STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

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 SS=D 483.15(b) SELF-DETERMINATION - RIGHT TO 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

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) DATE
		4/28-16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

MAY 04 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 2	F 242		

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 CNA's oversite and encouragement.

The tray card was viewed for the resident's likes and dislikes. The resident 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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280 SS=D	Continued From page 3 483.20(d)(3), 483.10(k)(2) RIGHT TO 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 by: 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	**F-280** **Corrective Action(s):** 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.	

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495350	A. BUILOING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET AOORESS. CITY. STATE. ZIP COOE
HERITAGE HALL WISE	9434 COEBURN MOUNTAIN ROAD WISE, VA 24293

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION OATE

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 intervenlions 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 lhat 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- indicaled 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 5 hamburgers for lunch. The resident said he didn't eat hamburgers. The CNA said they could get him something else. At approximately 12 PM, the surveyor observed the resident in his room with a meal tray that included a hamburger. The surveyor asked if he was going to eat his lunch and he stated he didn't like hamburgers. The resident's nurse stated that the resident "ate a lot of snacks". The resident's Meal Intake Roster for 4/13/16 lunch %eaten documented Refused- notify nurse. The surveyor did not find a nurse's note addressing the refusal of the meal in the clinical record. The administrator and director of nursing were notified of the concern on 4/13/16 and the concern was discussed at a summary meeting on 4/14/16.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 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 follow physician orders for 1 of 17 Residents in the sample survey, Resident #4.	F 309	**F309** **Corrective Action(s):** Resident #4's attending physician was notified that the facility failed to notify the attending physician of a weight gain of 2 pounds or more in a day or a weight gain of 5 pounds or more in a week. A facility Incident and Accident form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered weight monitoring may have been potentially affected. The DON, ADON, and Unit Managers will conduct a 100% audit of all resident's physician orders and MAR's that have physician ordered weight monitoring to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6	F 309		

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 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 dated 3/21/16. 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
2/21/16 130.0 pounds
2/22/16 131.0 pounds
2/27/16 139.1 pounds
3/8/16 131.0 pounds

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

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 physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician orders to include weight monitoring. The DON and/or Regional nurse consultant will inservice all licensed staff on the procedure for obtaining, transcribing, and completing physician ordered medication and treatment orders.

Monitoring:
The DON is responsible for maintaining compliance. The DON and/or Unit Managers will audit/review all physician orders and MAR's & TAR's weekly to monitor for compliance. Any all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.

Completion Date: May 20, 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 7	F 309		

Medication Administration Records (MAR's). The February and March 2016 MAR's documented Resident #4's weights. Review of the nursing notes and February and March 2016 MAR's failed to document that the physician was notified of Resident #4's 3 pound weight gain from 2/20/16 through 2/21/16, the 8 pound weight loss from 2/22/16 through 2/27/16 and the 8 pound weight gain from 2/27/16 through 3/8/16.

On April 13, 2016 at 2:05 p.m. the surveyor notified the MDS Nurse, who was a Licensed Practical Nurse (LPN), that the physician had not been notified as ordered regarding Resident #4's weight gain and weight loss. The surveyor reviewed the clinical record with the MDS Nurse (LPN). The surveyor reviewed the signed physician order sheets, weight record, nursing notes and February and March 2016 MAR's with the MDS Nurse (LPN). The surveyor pointed out the specific physician order for the nursing staff to notify the physician of a greater than 2 pound weight gain in a day or 5 pounds in a week. The surveyor pointed out that documentation could not be located in the clinical record that the facility staff notified the physician regarding Resident #4's weight gains. The MDS Nurse (LPN) reviewed the clinical record and was unable to locate documentation that the facility staff notified the physician of Resident #4's weight gains.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 greater than 2 pound weight gain in a day or of a 5 pound weight gain in a week. The surveyor notified the AT that Resident #4 had an 8 pound weight gain from 2/27/16 through 3/8/16. The surveyor notified the AT that the physician was not notified as ordered by the physician. No additional information was provided prior to exiting the facility as to why the facility staff failed to follow physician orders for Resident #4.	F 309		
F 311 SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. 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 physician ordered, restorative care for 4 of 17 residents (Residents #2, 7,14 and 11.) 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	F 311	**F 311** **Corrective Action(s):** Residents #2, #7, #11 and #14 have been reassessed by the nursing and therapy department and their restorative nursing programs have been reviewed and/or revised to reflect their current ADL and ROM status and any current interventions needed to maintain or improve their current functional abilities. Their comprehensive care plans have been revised to reflect their current ADL and ROM status to include any restorative nursing programs. **Identification of Deficient Practices & Corrective Action(s):** All other residents receiving restorative nursing programs may have potentially been affected. The DON, Therapy Program manager and/or designee will review each resident on a restorative nursing program to ensure that appropriate interventions are in place to meet their resident specific needs and that the program is being delivered per physician order. The residents comprehensive care plans will be revised to reflect their current needs to promote or maintain their current ADL and ROM level of function.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEOED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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(itions.) 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. **Completion Date: May 20, 2016**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 11	F 311		

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."

3. 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 moderately impaired cognitive function. She required staff to accomplish all the ADL activities.

The CCP, updated on 2/16/16, noted the resident required help with all her ADLs. The interventions included: PT/OT/ST/Restorative nursing as ordered.

Resident #14's current telephoned physician's orders, signed and dated on 3/31/16, included this order: D/C from PT/ST/OT. Refer to restorative nursing for transfers up to w/c. ROM, RLE and exercise program to LLE by wk (week) and BUE exercises.

Resident #14's restorative flow care sheet was reviewed for April 2016. Her sheet was completely blank for the exercises to be performed weekly as 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued 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 upper extremities) PROM/AROM (progressive range of motion/active range of motion) 2 X

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 that she was only able to provide RNP services about twice a week as she was usually pulled to work on the floor as a C.N.A.

No additional information was provided as to why the facility staff failed to provide physician ordered RNP to Resident #11.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		

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

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.

Completion Date: May 20, 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 15 problem, Cardiovascular/respiratory status...history of shortness of breath...history of respiratory failure. The interventions included, "O2 as ordered." The physician's orders, signed, 2/22/16, contained an order for 02 at 2 LPM via n/ (nasal cannula.) A second order, signed and dated 7/22/14 instructed staff to"Check O2 tank on w/c (wheel chair) q (every) 2 hours and as needed." On 4/12/16 at 3:10 PM, during the initial tour of the facility, Resident #2 was observed seated in the doorway of her room in a wheelchair. She had a portable oxygen tank on the back of her chair and oxygen tubing expending from the nasal cannula to the tank output valve. The tank was observe to be empty. RN I was requested to obtain her pulse oximeter rate. The reading was 85% (Normal is 94-100%.) 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. 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 328		
F 371 SS=D	483.35(i) FOOD PROCURE, 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 16	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. **Completion Date: May 20, 2016**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 17 ground hamburger on a regular bun and ST I took a knife in his right hand and held the bread in his bare left hand on the plate while he cut it with his knife. The resident indicated she did not want to eat the bun, so ST I picked up each small piece of bread and scraped the meat off of it to see if she would eat the meat without the bun. At no time during this did ST I don gloves to handle the resident's prepared foods. On 4/13/116 at 1:00 PM KS I (kitchen staff I) was interviewed about handwashing and gloving before handling prepared foods. She said she always used gloves, "I've had gloves on all day long. Oh no, never touch prepared foods with bare hands. It happens, but it's not supposed to." On 4/13/16 at 3:20 PM the DM (dietary manager) was consulted concerning handling prepared foods without gloving first. She stated, "Absolutely they should wear gloves. Mine use tongs on biscuits." The DON and administrator were informed of the observation on 4/13/16 at 12"45 PM. No additional evidence was presented.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	**F441** **Corrective Action(s):** The attending physician for resident #2 & #4 was notified that the facility failed to implement appropriate infection control practices for addressing resident #2 & #4 care needs. The volunteer and the DON have been inserviced on by the administrator on the possible indirect-transmission of infectious agents by their clothing touching multiple resident beds. An Incident & Accident form was completed for each incident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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. **Completion Date: May 20, 2016**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 seated--so they just sat on the bed.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 20	F 441		

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 10:00 AM CNA II and CNA III 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.

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 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 21	F 441		

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 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 22	F 441		

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 12:45 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 (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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 23 contact.....Clothing, uniforms, laboratory coats or isolation gowns..... No additional information was provided prior to the survey end.	F 441		
F 461 SS=E	483.70(d)(1)(vi)-(vii), (d)(2) BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET Bedrooms must have at least one window to the outside; and have a floor at or above grade level. The facility must provide each resident with-- (i) A separate bed of proper size and height for the convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident ' s needs, and individual closet space in the resident ' s bedroom with clothes racks and shelves accessible to the resident. CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1)(i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations-- (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety. This REQUIREMENT is not met as evidenced by:	F 461	**F461** **Corrective Action(s)** Residents #2, #3, #4, #6, #7, #8, #9 & #10 rooms have been assessed by the administrator and the maintenance director for appropriate room furnishings. The resident rooms involved in the review by the surveyor have had a chair placed in the rooms for comfort for each resident in the room. A Facility Incident & Accident form was completed for this incident. Identification of Deficient Practices & Corrective Action(s): All other resident rooms may be potentially affected. The facility Maintenance Director and Administrator conducted a 100% audit of resident rooms to identify any rooms that are in need of room chairs. All identified rooms will be logged and an accurate chair count obtained. Resident room chairs will be ordered to be placed in all rooms identified as needing chairs. Systemic Change(s): The facility's policy & procedure for providing functional furniture appropriate for the residents needs. No changes are warranted at this time. The administrator will inservice all staff on the requirement for providing functional furniture to meet the residents needs. As well as the proper notification system to use when repairs are needed throughout the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 461	Continued From page 25	F 461		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 461	Continued From page 26	F 461		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 (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."

No additional information was provided prior to the survey end.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 461	Continued From page 28	F 461		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 461	Continued From page 29	F 461		

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."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 461	Continued From page 30	F 461		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 461	Continued From page 31	F 461		

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."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 461	Continued From page 32	F 461		

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.

5. For Resident #3 the facility staff failed to provide a chair in the room for resident and visitor comfort.

Resident #4 was an 84 year old male who was originally admitted on 11/14/13 and readmitted on 4/14/15. Admitting diagnoses included, but were not limited to: dementia with behaviors, anxiety, diabetes mellitus, hypertension. aortic aneurysm, dysphagia, altered mental status and cognition and communication deficit.

The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment reference Date (ARD) of 2/03/16. The facility staff coded that Resident #3 had short and long term memory impairment (1/1) and was severely impaired (3) with daily decision making. The facility staff also coded that Resident #3 required extensive (3/3) to total nursing care (4/3) with Activities of Daily Living (ADL's).

On April 12, 2016 at 4:35 p.m. the surveyor observed Resident #3's room. The surveyor observed that it was a double occupancy room. The surveyor did not observe a chair in the room for either resident and for visitor comfort.

On April 13, 2016 at 7:20 a.m. the surveyor observed Resident #3's room. The surveyor did not observe that a chair was available for resident or visitor comfort.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495350	A. BUILOING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET AOORESS. CITY, STATE, ZIP CODE
HERITAGE HALL WISE	9434 COEBURN MOUNTAIN ROAD WISE, VA 24293

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 461	Continued From page 33	F 461		

not observe that a chair was available for resident or visitor comfort.
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 a chair for resident and visitor comfort in Resident #3's room.

No additional information was provided prior to exiting the facility as to why the facility staff failed to provide a chair for comfort for Resident #3 or for visitors.

6. For Resident #4 the facility staff failed to provide a chair in the room for resident and visitor comfort.
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 Daily Living (ADL's).
On April 12, 2016 at 4:35 p.m. the surveyor observed Resident #4's room. The surveyor observed that it was a double occupancy room. The surveyor did not observe a chair in the room for either resident and for visitor comfort.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 461	Continued From page 34	F 461		

On April 13, 2016 at 8:35 a.m. the surveyor observed Resident #4's room. The surveyor did not observe that a chair was available for resident or visitor comfort.
On April 14, 2016 at 9:25 a.m. the surveyor observed Resident #4's room. The surveyor did not observe that a chair was available for resident or visitor comfort.
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 a chair for resident and visitor comfort in Resident #4's room.

No additional information was provided prior to exiting the facility as to why the facility staff failed to provide a chair for comfort for Resident #4 or for visitors.
7. For Resident #8 the facility staff failed to provide a chair in the room for resident and visitor comfort.

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 deficits and impaired ability in daily decision-making. The resident was assessed with 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 place to sit when he visited.

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

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

Resident #10 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 461		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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 514	**F514** **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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 38	F 514		

MAR's documented that the facility staff were administering the Duoneb breathing treatments every six (6) hours as ordered by the physician. Continued review of the clinical record produced the Physician Order Sheet's (POS's) signed and dated 3/29/16. Review of the signed POS's failed to include the physician order for the Duoneb breathing treatments every six hours for shortness of the breath.

On April 13, 2016 at 7:55 a.m. the surveyor reviewed Resident #5's clinical record with the Unit Manager (UM), who was a Registered Nurse (RN). The surveyor reviewed the physician telephone order dated 3/25/15 that ordered for the Duoneb breathing treatments to be administered every six hours. The surveyor also reviewed the April 2016 MAR's with the UM. The surveyor pointed out that the facility staff were administering the Duonebs every six hours as ordered by the physician. Lastly the surveyor reviewed the signed POS's with the UM. The surveyor pointed out that the physician order for the Duonebs had not been transcribed by the facility staff to the POS's dated 3/29/16.

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 ensure a complete and accurate clinical record for Resident #5. The surveyor notified the Administrative Team (AT) that Resident #5 had a physician telephone order on 3/25/16 that ordered Duoneb breathing treatments every six hours. The surveyor notified the AT that the order for the Duonebs had not been transcribed to the POS's that were signed by the physician on 3/29/16.

No additional information was provided prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 39 exiting the facility as to why the facility staff failed to ensure a complete and accurate POS's for Resident #5.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495350	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	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