record proders dated 3/18/16. included, but were not required to the clinical record proders dated 3/18/16. included, but were not required to the clinical record proders dated 3/18/16. included, but were not required to the clinical record proders dated 3/18/16.	anded to the surveyor's dent restorative care. The pulled her when we need it.  aid they had their priorities for nort of help. "We must of care issues first."  as provided before the team of the facility staff failed to dered Restorative Nursing of the facility staff failed to dered Restorative Nursing of the facility staff failed to dered Restorative Nursing of the facility diagnoses of the facility diagnoses of the facility staff coded that on the facility staff coded that fort and long term memory was severely impaired (3) asking regarding Activities of the facility staff also coded facility staff also co				
	PROVIDER OR SUPPLIER  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS  Continued From page  On 4/14/16 at 12:45 administrator responding requests about resided they had CNA help on the half  The administrator search when they're shaddress the quality of the continued physician or Program (RNP).  Resident #11 was a admitted on 10/3/15. included, but were no status, urinary tract is anxiety.  The most current Minlocated in the clinical assessment with an A(ARD) of 3/23/16. The Resident #11 had show in the continued in the clinical assessment with an A(ARD) of 3/23/16. The Resident #11 had show in the clinical assessment with an A(ARD) of 3/23/16. The most current Minlocated in the clinical assessment with an A(ARD) of 3/23/16. The most current Minlocated in the clinical assessment with an A(ARD) of 3/23/16. The most current Minlocated in the clinical assessment with an A(ARD) of 3/23/16. The most current Minlocated in the clinical assessment with an A(ARD) of 3/23/16. 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Admitting diagnoses included, but were not limited to: altered mental status, urinary tract infections, herpes zoster and anxiety.  The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/23/16. The facility staff coded that Resident #11 had short and long term memory impairment (1/1) and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #11 required total nursing care (4/3)	TO DEFICIENCIES OF CORRECTION  (X1) PROVIDER SUPPLIER CLA DENTIFICATION NUMBER:  495350  PROVIDER OR SUPPLIER  GE HALL WISE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 12  Con 4/14/16 at 12:45 PM the DON and administrator responded to the surveyor's requests about resident restorative care. 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The facility staff also coded that Resident #11 required total nursing care (4/3) with ADL's.  On April 14, 2016 at 7:40 a.m. the surveyor reviewed Resident #11's clinical record. Review of the clinical record produced signed physician orders dated 3/18/16. Signed physician orders included, but were not limited to: "RNP (restorative nursing program) for BUE (bijlateral)	TO DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:  (X2) MULTIPLE (A BUILDING 495350  B. WING  PROVIDER OR SUPPLIER  GE HALL WISE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUILL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 12  Condinued From page 12  F 311  On 4/14/16 at 12:45 PM the DON and administrator responded to the surveyor's requests about resident restorative care. The DON said they had pulled her when we need CNA help on the hall.  The administrator said they had their priorities for care when they're short of help. "We must address the quality of care issues first."  Nothing additional was provided before the team exited.  4. For Resident #11 the facility staff failed to provide physician ordered Restorative Nursing Program (RNP).  Resident #11 was a 73 year old female who was admitted on 10/3/15. Admitting diagnoses included, but were not limited to: altered mental status, urinary tract infections, herpes zoster and anxiety.  The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/23/16. The facility staff coded that Resident #11 had short and long term memory impairment (1/1) and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #11 required total nursing care (4/3) with ADL's.  On April 14, 2016 at 7:40 a.m. the surveyor reviewed Resident #11's clinical record. Review of the clinical record produced signed physician orders dated 3/18/16. Signed physician orders included, but were not limited to: "RNP (restorative nursing program) for BUE (bilateral)	RS FOR MEDICARE & MEDICAID SERVICES  TO FORFICIENCIES  OF CORRECTION  A 195350  PROVIDER OR SUPPLIER  GE HALL WISE  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECIDED BY IFULL REGULATORY OR ISO DENTIFICATION OR ISO DENTIFICATION)  A 2434 COEBURN MOUNTAIN ROAD  WISE, VA 24293  TAG  TAG  PROVIDER OR SUPPLIER  GE HALL WISE  SUMMARY STATEMENT OF DEFICIENCIES  (EACH CORRECTIVE ACTION SHOULD REGULATORY OR ISO DENTIFICING INFORMATION)  CONTINUED FROM DEATH OF MAINT OR ISO DENTIFICING INFORMATION)  TO 4/14/16 at 12:45 PM the DON and administrator responded to the surveyor's requests about resident restorative care. The DON said they had pulled her when we need CNA help on the hall.  The administrator said they had their priorities for care when they're short of help. "We must address the quality of care issues first."  Nothing additional was provided before the team exited.  4. For Resident #11 the facility staff failed to provide physician ordered Restorative Nursing Program (RNP).  Resident #11 was a 73 year old female who was admitted on 10/3/15. Admitting diagnoses included, but were not limited to: altered mental status, urinary tract infections, herpes zoster and anxiety.  The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/2/15. The facility staff coded that Resident #11 had short and long term memory impairment (1/1) and was severely impaired (3) with ADLs.  On April 14, 2016 at 7:40 a.m. the surveyor reviewed Resident #11s clinical record. Review of the clinical record produced signed physician orders adaed 3/18/16. Signed physician orders included, but were not limited to: "RNP) (restorative nursing program) for BUE (bilateral

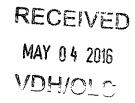
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range of motion/active range of motion) 2 X

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#### PRINTED: 04/21/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495350 B. WING 04/14/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9434 COEBURN MOUNTAIN ROAD HERITAGE HALL WISE WISE, VA 24293 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5: PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 311 Continued From page 13 F 311 (times) 15 reps (repetitions) all motions as resident will allow. 6X/wk (six times a week)." (sic) The order originated on 3/7/16. Continued review of the clinical record produced the "Restorative Care Flow Records" for March and April 2016. Review of the Restorative Care Flow Records documented that restorative nursing services were only provided on 3/16/16. 3/17/16, 3/23/16, 3/28/16, 3/30/16, 3/31/16, 4/8/16 and 4/13/16. On April 14, 2016 at 8:50 a.m. the surveyor asked to speak to the Restorative Nursing Aide (RNA). who was a Certified Nursing Assistant (C.N.A.). Within a few minutes the RNA approached the surveyor. The surveyor reviewed the restorative flow sheets with the RNA. The surveyor pointed out that the physician ordered for restorative services to be done 6 times a week. The RNA stated that she was only able to provide RNP about two times a week as she was usually pulled to work the floor as a C.N.A. On April 14, 2016 at 12:30 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to provide physician ordered RNP for Resident #11. The surveyor notified the AT that the physician ordered for Resident #11 to receive RNP six times a week. The surveyor notified the AT that Resident #11 had received RNP twice a week. The surveyor notified the AT that the RNA stated

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RNP to Resident #11.

work on the floor as a C.N.A.

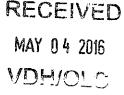
that she was only able to provide RNP services about twice a week as she was usually pulled to

No additional information was provided as to why the facility staff failed to provide physician ordered

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If continuation sheet Page 14 of 40



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# F 328 483.25(k) TREATMENT/CARE FOR SPECIAL SS=D NEEDS

The facility must ensure that residents receive proper treatment and care for the following special services: Injections;
Parenteral and enteral fluids;
Colostomy, ureterostomy, or ileostomy care;

Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview and clinical record review it was determined the facility staff failed to follow physician's orders for oxygen administration for 1 of 17 residents (Resident #2.)

#### Findings:

Resident #2 was admitted to the facility on 6/19/13. Her diagnoses included congestive heart failure, hypertension, chronic obstructive pulmonary disease, peripheral vascular disease, diabetes, anxiety, and muscle wasting and atrophy.

The resident's MDS (minimum data set) dated 3/17/16 coded the resident as cognitively unimpaired. She required staff assistance for all the ADLs (activities of daily living) with the exception of eating—which required only set-up assistance. The MDS was coded for oxygen use.

The CCP, updated 3/18/16, presented the

#### F 328

#### F 328

#### Corrective Action(s):

Resident #2 has had their oxygen administration orders clarified with the attending physician. The attending physician has been notified that the Resident #2 did not receive oxygen at the correct flow rate as ordered by the physician. 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 residents oxygen orders will be conducted by the DON, ADON or designee 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.

#### 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 inserviced on the facility policy and procedure for oxygen administration and monitoring by the DON. Inservices will include the delivery of oxygen per physician order and the monitoring of portable oxygen tanks throughout the shift.

#### Monitoring:

The DON is responsible for maintaining compliance. The DON, ADON and/or designee with 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.

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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respiratory failure. To a sordered."  The physician's ordered an order to cannula.) A second 7/22/14 instructed si (wheel chair) q (every characteristic) at 3:10 F the facility, Resident the doorway of her reaportable oxygen tall and oxygen tubing examnula to the tank cobserve to be empty.	coular/respiratory nortness of breathhistory of the interventions included, ers, signed, 2/22/16, for 02 at 2 LPM via n/ (nasal order, signed and dated taff to "Check O2 tank on w/c ry) 2 hours and as needed."  PM, during the initial tour of #2 was observed seated in boom in a wheelchair. She had nk on the back of her chair expending from the nasal output valve. The tank was	F3	28	
RN I was requested t	to obtain her pulse oximeter			

At 3:22 PM the surveyor returned to the room. RN I measured the pulse oximeter rate at the mid-range normal reading of 96%. The resident at no time appeared to be in stress.

rate. The reading was 85% (Normal is 94-100%.)

On 4/14/16 at 12:45 PM the DON and administrator were informed of the observation. The did not have any additional info.

F 371 483.35(i) FOOD PROCURE, SS=D STORE/PREPARE/SERVE - SANITARY

The facility must -

- (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
- (2) Store, prepare, distribute and serve food under sanitary conditions

F 371

#### F 371

Corrective Action(s):

The Speech Therapist involved with lunch and handling prepared food without gloves has been inserviced by the DON on proper infection control practices and the proper handling of prepared food when assisting residents with their meals. A Facility Incident & Accident form has been completed for this incident.

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### F 371 Continued From page 16

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview the facility staff failed to don gloves while handling prepared foods to serve to 1 of 17 residents in the dining room.

#### Findings:

Resident #7 was admitted to the facility on 8/14/15. Her diagnoses included anemia, congestive heart failure, hypertension and dementia. The resident's clinical record was reviewed on 4/13/16 at 9:00 AM

The latest MDS (minimum data set assessment) dated 2/2/16 coded the resident with significant cognitive impairment. She relied on staff assistance for all the ADLs (activities of daily living) but was observed to feed herself with encouragement from staff.

The resident's CCP (comprehensive care plan) updated on 2/3/16 documented nutritional requirements as "needs assistance with meal.....diet supplements as ordered, consults as needed, substitute food of equal value for foods refused or uneaten, learn preferences, assist with meals as needed.....restorative dining as ordered."

On 4/13/16 at 12:30 PM, ST I (facility speech therapist) was seated in the dining room to assist Resident #7 with her lunch. The resident had

### F 371 Identification of Deficient Practices & Corrective Action(s):

All other residents receiving Speech Therapy may have potentially been affected. The DON or Program manager will monitor the lunch meal to identify any negative findings. All negative findings will be corrected at time of discovery. A facility Incident & Accident form will be completed for each negative finding identified. All negative findings will result in additional inservice training and monitoring.

#### Systemic Change(s):

Current facility policy & procedure has been reviewed and no changes are warranted at this time. The DON and/or regional nurse consultant will inservice the all therapy and nursing staff on the proper procedure for handling prepared food for the residents during all meal times. The inservice will also include all aspects of infection & sanitation control measures.

#### Monitoring:

The Program Manager is responsible for maintaining compliance. The Administrator and/or Therapy Manager will complete meal observation audits 3 times a week at meal pass times for monitoring and maintaining 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.

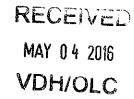
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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 37	ground hamburger of a knife in his right h	ge 17 on a regular bun and ST I took and and held the bread in his e plate while he cut it with his	F 3	71	
	bun, so ST I picked and scraped the me eat the meat without	ed she did not want to eat the up each small piece of bread at off of it to see if she would the bun. At no time during wes to handle the resident's			
	interviewed about hat before handling prep always used gloves, long. Oh no, never to	PM KS I (kitchen staff I ) was andwashing and gloving pared foods. She said she "I've had gloves on all day buch prepared foods with ens, but it's not supposed to."			
	<ul> <li>was consulted conce foods without gloving</li> </ul>	M the DM (dietary manager) erning handling prepared first. She stated, "Absolutely ves. Mine use tongs on			
	observation on 4/13/2 additional evidence w	istrator were informed of the 16 at 12"45 PM. No vas presented. CONTROL, PREVENT	F 44	1 F441 Corrective Action(s):	The second secon
	Infection Control Prog safe, sanitary and cor	blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission on.		The attending physician for resident that the facility failed to implement a control practices for addressing resid The volunteer and the DON have becadministrator on the possible indirect	appropriate infection lent #2 & #4 care needs. en inserviced on by the

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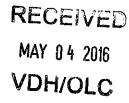
(a) Infection Control Program

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incident.

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infectious agents by their clothing touching multiple resident beds. An Incident & Accident form was completed for each

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### F 441 Continued From page 18

The facility must establish an Infection Control Program under which it -

- (1) Investigates, controls, and prevents infections in the facility;
- (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
- (3) Maintains a record of incidents and corrective actions related to infections.
- (b) Preventing Spread of Infection
- (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
- (2) 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.
- (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

#### (c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, facility document review and clinical record review if was determined the facility staff failed to implement appropriate infection control policies for Resident # 2 and #14.

Findings:

# F 441 Identification of Deficient Practice(s) & Corrective Action(s):

All residents may have the potential to be affected by using improper infection control practices when addressing the resident needs. The DON and Administrator will conduct a 100% room audit to determine which rooms require chairs for visitor/family to sit on when visiting or socializing with residents. A list of all rooms affected by the lack of chairs will be submitted to the Regional V.P. Operations for purchase approval to address the lack of seating arrangements and the potential infection related issues associated with the lack of chairs. A facility Incident and Accident form will be completed for each negative finding.

#### Systemic Change(s):

The facility policy and procedures have been reviewed and no changes are warranted at this time. All nursing staff will be inserviced on the facility policy and procedure for proper infection control techniques to be used when in resident rooms to include not setting on resident beds or wheelchairs to prevent cross-contamination from indirect exposure of infectious agents.

#### Monitoring:

The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will perform random weekly room audits to monitor nursing staff for compliance. Any negative findings will addressed at time of discovery and disciplinary action taken as warranted. 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.

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/21/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING \_ COMPLETED 495350 B. WING 04/14/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9434 COEBURN MOUNTAIN ROAD HERITAGE HALL WISE WISE, VA 24293 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 441 Continued From page 19 F 441 1. Resident #2 was admitted to the facility on 6/19/13. Her diagnoses included congestive heart failure, hypertension, peripheral vascular disease, diabetes, anxiety, chronic obstructive pulmonary disease and muscle wasting and atrophy. The resident's MDS (minimum data set) dated 3/17/16 coded the resident as cognitively unimpaired. She required staff assistance for all the ADLs (activities of daily living) with the exception of eating--which required only set-up assistance. The CCP, updated 3/18/16, did not address the furniture requirements for this resident. On 4/13/16 at 9:50 AM, an elderly volunteer was observed sitting on the bed reading prayer verses to the resident while Resident #2 sat in her wheelchair. The volunteer was followed by the surveyor as she made "her rounds." She stopped in four more rooms along the way and sat on two of their beds while reading prayer verses. The volunteer stopped to speak to the surveyor. She said she came several times a week because people "needed to know someone was there for them." On 4/13/16 at 10:30 AM the DON came into Resident #2's room and sat down on her bed to

inspect a large bruise on her arm. There were no chairs in the room for visitors or residents to be

On 4/14/16 at 7:35 AM RN I and CNA I were asked if they sat on the resident's beds. CNA I stated, "No I do not sit on beds here. I wouldn't go

seated -- so they just sat on the bed.

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	home and sit on my eitherbecause of g thembut they're ev	bed in these clothes germs. You can't see verywhere.			
	RN I said she tried t sometime she did si that's going to take a	to find a chair, but there was it on the bed "if it's something a little longer."			
	asked if they used the for seating. CNA II s	AM CNA II and CNA III were ne resident's personal beds aid since they had no chairs ould sit on the resident's bed			
	asked about sitting of have to sit on reside	PM, CNA's IV and V were on the beds. Both agreed they nt's beds to feed them no chairs in the rooms.			
	DON were asked about	PM the administrator and out the staff sitting on niture and the infection resented.			
	and the second s	new staff would sit on			1

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pick and choose whose bed I sit on."

The administrator said he didn't know that (infection control) applies to beds. He added the residents need a human touch, it's a psychosocial

issue. "We don't have chairs in the rooms because of space issues, so we sit on the beds."

On 4/14/16 at approximately 9:00 AM, the corporate representative brought the surveyor some information regarding F441 - Infection Control. It read, in part "....Prevent and control outbreaks and cross contamination using

### DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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	transmission-based standard ones"O measures that "are transmission of inference pidemiologically imspread by direct or i resident or the resident of an infootnaminated interm following are examp contactClothing, isolation gowns  No additional info was 2.8/16. Her diagnose brain cancer, myocal The latest MDS (2-6-moderately impaired required staff to account of the resident of the resident of the resident or the resident's bed while for the saked if they sat on the resident of the resident of they sat on the resident of the resident of they sat on the resident of th	precautions in addition to contact precautions" are intended to prevent the ctious agents, including aportant organisms, which are ndirect contact with the ent's indirect transmission involves fectious agent through a nediate objectThe les of indirect uniforms, laboratory coats or as provided.  admitted to the facility on a included hypertension, rdial infarction.  and infarction.  The les of indirect uniforms, laboratory coats or as provided.  Admitted to the facility on a included hypertension, rdial infarction.  All coded the resident with cognitive function. She omplish all the ADL activities.  AM CNA II and CNA III (in addressing incontinence ney used the resident's ating. CNA II said since they ooms she would sit on the eeding them.  MRN I and CNA I were ne resident's beds. CNA I ton beds here. I wouldn't go led in these clothes rms. You can't see	F 4	41			

RN I said she tried to find a chair, but there was

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		it on the bed "if it's something	1 4	71	
	sisters come nearly	about visitor seating, "Her every day. They just stand up e never noticed them sitting			
	DON were asked ab	PM the administrator and out the staff sitting on niture and the infection resented.			
	The DON said she ke bedsbut did not thir pick and choose who	new staff would sit on nk it was an issue. "I would ose bed I sit on."			
	(infection control) appresidents need a hun issue. "We don't have	id he didn't know that plies to beds. He added the nan touch, it's a psychosocial e chairs in the rooms sues, so we sit on the beds."			
	some information reg Control. It read, in pa outbreaks and cross	tive brought the surveyor arding F441 - Infection rt "Prevent and control			

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resident or the resident's

following are examples of indirect

standard ones....."Contact precautions" are measures that "are intended to prevent the transmission of infectious agents, including epidemiologically important organisms, which are spread by direct or indirect contact with the

environment.".....Indirect transmission involves the transfer of an infectious agent through a contaminated intermediate object......The

EvenI IO: 93CB11

Facility IO: VA0119

If continuation sheel Page 23 of 40

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/21/2016 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES			FURM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	TIPLE CDNSTRUCTION NG	(X3) DATE SURVEY COMPLETED
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HERITA	GE HALL WISE			9434 COEBURN MOUNTAIN ROAD WISE, VA 24293	
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F 441	Continued From pa	ge 23	F 44	<b>1</b> 1	
	contactClothing, isolation gowns	uniforms, laboratory coats or			
	the survey end.	nation was provided prior to			
F 461 SS=E	483.70(d)(1)(vi)-(vii) WINDOW/FLOOR,	, (d)(2) BEDROOMS - BED/FURNITURE/CLOSET	F 46	:1	
	Bedrooms must hav outside; and have a	e at least one window to the floor at or above grade level.			
	(i) A separate bed of the convenience of t (ii) A clean, comforta (iii) Bedding, app climate; and (iv) Functional fu resident's needs, as	rniture appropriate to the individual closet space in some with clothes racks and		F461 Corrective Action(s) Residents #2, #3, #4, #6, #7, #8, #9 & assessed by the administrator and the for appropriate room furnishings. Thinvolved in the review by the survey placed in the rooms for comfort for eroom. A Facility Incident & Accident for this incident.	e maintenance director e resident rooms or have had a chair each resident in the
	survey agency, may requirements specific (ii) of this section rela- cases when the facili- that the variations (i) Are in accordance residents; and (ii) Will not advers	of a nursing facility the permit variations in ed in paragraphs (d)(1)(i) and sting to rooms in individual ty demonstrates in writing with the special needs of the sely affect residents' health		Identification of Deficient Practice & Corrective Action(s): All other resident rooms may be pote facility Maintenance Director and Act a 100% audit of resident rooms to ideare in need of room chairs. All identilogged and an accurate chair count of chairs will be ordered to be placed in needing chairs.	entially affected. The dministrator conducted entify any rooms that ified rooms will be btained. Resident room
	and safety.	is not met as evidenced		Systemic Change(s): The facility's policy & procedure for furniture appropriate for the residents are warranted at this time. The admir all staff on the requirement for proving furniture to meet the residents needs, notification system to use when repairs.	s needs. No changes histrator will inservice ding functional As well as the proper

FORM CMS-2567(02-99) Previous Versions Obsolele

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### F 461 Continued From page 24

Based on observation, resident and staff interview and clinical record review, it was determined the facility staff failed to provide suitable furniture for the comfort of 9 of 17 residents (#2, 6, 7, 14, 3, 4, 8, 9, &10) and visitors (e.g., a chair.)

#### Findings:

1. Resident #2 was admitted to the facility on 6/19/13. Her diagnoses included congestive heart failure, hypertension, peripheral vascular disease, diabetes, anxiety, chronic obstructive pulmonary disease and muscle wasting and atrophy.

The resident's MDS (minimum data set) dated 3/17/16 coded the resident as cognitively unimpaired. She required staff assistance for all the ADLs (activities of daily living) with the exception of eating-which required only set-up assistance.

The CCP (comprehensive care plan), updated 3/18/16, did not address the furniture requirements for this resident.

On 4/13/16 at 9:50 AM, an elderly volunteer was observed sitting on the bed reading prayer verses to the resident while Resident #2 sat in her wheelchair. The volunteer was followed by the surveyor as she made "her rounds." She stopped in four more rooms along the way and sat on two of their beds while reading prayer verses.

The volunteer stopped to speak to the surveyor. She said she came several times a week because people "needed to know someone was there for them."

### F 461 Monitoring:

The Maintenance Director is responsible for maintaining compliance. The maintenance director and or administrator will make weekly documented room rooms to ensure each resident has a chair for comfort and to meet their needs and is in good repair. The results of these audits will be reviewed by the Risk Management Committee weekly. Cumulative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice

Completion Date: May 20, 2016

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Event (D: 93CB11

Facility ID: VA0119

If continuation sheet Page 25 of 40 MAY 04 2016

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### F 461 Continued From page 25

On 4/13/16 at 10:30 AM the DON came into Resident #2's room and sat down on her bed to inspect a large bruise on her arm. There were no chairs in the room for visitors or residents to be seated--so she just sat on the bed.

On 4/14/16 at 10:00 AM CNA II was asked if she used the resident's personal beds for seating. CNA II said since they had no chairs in the rooms she would sit on the resident's bed while feeding them.

On 4/14/16 at 7:35 AM RN I and CNA I were asked if they sat on the resident's beds. CNA I stated, "No I do not sit on beds here. I wouldn't go home and sit on my bed in these clothes either--because of germs. You can't see them--but they're everywhere.

At 4/13/16 at 12:30 PM, CNA's IV and V were asked about sitting on the beds. Both agreed they have to sit on resident's beds to feed them because there were no chairs in the rooms.

RN I said she tried to find a chair, but there was sometime she did sit on the bed "if it's something that's going to take a little longer."

CNA III was asked about visitor seating, "Her sisters come nearly every day. They just stand up during their visit. I've never noticed them sitting on the beds."

On 4/14/16 at 12:30 PM the administrator and DON were asked about the staff sitting on resident's private furniture (lack of chairs) and the infection control issues that presented.

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	HERITAGE HALL WISE			STREET ADDRESS, CITY, STATE, ZIP COI 9434 COEBURN MOUNTAIN ROAD WISE, VA 24293		
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F 461	The DON said she l	knew staff would sit on ink it was an issue. "I would	F 46	31		

pick and choose whose bed I sit on."

The administrator said he didn't know that (infection control) applies to beds. He added the residents need a human touch, it's a psychosocial issue. "We don't have chairs in the rooms because of space issues, so we sit on the beds." The administrator said he preferred to sit over the bed rather than hover over a resident--because that was a dignity issue.

On 4/14/16 at approximately 9:00 AM, the corporate representative brought the surveyor some information regarding F441 - Infection Control. It read, in part "....Prevent and control outbreaks and cross contamination using transmission-based precautions in addition to standard ones....."Contact precautions" are measures that "are intended to prevent the transmission of infectious agents, including epidemiologically important organisms, which are spread by direct or indirect contact with the resident or the resident's environment."......Indirect transmission involves the transfer of an infectious agent through a contaminated intermediate object......The following are examples of indirect contact.....Clothing, uniforms, laboratory coats or isolation gowns.....

No additional info was provided.

2. Resident #14 was admitted to the facility on 2/8/16. Her diagnoses included hypertension, brain cancer, myocardial infarction.

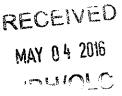
The latest MDS (2-6-16) coded the resident with

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Facility ID: VA0119

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/21/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY AND PLAN OF CORRECTION IOENTIFICATION NUMBER. A. BUILDING \_ COMPLETED 495350 B. WING 04/14/2016 NAME OF PROVIOER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 9434 COEBURN MOUNTAIN ROAD HERITAGE HALL WISE WISE, VA 24293 SUMMARY STATEMENT OF OFFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION 10 PREFIX (EACH OFFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY) F 461 Continued From page 27 F 461 moderately impaired cognitive function. She required staff to accomplish all the ADL activities. On 4/14/16 at 10:00 AM CNA II and CNA III (in Resident # 14's room addressing incontinence care) were asked if they used the resident's personal beds for seating. CNA II said since they had no chairs in the rooms she would sit on the resident's bed while feeding them. CNA III was asked about visitor seating, "Her sisters come nearly every day. They just stand up during their visit. I've never noticed them sitting on the beds." At 4/13/16 at 12:30 PM, CNA's IV and V were asked about sitting on the beds. Both agreed they have to sit on resident's beds to feed them because there were no chairs in the rooms. On 4/14/16 at 12:45 PM the administrator and DON were asked about the staff sitting on resident's private furniture and the infection control issues that presented. The DON said she knew staff would sit on beds---but did not think it was an issue. "I would pick and choose whose bed I sit on." The administrator said he didn't know that

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(infection control) applies to beds. He added the residents need a human touch, it's a psychosocial

No additional information was provided prior to

issue. "We don't have chairs in the rooms because of space issues, so we sit on the beds."

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### F 461 Continued From page 28

3. Resident #7 was admitted to the facility on 8/14/15. Her diagnoses included anemia, congestive heart failure, hypertension and dementia. The resident's clinical record was reviewed on 4/13/16 at 9:00 AM

The latest MDS (minimum data set assessment) dated 2/2/16 coded the resident with significant cognitive impairment. She relied on staff assistance for all the ADLs (activities of daily living) but was observed to feed herself with encouragement from staff.

The resident's CCP (comprehensive care plan) updated on 2/3/16 documented nutritional requirements as "needs assistance with meal.....diet supplements as ordered, consults as needed, substitute food of equal value for foods refused or uneaten, learn preferences, assist with meals as needed.....restorative dining as ordered."

On 4/13/14 at 8:15 AM the resident was observed eating breakfast in her bed unassisted. The resident was positioned badly and slumped nearly under the bed tray so it was just at the level of her mouth. She was still getting Rice Crispiest to her mouth, but could not reach her milk--which was on the far side of the tray.

The surveyor stepped out of the room and spoke to RN I about the resident's positioning and her ability to eat independently. RN I stated, "She needs help to eat."

CNA I came into the room to reposition the resident and assist her to eat. Once in the appropriate position, upright and comfortable the resident was able to eat more of her food with the

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F 461	Continued From pa	ge 29	F 4	61		

CNA's oversite and encouragement.

CNA I continued to feed the resident until 9:05 AM. During this time the surveyor stood at the end of the bed while CNA I hovered over her to eat. The surveyor did not observe any seating in the room other than the resident's bed and her wheelchair. The surveyor was asked what visitors do when they come to visit with resident. The CNA I just said, "Oh we can get them a chair if they want one." At no time during this survey were friends and family members observed with chairs—they were all standing around in the room or seated on the resident's personal bed.

On 4/13/16 at 9:50 AM, an elderly volunteer was observed sitting on the bed reading prayer verses to the resident while Resident #2 sat in her wheelchair. The volunteer was followed by the surveyor as she made "her rounds." She stopped in four more rooms along the way and sat on two of their beds while reading prayer verses.

On 4/14/16 at 7:35 AM RN I and CNA I were asked if they sat on the resident's beds. CNA I stated, "No I do not sit on beds here. I wouldn't go home and sit on my bed in these clothes either--because of germs. You can't see them--but they're everywhere.

RN I said she tried to find a chair, but there was sometime she did sit on the bed "if it's something that's going to take a little longer."

CNA III was asked about visitor seating, "Her sisters come nearly every day. They just stand up during their visit. I've never noticed them sitting on the beds."

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

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		495350	B. WING _		0.	4/14/2016
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### F 461 Continued From page 30

On 4/14/16 at 12:30 PM the administrator and DON were asked about the staff sitting on resident's private furniture (lack of chairs) and the infection control issues that presented.

The DON said she knew staff would sit on beds--but did not think it was an issue. "I would pick and choose whose bed I sit on."

The administrator said he didn't know that (infection control) applies to beds. He added the residents need a human touch, it's a psychosocial issue. "We don't have chairs in the rooms because of space issues, so we sit on the beds." The administrator said he preferred to sit over the bed rather than hover over a resident--because that was a dignity issue.

On 4/14/16 at approximately 9:00 AM, the corporate representative brought the surveyor some information regarding F441 - Infection Control. It read, in part "....Prevent and control outbreaks and cross contamination using transmission-based precautions in addition to standard ones....."Contact precautions" are measures that "are intended to prevent the transmission of infectious agents, including epidemiologically important organisms, which are spread by direct or indirect contact with the resident or the resident's environment."......Indirect transmission involves the transfer of an infectious agent through a contaminated intermediate object......The following are examples of indirect contact.....Clothing, uniforms, laboratory coats or isolation gowns.....

No additional info was provided.

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4. Resident #6 was admitted to the facility on 1/28/15. His diagnoses included congestive heart failure, hypertension, diabetes, cerebral palsy, paraplegia depression and psychosis.

The latest MDS assessment, dated 2/10/16, coded the resident as cognitively intact. He was completely dependent on staff members to assist him with ADL activities—with the exception of eating, which only required a set-up.

Resident #6's room did not have a chair for the resident (other than a wheelchair) or visitors. He was observed in his room on 4/12/16 at 3:00 PM. The resident shared this room with another resident and no chairs were found on either side of the room.

On 4/14/16 at 7:35 AM RN I and CNA I were asked if they sat on the resident's beds. CNA I stated, "No I do not sit on beds here. I wouldn't go home and sit on my bed in these clothes either—because of germs. You can't see them—but they're everywhere.

RN I said she tried to find a chair, but there was sometime she did sit on the bed "if it's something that's going to take a little longer."

On 4/14/16 at 12:30 PM the administrator and DON were asked about the staff sitting on resident's private furniture (lack of chairs) and the infection control issues that presented.

The DON said she knew staff would sit on beds--but did not think it was an issue. "I would pick and choose whose bed I sit on."

Event IO: 93CB11

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	(infection control) appresidents need a hurissue. "We don't have because of space is The administrator say bed rather than hove that was a dignity iss. 5. For Resident #3 provide a chair in the comfort.  Resident #4 was an originally admitted or 4/14/15. Admitting donot limited to: demer diabetes mellitus, hy dysphagia, altered mand communication of the most current Mirlocated in the clinical assessment with an A(ARD) of 2/03/16. The Resident #3 had show impairment (1/1) and with daily decision may coded that Resident #3 to total nursing care (Living (ADL's).  On April 12, 2016 at 40 observed Resident #3 observed that it was at The surveyor did not compair to total nursing care (Living (ADL's).	aid he didn't know that oplies to beds. He added the man touch, it's a psychosocial we chairs in the rooms sues, so we sit on the beds." aid he preferred to sit over the er over a residentbecause sue.  I the facility staff failed to e room for resident and visitor  84 year old male who was n 11/14/13 and readmitted on liagnoses included, but were not with behaviors, anxiety, pertension, aortic aneurysm, lental status and cognition deficit.  Inimum Data Set (MDS) record was a Quarterly MDS Assessment reference Date ne facility staff coded that rt and long term memory was severely impaired (3) aking. The facility staff also #3 required extensive (3/3) 4/3) with Activities of Daily  1:35 p.m. the surveyor 8's room. The surveyor adouble occupancy room, observe a chair in the room	F 46	51			

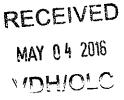
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On April 14, 2016 at 9:30 a.m. the surveyor observed Resident #3's room. The surveyor did

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PRINTED: 04/21/2016 FORM APPROVED OMB NO 0938 0301

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			^	FORM APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULT	TPLE CONSTRUCTION	0	MB NO. 0938-039 (X3) OATE SURVEY COMPLETEO
		495350	B. WING			04/44/00 - 0
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET AOORESS. CIT	LY STATE ZIB CODE	04/14/2016
HERITA	GE HALL WISE			9434 COEBURN MOL WISE, VA 24293		
(X4) ID PREFIX TAG	: (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEOED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	I'S PLAN OF CORRECTION ECTIVE ACTION SHOULO ENCEO TO THE APPROPE DEFICIENCY)	BE COMPLETION
; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	or visitor comfort. On April 14, 2016 at met with the Adminis Nursing (DON) and (CCN). The surveyo Team (AT) that the factair for resident and #3's room.  No additional information exiting the facility as to provide a chair for for visitors.  6. For Resident #4 provide a chair in the comfort. Resident #4 was an Expressionally admitted on 2/9/16. Admitting diagnot limited to: weaknest all with rib fractures, anxiety, osteoporosis, bulmonary disease, distribution. The most current Minimized in the clinical reseasement with an AARD) of 3/22/16. The Resident #4 had a County of the facility staff all equired extensive (3/3/2/16 Activities of Daily on April 12, 2016 at 4:	nair was available for resident 12:30 p.m. the survey team strator (Adm), Director of Corporate Compliance Nurse r notified the Administrative acility staff failed to provide a d visitor comfort in Resident  ation was provided prior to to why the facility staff failed comfort for Resident #3 or  the facility staff failed to room for resident and visitor (a) year old female who was 12/16/15 and readmitted on gnoses included, but were less, myocardial infarction, congestive heart failure, chronic obstructive abetes mellitus and atrial  mum Data Set (MDS) lecord was a Quarterly MDS sessesment reference Date of facility staff coded that gnitive Summary Score of so coded that Resident #4 b) to total nursing care (4/3) Living (ADL's). 35 p.m. the surveyor	F 46	1	RECEIVE MAY 0 4 201	_
: O	bserved Resident #4'. bserved that it was a	s room. The surveyor com. The surveyor double occupancy room. bserve a chair in the room			VDH/OL	İ

for either resident and for visitor comfort.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/21/2016 FORM APPROVED

		& MEDICAID SERVICES				IO. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) [	DATE SURVEY COMPLETED
		495350	B. WING			3.444.4100.40
1	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	TE, ZIP CODE	<b>04/14/2</b> 016
HERIIA	GE HALL WISE			WISE, VA 24293	ROAD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
	observed Resident not observe that a cor visitor comfort. On April 14, 2016 at observed Resident; not observe that a cor visitor comfort. On April 14, 2016 at met with the Adminis Nursing (DON) and (CCN). The surveyor Team (AT) that the fichair for resident and #4's room.  No additional information and the facility as to provide a chair for for visitors.  7. For Resident #8 to provide a chair in the comfort.  Resident #8 was adwith diagnoses included is a chair in the comfort.  Resident #8 was adwith diagnoses included is a seed with side ficits and impaired decision-making. The inattention, and occar resident was coded a loss of 5% or more in	t 8:35 a.m. the surveyor #4's room. The surveyor did thair was available for resident t 9:25 a.m. the surveyor #4's room. The surveyor did hair was available for resident 12:30 p.m. the survey team strator (Adm), Director of Corporate Compliance Nurse or notified the Administrative acility staff failed to provide a d visitor comfort in Resident  ation was provided prior to to why the facility staff failed or comfort for Resident #4 or the facility staff failed to the room for resident and visitor  mitted to the facility 11/27/15 ding cardiopulmonary erebrovascular accident, ion. On the minimum data b) dated 3/10/16, the resident mort- and long-term memory ability in daily the resident was assessed with sional rejection of care. The t K0300 Weight Loss with the last month or 10% or onths 2=yes, not on physician	F 4	61		

On 4/13/16, the surveyor observed the resident

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/21/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING CDMPLETED 495350 B. WING 04/14/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HERITAGE HALL WISE 9434 COEBURN MOUNTAIN ROAD WISE, VA 24293 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY F 461 Continued From page 35 F 461 eating breakfast while sitting in a wheelchair. The surveyor observed there was no other chair in the room. During a discussion of staff care on 4/13/16, the administrator stated there was not enough space in resident rooms for chairs. 8. For Resident #9 the facility staff failed to provide a chair in the room for resident and visitor comfort. Resident #9 was admitted to the facility on 4/12/16 with diagnoses including cardiopulmonary disease, end stage renal disease with hemodialysis, and hypertension. On the minimum data set assessment (MDS) dated 4/10/16, the resident scored 15/15 on the brief interview for mental status and was assessed without symptoms of delirium, psychosis, or behaviors affecting others. During an interview on 4/13/16, the resident mentioned her son's frequent visits. The surveyor asked if he had to stand during the visits. The resident indicated a folding chair leaning against the closet door and stated that he had purchased a folding chair so he would have a RECEIVED place to sit when he visited.

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Resident #10 was admitted to the facility on

9. For Resident #10 the facility staff failed to provide a chair in the room for resident and visitor

in resident rooms for chairs.

During a discussion of staff care on 4/13/16, the

administrator stated there was not enough space

comfort.

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		E G MEDIOAID SERVICES			<u>OMB NO. 0938</u>	-039	
STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURV COMPLETED	 'EY	
		495350	B. WING		04/44/204	4.0	
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL WISE				STREET ADDRESS. CITY, STATE, ZIP CODE 9434 COEBURN MOUNTAIN ROAD	1 04/14/20	04/14/2016	
<u> </u>				WISE, VA 24293			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE	LD BE COMPL	ETION	
-						·	

### F 461 Continued From page 36

5/5/15 with diagnoses including atrial fibrillation, insomnia, hypertension, neuralgia, and arthropathy. On the quarterly minimum data set assessment dated 4/4/16, the resident scored 15/15 on the brief interview for mental status, and was assessed without symptoms of delirium or psychosis and with the only behavior symptoms occasionally rejecting care.

On 8/13/15 at 9 AM, the surveyor asked the resident about the stains on his shirt. He stated that he had spilled his coffee while eating breakfast because he found it difficult to sit up straight on the bed. The surveyor asked if he had a chair in his room. He stated he did not have a chair other than his wheelchair.

During a discussion of staff care on 4/13/16, the administrator stated there was not enough space in resident rooms for chairs.

### F 514 483.75(I)(1) RES

# SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIB LE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

F 461

### F 514 F514

Facility ID: VA0119

#### Corrective Action(s):

Resident #5's attending physician has been notified that the facility staff inaccurately transcribed Resident #5's physician ordered duo-neb medication orders. Resident #5's medication orders have been reviewed and verified by the attending physician. A facility incident and 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% audit of all residents current physician orders and MAR's and Tar's will be conducted by the DON, ADON and/or Unit Manager to identify residents at risk for inaccurate medication orders, MAR's & TAR's. All negative findings will be clarified and/or corrected as applicable at time of discovery and the attending physician notified of the incident. A facility Incident & Accident form will be completed for each negative finding.

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PRINTED: 04/21/2016 FORM APPROVED OMB NO. 0938 0391

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		495350	B. WING _		04	/14/2016
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		14,2010
HERITAGE	HALL WISE			9434 COEBURN MOUNTAIN ROAL WISE, VA 24293		
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### F 514 Continued From page 37

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate clinical record for 1 of 17 Residents in the sample survey, Resident #5.

The Findings Included:

For Resident #5 the facility staff failed to ensure complete and accurate Physician Order Sheets (POS's).

Resident #5 was a 78 year old male who was originally admitted on 6/19/14 and readmitted on 3/23/16. Admitting diagnoses included, but were not limited to: cerebrovascular accident, chronic obstructive pulmonary disease, hemiplegia, dementia, heart failure, depression, anxiety, contracture of the left hand, cirrhosis of the liver and an enlarged prostate.

The most current Minimum Data Set (MDS) located in the clinical record was a 14 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 4/4/16. The facility staff coded that Resident #5 had a Cognitive Summary Score of 9. The facility staff also coded that Resident #5 required extensive (3/3) to total nursing care (4/3) with Activities of Daily Living (ADL's).

On April 13, 2016 at 7:35 a.m. the surveyor reviewed Resident #5's clinical record. Review of the clinical record produced a physician telephone order dated 3/25/16. The physician telephone order read: "Duoneb 0.5/2.5mg/3ml Q 6 (every six) hours and Q4 hrs (every four hours) PRN (as needed) for SOB (shortness of the breath). " (sic)

Further review of the clinical record produced the March and April 2016 Medication Administration Records (MAR's). The March and April 2016

### F 514 Systemic Change(s):

The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON or regional nurse consultant 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 accurate Physician Orders, the MAR's & TAR's according to the acceptable professional standards and practices.

#### Monitoring:

The DON is responsible for maintaining compliance. The DON, ADON and/or designee will audit physician orders, MAR's & TAR's weekly coinciding with the care plan calendar 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: May 20, 2016

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/21/2016

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F 514	administering the Devery six (6) hours a Continued review of the Physician Order dated 3/29/16. Revolve to include the physician breathing treatment shortness of the breathing treatment shortness of the breathing treviewed Resident at Unit Manager (UM), (RN). The surveyor telephone order date the Duoneb breathing administered every a reviewed the April 20 surveyor pointed out administering the Duordered by the physicial reviewed the signed surveyor pointed out the Duonebs had no facility staff to the PO On April 14, 2016 at met with the Adminis Nursing (DON) and (CCN). The surveyor	If that the facility staff were buoneb breathing treatments as ordered by the physician. If the clinical record produced r Sheet's (POS's) signed and view of the signed POS's failed cian order for the Duoneb its every six hours for eath. If 7:55 a.m. the surveyor #5's clinical record with the who was a Registered Nurse reviewed the physician ed 3/25/15 that ordered for ing treatments to be six hours. The surveyor also 016 MAR's with the UM. The It that the facility staff were unnebs every six hours as sician. Lastly the surveyor I POS's with the UM. The It that the physician order for the been transcribed by the	F 5	14			
	Resident #5. The su				RECEIVE	ΞD	
	physician telephone	(AT) that Resident #5 had a order on 3/25/16 that ordered eatments every six hours.			MAY 04 201	16	
	The surveyor notified Duonebs had not bee	If the AT that the order for the en transcribed to the POS's the physician on 3/29/16.			VDH/OL	C	

No additional information was provided prior to

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State of Virginia FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER COMPLETED A. BUILDING 495350 B. WING 04/14/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HERITAGE HALL WISE 9434 COEBURN MOUNTAIN ROAD WISE, VA 24293 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Initial Comments F 000 An unannounced biennial State Licensure Inspection was conducted 4/12/16 through 4/14/16. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 97 bed facility was 84 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents 1 through 14). F 001 Non Compliance F 001 The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. 12 VAC 5-371--250F, G Cross reference to F280 12 VAC 5-371--220A Cross reference to F309 12 VAC 5-371--180 Cross reference to F441 12 VAC 5-371--360 A, E Cross reference to F514 12 VAC 5-421-450 (Food Regulation) Cross reference to F371 RECEIVED MAY 04 2016 VDH/OLC

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

If continuation sheet