Our family exists to care for yours.

April 25, 2017

Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive – Suite 401
Attn: Rodney Miller, Long Term Care Supervisor
Richmond, VA 23233

Mr. Miller;

Attached to this cover letter you will find Heritage Hall – Wise's Plan of Correction and our credible allegation of compliance. The Plan of Correction addresses the corrective action, identification of deficient practices, systemic changes, and monitoring that will be implemented to address deficient practices identified during the annual survey process.

If I can be of further assistance don't hesitate to contact me at (276) 328-2721.

Sincerely;

Sam Justus Administrator

APR 28 2017
VDH/OLC



DEPARTMENT OF HEALTH AND HUMAN SERVICES NTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/20/2017 FORM APPROVED OMB NO. 0938-0391

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TAG REGULATOR			200		
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F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid standard survey was conducted 04/4/17 through 04/6/17. Corrections are required for compliance with 42 CRF Part 483 Requirements for Federal Long Term Care facilities. The Life Safety Code survey/report will follow.

The census in this 97 certified bed facility was 88 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents 1 through 16 and 19) and 3 closed record reviews (Residents # 17, #18 and # 20).

F 272 483.20(b)(1) COMPREHENSIVE

SS=D ASSESSMENTS

(b) Comprehensive Assessments

- (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
- (i) Identification and demographic information
- (ii) Customary routine.
- (iii) Cognitive patterns.
- (iv) Communication.
- (v) Vision.
- (vi) Mood and behavior patterns.
- (vii) Psychological well-being.
- Physical functioning and structural (viii) problems.
- (ix) Continence.
- (x) Disease diagnosis and health conditions.
- (xi) Dental and nutritional status.
- (xii) Skin Conditions.

F 272

F2.72 Corrective Action(s):

Resident #4 has had a modification completed for their current quarterly MDS to accurately reflect the use of a restraint and restorative nursing care.

Identification of Deficient Practices & Corrective Action(s):

All other residents using restraints or receiving restorative nursing may have been potentially affected. A 100% review of all residents using restraints or receiving restorative nursing will be completed by the RCC to identify residents affected. All residents affected will have their current MDS assessments modified at the time of discover and their 《 comprehensive care plans updated.

Systemic Change(s):

TITLE

The facility policy and procedure was reviewed and no changes are warranted at this time. The regional nurse consultant will inservice the Resident Care Coordinator's and the interdisciplinary

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

(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES R MEDICARE & MEDICAID SERVICES

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F 272	Continued From particles (xiii) Activity pur (xiv) Medication (xv) Special treatm (xvi) Discharge (xvii) Documen regarding the addron the care are of the Minimum D (xviii) Documen assessment. The include direct observation of the resident, as we licensed and non-lice on all shifts.	age 1 rsuit. ns. nents and procedures. planning. tation of summary information itional assessment performed eas triggered by the completion tata Set (MDS). Itation of participation in assessment process must ation and communication with rell as communication with		272	Care Plan Team on accur sections of the MDS. This accurate coding of section and section O for restoral Monitoring: The RCC is responsible compliance. The RCC with MDS audit tool weekly of the MDS calendar to mo compliance. Any/all negwill be reported to the R at the time of discovery correction. Aggregate for reported to the Quality of Committee for review, a recommendations for chaprocedure, and/or facility Completion Date: May	is will include in P for restrative nursing. for maintaining will complete coinciding winitor for ative findings CC and the E for immediate indings will be Assurance in alysis, and langes in policy practice.	ents ing th soon e
	observation and as well as comm non-licensed dire shifts. This REQUIREM by: Based on obser record review, th accurate minimu 20 residents (ReThe findings incomplete The facility staff Resident #4's planursing.	luded: failed to accurately code hysical restraint and restorative	al of			CEIVE 8 2 8 201 0 H/OL (
	Resident #4's cl and 4/6/17. Re	linical record was reviewed 4/5/ sident #4 was admitted to the	1 /				

PRINTED: 04/20/2017

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CHACKE	S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/SLIA IDENTIFICATION NUMBER			STRUCTION	CO	MPLETED
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an and the later of the later o	and the second s			STREET	ADDRESS, CITY, STATE, ZIP CO	DE	
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F 272	Continued From p	page 2	·		<i>y</i>		
	طحما	cluded but not limited to heart estructive pulmonary disease,					
	failure, chronic ou	pation, dementia with behavior	al				
	disturbances, and	emia, and insomma.					
	Resident #4's mo	est recent quarterly minimum	,				
	1 (MAT)C) 0	ceaecment will all assessing.	t				
	. f non data (A	KIII UL Z/3/ 11 92262200 110					
	r s . s s - horsen	hath charl and long long					
		is and moderately impaired or daily decision making.					
	cognitive skills to	cisions were identified to be po	or				
	Resident #4 5 00	pervision required.					
	(a). The facility	staff failed to accurately code					
		With an ARD of 0/25/10 diffe of					
		vith an ARD of 11/17/16.					
	The surveyor of	eserved Resident #4 on 4/5/17 a	at				
	mar Donie	font the was silling at the hard	~				
	-larming cos	their on the wiletician and ac-	(ea				
	interest if of	no como imposiem me pere					
	- · · · · · · · · · · · · · · · · · · ·	e able to litilastell the source.	lish				
	with some diffic	ulty but did manage to accompl					
	the task.						
	Desident #A's C	linical record contained a					
		dated 6/13/16 Will a signed					
			.				
	alabair and	orders to check every every	ies				
	and release for	10 minutes every flour.					
	The quarterly N	MDS with an ARD of 8/25/16	r				
	Doci	Aggrand Have Impairing the	1				
	1 11 1	long term mellioly and severe	,				
	impaired cogni	tive skills for daily decision mak					

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

Section P (Restraints) was reviewed. There was Event ID: 37XF11

Facility ID VA0119

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY STATE, ZIP CODE 9434 COEBURN MOUNTAIN ROAD WISE, VA 24293	
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F 272	#4. The surveyor of Assessment Form' by registered nurse of the quarterly MDS assessed Resident both short and long impaired cognitive Section P (Restrain no documentation #4. The surveyor of Assessment Form completed by regis interviewed R.N. # #3 stated she miss surveyor also interviewed regis interviewed R.N. # #3 stated she miss surveyor also interviewed regis interviewed R.N. # #3 stated she miss surveyor also interviewed R.N. # #3 stated she miss surveyor also interviewed R.N. # #45/17 at 3:30 p. Resident #4 had the June 2016, the fact DON provided the that included seatt	of restraint use for Resident reviewed the "Restraint Need" dated 8/25/16 and completed e #3. with an ARD of 11/17/16 t #4 to have impairments for g term memory and moderately skills for daily decision making. Ints) was reviewed. There was of restraint use for Resident reviewed the "Restraint Need" dated 11/17/16 and stered nurse #3. The surveyor 3 on 4/5/17 at 2:45 p.m. R.N. sed coding the restraint. The viewed the director of nursing o.m. The DON stated since the order for the seatbelt from saility had used the seatbelt. The March 2017 completed tasks		272	

(b) The facility staff failed to accurately code restorative nursing on two (2) quarterly MDSs-a quarterly MDS with an ARD of 10/11/16 and a quarterly MDS with an ARD of 2/9/17.

Resident #4 had physician orders dated 10/13/16 that read "patient discontinued from occupational therapy to restorative nursing for BUE (bilateral upper extremity) AROM (active range of motion) exs (exercises) 2 x 15 reps (repetitions), sit to stand 5 reps and transfers with ? (unable to read)."

The quarterly MDS with an ARD of 11/17/16 assessed the resident with short and long term memory problems and moderately impaired

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112111111				PROVIDER'S PLAN OF CORREC	CTION X5.
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F 272	Continued From pa	age 4	F 2	72	
	cognitive skills for O Special Treatmer was reviewed. Re (Section 00500) where were no recommendated program. The Oct 2016 rehabilitative reviewed. During (11/11/16 through Resident #4 was destremity exercise transfers (11/15/16 11/17/16) were comparticipation in resimarked on the qualitative boxes was a The quarterly MDS also reviewed as a restorative flowship restorative nursing	daily decision making. Section ents. Procedures and Programs storative nursing programs as reviewed for accuracy. Orded number of days Resident in the restorative nursing ober 2016 through November (restorative flowsheets were the look back period of 7 days and including 11/17/16) Checked that bilateral upper s, transfers and sit to stand and 11/16/16 and refused on mpleted. Resident #4's storative nursing was not earterly MDS. The coding for			

The surveyor interviewed registered nurse #3 on 4/5/17 at 2:45 p.m. about the restorative coding on both quarterly MDSs for Resident #4. R.N. #3

transfers (2/3/17 through 2/9/17-7 days) and sit stand transfers 2/3/17, 2/4/17, 2/5/17, and 2/7-2/9/17-6 days. Resident #4 refused sit to stand transfers on 2/6/17. Section O was reviewed for accuracy of restorative coding. Resident #4 was coded for 3 days of eating and/or swallowing. The surveyor found no order for this in the clinical record. There was no recorded number of days for active range of motion for the bilateral upper extremity exercises, transfers or sit to stand transfers. The coding for

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APR 28 2017



these boxes was a 0 (zero).

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STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495350	B WING		04/06/2017
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F 272	Continued From pa stated that the rest done correctly-it wa	orative nursing coding was not	F 272		
	director of nursing, and the administra	med the administrator, the the corporate registered nurse tor in training of the above for restraints and restorative in #4's MDSs in the end of the 5/17 and on 4/6/17.			
F 281 SS=D	exit conference on	RVICES PROVIDED MEET STANDARDS	F 281	F281 Corrective Action(s): Resident #13's attending physic been notified that the facility state to follow infection control pract	ff failed
	The services provi as outlined by the must-	ded or arranged by the facility, comprehensive care plan,		resident #13 who had Influenza Facility Incident & Accident Fo completed for these incidents.	A. A
	This REQUIREME by: Based on observa document review a facility staff failed t practice in regards residents with Influ The findings include 1. The facility staff	ded: failed to follow infection control		Identification of Deficient Practices/Corrective Action(s) All other residents may have be potentially affected. The DON of Manager will conduct a 100% reall resident's with Influenza As infection control practices in plaidentify any residents at risk. As identified at risk will be correct of discovery and the attending point will be notified of each improposition of the practice noted. A facility & Accident form will be complete.	en or Unit eview of and the ace to Il residents ed at time bhysician er infection y Incident
	Influenza A. Resident #13 was	readmitted to the facility on owing diagnoses of, but not		each negative finding.	

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Event ID: 37XF11

Facility ID: VA0119

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTER'S FOR MEDICARE & MEDICARD SERVICES

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t to constitute the constitute of the constitute	pressure, urinary trafibrillation, and gene MDS (Minimum Dat (Assessment Reference the resident as having Mental Status) scorof 15. Resident #13 set up supervision for the supervision for the supervision for the supervision for the stationary of the staff will go and sometimes become also have another alloway too." At approximately 2:3 the team leader for the staff will supervision for the surveyor went to Hall was observed that the front of the nurse esidents laughing and were sitting near Resident and we from Resident supervision of the staff will surveyor went to Hall was observed that the front of the nurse esidents laughing and were sitting near Resident supervision Resident supervision Resident Res	eart failure, high blood act infection, depression, atrial aralized edema. The quarterly as Set) with an ARD ence Date) of 1/24/17 codeding a BIMS (Brief Interview for e of 10 out of a possible score as was also coded as requiring or eating and personal Resident #13 requires e from 1 staff member for a ron Hall 1 with unit manager eximately 1:45 pm, the areport that "This resident is in isolation, but he does are the comes out of his room aim to put on his face mask or get it and put it on him. He me mad and curse the staff, er case of Influenza A on this are companied by another and to the nurses' station and Resident #13 was sitting in s' station with 10 other and talking. Resident #19 did but the other residents that sident #13 were less than 3	F 2	Systemic Change(s): The facility policy and proced been reviewed and no revision warranted at this time. The nu assessment process as evidence 24 Hours Report, documentating medical record and physician remains the source document development and monitoring of which includes, proper infection practices to prevent the spread Influenza A and administering ordered medications per physician Licensed staff will be inserviced DON and/or regional nurse control to include proper control prevent the spread of Influenza Monitoring: The DON is responsible for macompliance. The DON and/or Manager will review physician the care plans of residents diagonal Influenza A to ensure proper Influenza A to ensure pro	as are rsing ced by the con in the corders for the cof care con control l of g physician cian order. ed by the insultant on cection rols to a A. aintaining Unit n orders and gnosed with infection instituted in Any/all cted at time iction taken is of these coulity y for endations rocedure,
1	ne survey team mei	. with the authinistrative			1

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team at approximately 3:30 pm in the conference

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Facility ID: VA0119

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	room. The surveyor team of the above to concerns of the surthe nurses' station: DON (director of number had been treated without no longer had a few proper precautions resident and no one only ones that have requested the facilit Influenza. The surveyor was putitled "Influenza, Pre Seasonal" on 4/5/17 nurse. In this policy "Influenza Modes of 1a. Transmission with requires close conta (approximately six (final content of the surveyor of the surveyor of the surveyor of the surveyor of 4/6/17 between the surveyor of 4/6/17	or notified the administrative documented findings and the vey team of Resident #13 at as described above. The arsing) stated that the resident ith Tamiflu since 4/1/17 and he er. The staff has taken the when giving care to this else besides these 2 are the Influenza A. The surveyor y's policy concerning rovided a copy of the policy evention and Control of at 8 am by the corporate it stated the following: Transmission is large-particle droplets of between distances of feet or less) through the air increased influenza activity of minimize elective visits by elected or confirmed influenza symptoms of respiratory couraged to sit as far as away bile "	F 2	81	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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HERITA	GE HALL WISE		Second many annual spaces.	9434 COEBURN MOUNTAIN ROAL WISE, VA 24293)	
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F 281	Continued From pa	ge 8	F 2	281		
	placed in Contact Is received on 4/1/17.	solation after the results were Then according to the e plan the resident was placed	}			
	asked the unit manaresidents resided or stated "there are 58 The surveyor also a many residents wer The unit manager remanager also stated this hall have been a precautionary meas	simately 3:30 pm, the surveyor ager for Hall1 how many in Hall 1. The unit manager is residents on this hallway." I sked the unit manager how e positive for Influenza A. Explied "only 2". The unit id "all the other residents on started on Tamiflu as a ure". The surveyor asked the approximately 6 pm".				
	concerns document Resident #13 having nursing station in clo residents even thou mask on. This occu approximately 5 pm	eam was notified of the ed above concerning g Influenza A and was at the ose proximity of other gh the resident had a face rred on 4/5/17 at and then again on 4/6/17 at om by the surveyor in the				
	surveyor prior to the	on was provided to the exit conference on 4/6/17. PROVIDE CARE/SERVICES LL BEING	F 30	Corrective Action(s):	112a attan din a	
	applies to all care an residents. Each resi	ndamental principle that d services provided to facility dent must receive and the the necessary care and		Residents #2, #4, #7 & # physicians were notified failed to administer or fol protocol as ordered by the standing prders. A facility Accident form was comp	that the facility llow the bowel e physician y Incident and	

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services to attain or maintain the highest

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Facility ID: VA0119

incident.

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				9434 COEBURN MOUNTAIN ROAD	
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F 309	Continued From pa	one Q	F 30	OO Identification of Deficient	
1 303	· · · · · · · · · · · · · · · · · ·	-	ГЭ	Practices/Corrective Action(s	s):
		al, mental, and psychosocial		All other residents may have be	
		ent with the resident's		potentially affected. The DON	
	comprehensive ass	sessment and plan of care.		and Unit Managers will conduc	
	402 25 Quality of a	are		audit of all resident bowel repo	rts to
	483.25 Quality of care is a	fundamental principle that		identify residents at risk.	
		nent and care provided to		Residents identified at risk will	
		ased on the comprehensive		corrected at time of discovery a	
	-	sident, the facility must ensure		attending physicians will be no each negative finding and a fac	
		ve treatment and care in		Incident & Accident Form will	
		ofessional standards of		completed for each negative fin	
		ehensive person-centered		completed for each negative in	umg.
		residents' choices, including		Systemic Change(s):	
	but not limited to the			The facility policy and procedu	res have
		-		been reviewed and no revisions	
	(k) Pain Manageme	ent.		warranted at this time. The nurs	
		sure that pain management is		assessment process as evidence	
		ts who require such services,		24 Hour Report and documenta	
		essional standards of practice,		medical record /physician order	
		person-centered care plan,		the source document for the dev	
	and the residents' g	poals and preferences.		and monitoring of the provision which includes following and	of care,
	an Disk in The fee	444		administering the bowel protoco	ol ner
		cility must ensure that		physician standing orders. The	
		ire dialysis receive such		and/or Regional nurse consultar	
		t with professional standards apprehensive person-centered		inservice all licensed nursing st	
	care plan, and the re	•		procedure for following and add	ninistering
	preferences.	esidents goals and		the bowel protocol per physicia	
	,	T is not met as evidenced			
	by:	II is not met as evidenced		Monitoring:	
		rview, facility document		The DON will be responsible for	
		record review, the facility staff		maintaining compliance. The D	
		established bowel protocol for		ADON and/or Unit Managers w	
		esident #4, Resident #7,		perform daily audits of the bow	
	Resident #2, and Re			to monitor for bowel protocol co Any/all negative findings and or	
	, , , , , , , , , , , , , , , , , , , ,	,		will be corrected at time of disc	
	The findings include	ed:		disciplinary action will be taken	

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1. The facility staff failed to follow the bowel

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needed. Aggregate findings of these







DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
	495350	B. WING		04/06/2017
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL WISE			STREET ADDRESS, CITY STATE, ZIP COI 9434 COEBURN MOUNTAIN ROAD WISE, VA 24293	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE COMPLETION
to follow the physici constipation [MOM mouth) 1 oz (ounce needed) Not to exceeded pulcolax sup (support day prn (not to exceeded) Policolax sup (support day prn (not to exceeded) Policolar sup (support day prn). Resident #4's clinicated facility 5/17/16 and indiagnoses that inclust failure, chronic obstruction obstruction obstruction of the facility support follows and support for the facility support follows and super required extensive attransfers and toileting always be incontined. Resident #4's current dated 2/10/17 identificated follows and super required extensive attransfers and toileting always be incontined. Resident #4's current dated 2/10/17 identificated follows and super required extensive attransfers and toileting always be incontined.	ant #4. The facility staff failed an's standing orders for (Milk of Magnesia) PO (by) q (every) day PRN (as seed 2 days in a row], ository) 10 mg (milligrams) qued 2 days in a row), fleets all record was reviewed 4/5/17 ant #4 was admitted to the readmitted 5/25/16 with aded but not limited to heart ructive pulmonary disease, tion, dementia with behavioral ia, and insomnia. Trecent quarterly minimum ressment with an assessment D) of 2/9/17 assessed the h short and long term and moderately impaired	F	audits will be reported to the Assurance Committee quarter review, analysis, and recomfor change in facility policy, and/or practice. Completion Date: May 11,	erly for mendations , procedure,
Approaches: Monito	r for s/s (signs or symptoms)			

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	NO TON MEDIONIN	- A MILDIO/ND OLIVIOLO			OIVID IN	<u>U. 0936-035</u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		ATE SURVEY OMPLETED
		495350	B. WING		0,	4/06/2017
NAME OF	A95350 AME OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 11 of UTI (urinary tract infection) constipation or fecal impaction. Monitor BMs (bowel movements) & doc (document)." The surveyor reviewed the June 2016 through April 2017 bowel report roster in the electronic clinical record. The July 2016 bowel movement documentation revealed Resident #4 had no bowel movement from 7/1/16 through 7/4/16 (4 days) and 7/17/ through 7/21/16 (5 days). The July 2016 progress notes for these days were reviewed at there was no documentation that Resident #4 been incontinent of bowel. The July 2016 electronic medication administration records (eMARs) were reviewed at the eMARs had no documentation that the physician's standing order for constipation had been implemented. There was documentation			STREET ADDRESS, CITY, STATE, ZIP C		
HERITA	GE HALL WISE			9434 COEBURN MOUNTAIN ROAD WISE, VA 24293		
(X4+1E) PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		SHOULD BE	FX56 COMPLETION DATE
F 309	Continued From pa	age 11	F 3	309		
	fecal impaction. M	onitor BMs (bowel				
	April 2017 bowel re	_				
	revealed Resident # from 7/1/16 through through 7/21/16 (5 c progress notes for there was no document there was no document.)	#4 had no bowel movements in 7/4/16 (4 days) and 7/17/16 days). The July 2016 these days were reviewed and mentation that Resident #4 had				
	administration recor The eMARs had no physician's standing been implemented. 7/22/16 that the resi	rds (eMARs) were reviewed. documentation that the gorder for constipation had				

The September 2016 and October 2016 bowel report roster indicated Resident #4 did not have a bowel movement from 9/29/16 through 10/4/16 (6 days). The September 2016 and October 2016 eMARs did not have documentation that Resident #4 received medications for constipation from the physician's standing orders. The September 2016 and October 2016 progress notes for 9/29/16 through 10/4/16 were reviewed. There was no documentation of bowel continence in the notes.

day that Resident #4 had no bowel movement.

The December 2016 bowel report roster indicated Resident #4 did not have a bowel movement

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1			(X3) DATE SURVEY COMPLETED
		495350	B WING			04/06/2017
	EMENT OF DEFICIENCIES PLAN OF CORRECTION X1) PROVIDER SUPPLIER X495350 X495350 X91 MUNG					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFI	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETION
	between 12/5/16 the from 12/10/16 throw received medication. December 2016 eN documentation that a fleets enema. The surveyor informative above finding or requested the facility. The surveyor intervicensed practical in L.P.N. #1 stated the to pull a "No BM for and then per the stasuppository and the surveyor reviewed thave a bowel move those dates. L.P.N in her position since comment about the movement concern. The administrator protocol to the surveyor read as for Unit manager will of Activities of Daily Li will be responsible for dayshift has a list of the surveyor for the surveyor surveyor for the surveyor	rough 12/8/16 (4 days) and ugh 12/15/16 (6 days) or ins for constipation. The MAR did not have Resident #4 received MOM or med the administrative staff of in 4/5/17 at 5:40 p.m. and the bowel protocol. iewed the unit manager urse #1 on 4/6/17 at 9:20 a.m. in a days report each morning anding orders give MOM, a in a fleets enema. The interest he dates Resident #4 did not ment and no interventions for its formal to the cotober 2016 but had no December 2016 bowel	F 3	09	DEFICIENCY)	
	to the list anyone wl bowel protocol. The bowel protocol	ck the 24-hour report to add no needs next step in the will be initiated on Day 3 of no in the day shift unless the				

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resident wishes to wait until the evening shift of

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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CENTERS FOR MEDICAR	(E & MEDICAID SERVICES			WOLDATE CHOVEY
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	NG	001111 20 122
The state of the s				
ALL CONTRACTOR OF THE PROPERTY	495350	B WING		04/06/2017
			STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIE	K	na n	9434 COEBURN MOUNTAIN ROAD	
HERITAGE HALL WISE				
HERITAGE HALL WISE		-	WISE, VA 24293	
POSETS (FACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION

F 309 Continued From page 13

that day).

The "standing orders" for bowel protocol will be as follows:

- 1. Milk of Magnesia 1 oz every day PO prn on day 3 of no bowel movement (not to exceed 2 days in a row).
- 2. Dulcolax Suppository 1 per rectum (PR) prn on day 5 of no bowel movement (not to exceed 2 days in a row).
- 3. Fleets enema 1 per rectum (PR) prn on day 7 of no bowel movement (BM). Call medical doctor (MD) if no bowel movement within 24 hours of initiation of above protocol. Call responsible party (RP) if any change in condition is apparent.

Results of intervention will be documented.

No further information was provided prior to the exit conference on 4/6/17.

2. The facility staff failed to follow the physician standing orders protocol when the resident had no bowel movements for greater than 3 days; for Resident #7.

Resident #7 was admitted to the facility 3/3/16 with the diagnoses that included but was not limited to: diabetes mellitus, Aphasia, Seizure disorder, depression, and stroke with right sided weakness.

Resident #7's admission minimum data set assessment (MDS) with an assessment reference date (ARD) of 3/10/16 assessed the resident to sometimes be understood and usually understands. Resident #7's bed mobility was coded as extensive assistance of 2 persons. He was also coded as incontinent of bowel and bladder requiring assistance with toileting.

F 309

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	OND SERVICES				C	MB NO	. 0938-0391
CENTERS FOR MEDICARE & MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDENT	VIDER/SUPPLIER/CLIA FIFICATION NUMBER	1		NSTRUCTION			E SURVEY MPLETED
	495350	B WING 04		04/	/06/2017		
NAME OF PROVIDER OR SUPPLIER			9434	COEBURN MOUNT			
HERITAGE HALL WISE			WISE	E, VA 24293			
(X4) ID SUMMARY STATEMENT O PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFI TAG		(EACH CORRECT CROSS-REFERENCE)	PLAN OF CORRECTION TIVE ACTION SHOUL CED TO THE APPROF EFICIENCY)	D BE	(X5) COMPLETION DATE
F 309 Continued From page 14 The March 2017 signed phy reviewed 4/6/17. Included ir routine standing orders. The orders dated 3/17/17 read, oz. (ounce) Q (every) day P exceed 2 days in a row: Dumg Q day PRN, fleets Q day PRN, fleets Q day and March 2017 rehad no bowel movements from 1/27/17 and 3/7/17 through, the medication administration reveal that the bowel protocon The resident did not receive standing order medications months of January or March On 4/5/17 during a meeting administrator, director of numure consultant the above discussed. The facility bower equested and provided to director of nurses. The director of nurses proving protocol to the surveyor on protocol titled "Bowel Evacuation Protocol" read as follows un Unit manager will check be Activities of Daily Living (Ali will be responsible for making shift has a list of anyone not so bowel protocol can be sinurses will also check the 2 to the list anyone who need to bowel protocol.	rsician orders were a the orders were the e routine standing 'Constipation: MOM RN (as needed) not elected a suppository 10 y PRN. In the orders were the e routine standing 'Constipation: MOM RN (as needed) not elected Resident #7 rom 1/23/17 through 3/10/17. Review of on record did not elected had been followed any of the bowel during the entire in. In with the insess and the regional information was ell protocol was the surveyor by the lided the facility bowel was allowed and the rocedure: well movement (BM) DL) sheets-the nurses and started. The shift 24-hour report to add	1 to D	309		POLENCT)		

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The bowel protocol will be initiated on Day 3 of no

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO	0.0938-0391
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(¥2) MUI	TIPLE CO	ONSTRUCTION		TE SURVEY
STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:				COI	MPLETED
		495350	B. WING				/06/2017
NAME OF BE	ROVIDER OR SUPPLIER			ł .	ET ADDRESS, CITY, STATE, ZIP CO	DE	
				1	COEBURN MOUNTAIN ROAD		
HERITAGI	E HALL WISE			WIS	E, VA 24293	DECTION!	(X5)
(X4) ID PREFIX TAG	CAOU DEDOUGHO	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
E 200	Continued From page	age 15	F	309			
F 309	Rowel Movement (on the day shift unless the					
	resident wishes to	wait until the evening shift of					
	that day)						
	The "standing orde	ers" for bowel protocol will be					
	as follows:	ia 1 oz every day PO prn on					
	day 3 of no bowel	movement (not to exceed 2					
	dave in a row)						
	2. Dulcolax Suppo	ository 1 per rectum (PR) prn vel movement (not to exceed 2					
	dave in a row)						
	3. Fleets enema 1	1 per rectum (PR) prn on day 7					
	of no howel move	ment (BM).					
	Call medical docto	or (MD) if no bowel movement initiation of above protocol.					
	Call responsible D	arty (RP) if any change in					
	condition is appar	ent.					
- Charles and Char	Results of interver	ntion will be documented.					
	No further informa	ation was provided by the facility					
	prior to the exit co	inference.					
	3. The facility fail	ed to follow the facility's bowel					
	protocol for Resid	ent #2.					
	D == 1 d == #2 14/25	admitted to the facility on					
	5/22/14 with the d	liagnoses of, but not limited to					
	anemia high bloc	od pressure, urinary tract					
	infaction stroke	hemiplegia, seizure disorder,					
	anxiety disorder,	depression, psychotic disorder uctive pulmonary disease. The					
	regident was code	ed on the annual MDS					
	(Minimum Data S	et) with an ARD (Assessment					
	Peterence Date)	of 3/7/17 as not being able to					
	complete the BIM	IS (Brief Interview Mental Status bol) interview. Resident #2 was	ī				
	also coded as rec	nuiring only set up supervision					
	with personal hyd	liene. The resident requires					
	extensive assista	nce by 1 staff member for					

bathing.

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Facility ID. VA0119

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DEPARTMENT OF HEALTH	AND HUMAN SERVICES			FORM APPROVED OMB NO 0938-0391
CENTERS FOR MEDICARE	& MEDICAID SERVICES		with the second of the second	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG	COMPLETED
	495350	B. WING		04/06/2017
		1	STREET ADDRESS, CITY STATE, ZIP C	CODE
NAME OF PROVIDER OR SUPPLIER			9434 COEBURN MOUNTAIN ROAD WISE, VA 24293	
HERITAGE HALL WISE			PROVIDER'S PLAN OF CO	RRECTION (X5)
(A4) IU (EACH DEEKICIENIC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION	A SHOULD BE
F 309 Continued From p	age 16	F.	309	
Resident #2's clini	cal record was reviewed by the			
curveyor on 4/5/17	7. The surveyor noted that on			
the bowel report the	ne following documentation			
stated that the res	ident had no bowel for these /11/17, 2/9/17 to 2/12/17, and			
dates: 1/3/1/ 10 1	There was no documentation			
noted in the nurse	es' notes for these days			
regarding if the re	sident had a bowel movement.			
On 4/5/17at appro	eximately 5 pm, the			
administrative tea	im was notified of the above			
documented finding	ngs by the surveyor in the The surveyor requested a			
copy of the facility	s bowel protocol.			
On 4/6/17 at 2:15	pm, the administrator provided			
a copy of the bow	vel protocol titled "Bowel am and Protocol". The protocol			
Evacuation Progr stated the following	all and Lorocot . The brass.			
" " Unit Mana	ager will check bowel movement	t		
(RM) or Activities	of Daily Living (ADL) sheets -			
the nurses will be	responsible for making sure			
that the dayshift h	has a list of anyone not having			
BM X (times) 3 d	ays so bowel protocol can be			
started	g orders" for bowel protocol will			
" The "standing	g orders for bower protessor			
be as follows:	nesia 1 oz. every day PO (by			
mouth) prn (as ne	eeded) on day 3 of no bower			
movement (not to	n exceed 2 days in a row).			
2 Dulcolay Sur	pository 1 per rectum (PK) PITE)		
on day 5 of no bo	owel movement (not to exceed 2	_		
days in a row).	- 1 mar rootum (DR) orn on day	7		
" Fleets enem	a 1 per rectum (PR) prn on day	-		
of no bowel mov	doctor (MD) if no bowel			
Call medical	ti-Watton of above			

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protocol ..."

movement within 24 hours of initiation of above

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DEDART	MENT OF HEALTH	AND HUMAN SERVICES			OMB NO. 0938-0391
DEFARIT	S FOR MEDICARE	& MEDICAID SERVICES		SUPERING TO BY TOTAL	(X3) DATE SURVEY
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		PLE CONSTRUCTION G	COMPLETED
		495350	B WING	ens a constitution, symmetric Edit is the year of the state of the sta	04/06/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	
				9434 COEBURN MOUNTAIN ROA WISE, VA 24293	AD .
HERITAG	E HALL WISE			PROVIDER'S PLAN OF	CORRECTION (X5)
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE DATE
L 300	Continued From p	page 17	F 30	9	
F 309	The curveyor revi	ewed the resident's MAR for the	e		
	. I	ad dates of no buwer			
	movements The	surveyor did not note any or an			
	decomposited as h	ns in the bowel protocol eing given in the nurses' notes			
	nor on the MAR (Medication Administration			
	Record) for Resid	dent #2.			
	Op 4/5/17 at app	roximately 5 pm, the			
	administrative tea	am was notified of the			
	documented find	ings by the surveyor in the			
	conference room				
	On 4/6/17 at app	roximately 3 pm, the corporate			
	d tho cu	rveyor reviewed the above lings. The corporate nurse cou			
	documented find	staff followed the standing orde	rs		
	for the bowel pro	otocol.			
	No further finding	gs were provided to the surveyo conference on 4/6/17.	or		
	·				
	4. The facility st	aff failed to follow the facility's			
	bowel protocol f	or Resident #11.			
	Resident #11 wa	as admitted to the facility on			
	a lake with the f	allowing diagnoses of, but not			
	limited to blood	clots, heart failure, high blood tes, dementia, anxiety disorder,			
	doproceing and	Fibromyaigia. On the quarter,	y		
	* *DC /Minimum	Data Seti with all AND			
	(Assessment R	eference Date) of 1/25/17, the ded as having a BIMS (Brief			
	totaminus for Me	antal Status, all assessine in			
	t = == 1\ of OO:	the resident was ullable to	ał.		
	samplete the R	IMS interview. The resident has	u		
	short term and	long term memory problems. ras also coded as requiring			
	Resident #11 W	tance of 1 staff member for			

extensive assistance of 1 staff member for

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	MENT OF HEALTH	AND HUMAN SERVICES			OMB NO. 0938-0391	
DEPART	S FOR MEDICARE	& MEDICAID SERVICES		TO CONCEDUCTION	(X3) DATE SURVEY	
CENTER	OF DEFICIENCIES			TIPLE CONSTRUCTION ING	COMPLETED	
ND PLAN O	CORRECTION	IDENTIFICATION NUMBER	A BUILDI	NG		
		495350	B WING	A STATE OF THE STA	04/06/2017	
			1	STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
NAME OF F	PROVIDER OR SUPPLIER			9434 COEBURN MOUNTAIN ROAD		
THENTAC	SE HALL WISE			WISE, VA 24293		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ADDOC DEFERENCED TO THE	SHOULD DE ""	
F 309	Continued From p	age 18	F	309		
F 303	personal hygiene	and bathing.				
	the surveyor on 4/ on the bowel repo stated that the res dates of 1/6/17 to 2/21/17 to 2/25/1	nical record was reviewed by 1/5/17. The surveyor noted that ort the following documentation sident had no bowel for these 1/11/17, 1/23/17 to 1/27/17, 7 and 3/7/17 to 3/12/17. There tation noted in the nurses' notes garding if the resident had a				
	bowel movement					
	nurse and the su	roximately 3 pm, the corporate rveyor reviewed the above ings. The corporate nurse could staff followed the standing orderstocol.	d s			
	administrative te documented find	roximately 5 pm, the sam was notified of the above dings by the surveyor in the n. The surveyor requested a				

On 4/6/17 at 2:15 pm, the administrator provided a copy of the bowel protocol titled "Bowel Evacuation Program and Protocol". The protocol stated the following:

copy of the facility's bowel protocol.

" ...Unit Manager will check bowel movement (BM) or Activities of Daily Living (ADL) sheets the nurses will be responsible for making sure that the dayshift has a list of anyone not having BM X (times) 3 days so bowel protocol can be started ...

The "standing orders" for bowel protocol will be as follows:

1. Milk of Magnesia 1 oz. every day PO (by mouth) prn (as needed) on day 3 of no bowel movement (not to exceed 2 days in a row).

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DEPARTM	ENT OF HEALTH	AND HUMAN SERVICES				OMB NO. 09	938-0391
CENTERS	FOR MEDICARE	& MEDICAID SERVICES	Two war	TICH E CON	STRUCTION	(X3) DATE S	
TATCHAENT OF	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPLI	
		405250	B WING				/2017
		495350	1		ADDRESS, CITY, STATE, ZIP C	ODE	
NAME OF PR	OVIDER OR SUPPLIER			9434 C	DEBURN MOUNTAIN ROAD		
HERITAGE	HALL WISE			WISE,	VA 24293		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE .	(X5) COMPLETION DATE
		40	F	309			
F 309 (Continued From p	page 19					
	2. Dulcolax S	Suppository 1 per rectum (PR) bowel movement (not to					
	d O dove in	2 FOW()					
	Fleets enema	1 per rectum (PR) printing day	7				
	of no howel move	ment.					
	Call medical of	doctor (MD) if no bowel 24 hours of initiation of above					
	protocol"	24 110015 01 1111000000					
	•		_				
	The surveyor revi	iewed the resident's MAR for the	3				
	above documente	ed dates of no bowel e surveyor did not note any of th	е				
		se in the nawei bibliocoi					
	de aumonted as h	reing given in the hurses holes					
	nor on the MAR (Medication Administration					
	Record) for Resid	dent #2.					
	On 4/5/17 at ann	roximately 5 pm, the					
	- Iministrative te	am was notified of the					
	documented find	lings by the surveyor in the					
	conference room	1.					
	No further finding	gs were provided to the surveyo	ır				
		onterence on 4/0/17		387	F387		
F 387	483.30(c)(1)(2) F	REQUENCY & HIVELINESS C	J⊢ r	- 301	Corrective Action(s):	for Docident #11	
SS=D	PHYSICIAN VIS	IT			The Attending Physicia has been contacted reg	in for Resident #11	
		f Physician Visits			delinguent visits and h	as been in to see	
	•				resident #11. A facility	y Incident and	
	(1) The resident	s must be seen by a physician a	aī tor		Accident form has bee	n completed for	
	1 1 01/08	, an dave for the hist ac days a			each incident.		
	admission, and	at least once every 60 thereafte			Identification of Defi-	cient Practice(s)	
	(2) A physician (visit is considered timely if it			Corrective Action(s):		
	occurs not later	than 10 days after the date the			All residents in the fact potentially been affect	anty may have	
	1 12 June require	ad .			of all resident clinical	records will be	
	This REQUIRE	MENT is not met as evidenced			completed to identify	residents at risk.	

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by:

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DEDADTMENT	OF HEALTH	AND HUMAN SERVICES			<u>Ol</u>	MB NO. 0938-0391
DEPARTMENT	MEDICARE	& MEDICAID SERVICES				(X3) DATE SURVEY
CENTERS FUR	Y IVIEDIONINE			IPLE CONSTRUCTION	COMPLETED	
STATEMENT OF DEF AND PLAN OF CORR	ICIENCIES :	T WELCHONTON NIBARTER	A BUILDI	KG		
AND PLAN OF CORN						04/06/2017
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	والمراوية والمعاون وا			STREET ADDRES	S CITY, STATE, ZIP CODE	
NAME OF PROVIDE	ER OR SUPPLIER		and the same of th	9434 COEBURN	MOUNTAIN ROAD	
	LANGE			WISE, VA 242	93	
HERITAGE HAL				PRO	VIDER'S PLAN OF CORRECTIO	IN (X5) COMPLETION
(X4) ID PREFIX (TAG R		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROF DEFICIENCY)	J [J] [
Bas revie	cr	erview and clinical record staff failed to ensure timely r 1 of 20 residents in the survey	·	time to th tard	negative findings will be add of discovery. To include note attending Physicians of the iness with the residents visithity Incident & Accident for upleted for each incident ide	otification te i. A m will be
The	findings inclu			The revi	temic Change(s): facility policy and procedu ewed and no changes are w time. All attending Physici erviced and issued a copy of	arranted at ians will be the State

Resident #11 was admitted to the facility on 8/3/16 with the following diagnoses of, but not limited to blood clots, heart failure, high blood pressure, diabetes, dementia, anxiety disorder, depression, and Fibromyalgia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/25/17, the resident was coded as having a BIMS (Brief Interview for Mental Status, an assessment protocol) of 99; the resident was unable to complete the BIMS interview. The resident had short term and long term memory problems. Resident #11 was also coded as requiring

extensive assistance of 1 staff member for

personal hygiene and bathing.

During the clinical record review on 4/4/17, it was noted by the surveyor that there was 1 progress note that could not be found in the clinical record. There were progress notes dated for 8/5/16, 9/6/16, 10/7/16 and the next progress note in the clinical record was dated for 12/2/16.

On 4/5/17 at approximately 5:00 pm, the administrative team was notified of the above documented findings by the surveyor.

On 4/6/17 at approximately 10 am, the director of nursing returned to the surveyor and stated, "We

The facility policy and procedure was reviewed and no changes are warranted at this time. All attending Physicians will be inserviced and issued a copy of the State and Federal guidelines for Physicians visits and monitoring the resident's medical plan of care. Any physician identified to be out of compliance will be notified by fax and phone of the untimely physician visit. If compliance is not established within 24-hours the Medical Director will be notified of the noncompliance by the attending physician and he will perform the required physician visit.

Monitoring:

The Administrator and the Director of Nursing are responsible for maintaining compliance. A list of required physician visits will be given to the Administrator at the beginning of each month. The administrator, DON, and/or designee will audits the charts of resident requiring visits for the month to ensure compliance. Aggregate findings of these audits will be reported to the Quality Assurance Committee and Corporate Office for review, analysis and recommendations for change in facility policy, procedure, and/or practice.

Completion Date: May 11, 2017

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Event ID: 37XF11

Facility ID: VA0119

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DEPARH	MENT OF HEALTH	AND TOM OF CED VICES				JIVIB INO. 0930-039 I
CENTERS FOR MEDICARE & MEDICAID SERVICES		(X2) MIII	TIPLE CO	(X3) DATE SURVEY COMPLETED		
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ING	CONFEETED	
AND PLAN OF	- CORRECTION					04/06/2017
		495350	B WING		CTATE 710 CODE	04/06/2017
NAME OF D	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE COEBURN MOUNTAIN ROAD	
					, VA 24293	
HERITAG	E HALL WISE			WISE	PROVIDER'S PLAN OF CORRECTION	ON 'X5
(X4) f() PREFIX TAG	THE PRESENCE AND THE PROPERTY OF THE PARTY O	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE
r 207	Continued From pa	age 21	F	387		
F 307	could not find a prothis resident.	ogress notes for November on				
	surveyor prior to the 483.45(a)(b)(1) Ph	ation was provided to the ne exit conference on 4/6/17. HARMACEUTICAL SVC - CEDURES, RPH	F	425	F425	
	(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed				Corrective Action(s): Resident #19's attending physisen notified that the facility factorized that the physician order medication Flonase was availated pharmacy for administration to #19. A facility Incident and Actorized form has been completed for the	ailed to ed ble from b Resident ccident nis incident.
	provision of pharm This REQUIREM by: Based on staff in review, the facility	cultation on all aspects of the macy services in the facility; ENT is not met as evidenced sterview and clinical record y staff failed to ensure a dimedication was available for 1 of 20 residents in the survey at #19).			Identification of Deficient Pr Corrective Action(s): All residents may have potenti affected. A 100% review of all medication regimes has been of by the DON and/or Unit mana identify residents at risk. Residentify residents at risk. Resident to be at risk due the medication unavailable from the pharmacy corrected at time of discovery attending physicians will be no facility Incident and Accident been completed for each.	ally been I resident's conducted agers to dents found ns being y will be and their otified. A
	ordered medicating Resident #19. Resident #19 was 9/23/15 with the limited to high bloom.	Iff failed to have a physician ion available for administration the sadmitted to the facility on following diagnoses of, but not ood pressure, diabetes, der, anemia, and chronic			Systemic Changes: The Pharmacy Policy and Probeen reviewed and no changes warranted. All licensed nursing been inserviced on the Policy Procedure for medication admits included medications that a unavailable or do not arrive as	s are g staff have and ninistration are

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EPAR IMENT OF HEALTH	AND HUMAN SERVICES			ОМВ NO. 0938-0391
ENTERS FOR MEDICARE	& MEDICAID SERVICES	/V2\ MIII 7	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AME OF PROVIDER OR SUPPLIER			9434 COEBURN MOUNTAIN ROAD)
IERITAGE HALL WISE			WISE, VA 24293	1377
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F 425 Continued From pasinusitis. The MDS ARD (Assessment scored the residen Interview for Mentapossible score of 1 coded as being tot member for person During the observation and pour on 4/5/17 practical nurse) #1 Flonase to give to clinical record was 4/5/17. On the ph March, 2017, the pallergy RLF (relief to each nostril BID documented on the Administration Relation 10:00 Am was at 10:00 Am was they had received resident and the predication to be today. The administrative documented finding 5:00 pm by the standard for the surveyor requested for the su	age 22 S (Minimum Data Set) with an Reference Date) of 3/20/17 tas having a BIMS (Brief al Status) score of 12 out of a 5. Resident #19 was also ally dependent on 1 staff hal hygiene and bathing. Action of the medication pass of at 9:45 am LPN (licensed stated "I don't have the the resident. Resident #19's reviewed by the surveyor on ysician orders for the month of the properties of the month of th	of se ray ove ly m.	timely from the pharma administration. The inso the steps the nurses sho medication not be delive the pharmacy. Monitoring: The DON is responsible compliance. The DON weekly audits of reside week to confirm the away ordered drugs. All negate be corrected at the time Results of the reviews the Quality Assurance or review, analysis, and refor change in facility pand/or practice. Completion Date: Ma	ervice will include uld take should a ered timely from e for maintaining will conduct nt MAR's each ailability of all tive findings will of discovery. will be reported to Committee for ecommendations olicy, procedure,

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nurse does not have to administer to the resident Event ID: 37XF11

Facility ID: VA0119

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DEPARTM	IENT OF HEALTH	AND HUMAN SERVICES				OMB NO. 09	<u> 938-0391</u>
CENTERS	FOR MEDICARE	& MEDICAID SERVICES	/VOLANIE	TIPLE CONSTR	EUCTION	(X3) DATE S	
ATEMENT ()	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ING		COMPL	EICh
ID PLAN OF	CORRECTION		/ 00120				
		495350	B. WING				5/2017
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JAME OF PR	OVIDER OR SUPPLIER			9434 COEB	BURN MOUNTAIN ROAD)	
HERITAGE	HALL WISE			WISE, VA			
The Tax Tax		TENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CO	ORRECTION	(X5) COMPLETION
(X4) ID PREFIX	- CONTRACTOR AND	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL THE STATE OF THE	PREF TAG	CDC	EACH CORRECTIVE ACTIONS - REFERENCED TO TH	IE APPROPRIATE	DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			DEFICIENCY)	
and the state of t							
F 425	Continued From p	age 23	F	425			
	in to notify the pha	rmacy and the pharmacy will					
	call the backup ph	armacy to obtain the					
	- disation "						
	The supposer Was	provided a copy of the policy					
	titled " Receipt of	of Interim/STAT/Emergency are the section of Procedure the					
	Deliveries". Unde	et.					
	following was note	should arrange either:					
	a d Mith Dha	rmacy to include the					
	intorim/stat/emero	gency medication(s) in all earlier	*				
	scheduled deliver	y or a special delivery as					
	required of						
	2.2 For deliv	ery by contract courier, or,					
	2.3 For the n	nedication to be dispensed and ird Party Pharmacy to ensure					
	timely receipt"	illu Party i Harridoy so si					
	No further inform	ation was provided to the					
	- version prior to	the exit conference on 4/0/1/	_	- 444			
F 441	493 80(a)(1)(2)(4	I)(e)(f) INFECTION CONTROL,	۲	441	F 441		
SS=F	PREVENT SPRE	EAD, LINENS			Corrective Action(s)	:	
					Resident #13's attend	ing physician was	
	(a) Infection prev	ention and control program.			notified that the facilities implement and follow	ty failed to	
	Ti failite must	establish an infection prevention	1		Prevention and control	of policy for resident	
	I he facility must	ram (IPCP) that must include, at			#13. A facility Incide	nt & Accident form	
	a minimum, the	following elements:			has been completed for	or each of these	
					incidents.		
	(1) A system for	preventing, identifying, reporting	١,		عراض المراجع ا	Scient Practicals)	
	· Limpting an	d controlling injections and			Identification of Def and Corrective Action	on(s):	
		liseases for all residents, starr,			All other residents wi	ith confirmed	
	volunteers, visito	ors, and other individuals			Influenza A may have	e potentially been	
	nont ha	es under a contractual sed upon the facility assessmen	t		affected. A 100% rev	view of all residents	
	dusted acco	rding to 6483. / U(E) and 10110 Wills	j		with confirmed Influe	enza will be	
	accented nation	al standards (facility assessmen	t		conducted to identify	whether the	
	implementation	is Phase 2);			Influenza prevention	and control policy	
-	amplemente				and procedures are be	emg minated and	

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IEPAK II	C EOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			1011	OMB NO.	SURVEY
ENIER	S FOR WILDION CE	DOM BOOM REPOSITED OF D		(X2) MULTIPLE CONSTRUCTION		COME	PLETED
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION				A BUILDING			
			B WING			04/0	6/2017
		495350	1 B Wilde	STREET ADDRE	SS. CITY, STATE, ZIP CO	DE	
NAME OF PROVIDER OR SUPPLIER			9434 COEBUR	N MOUNTAIN ROAD			
			WISE, VA 24				
HERITAGE HALL WISE		ID		NADERIS BLAN OF CORE	RECTION	(X5) COMPLETIO	
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAC	" chose	H CORRECTIVE ACTION S REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
and the second second second				foll	owed. Any/all negative	e findings	
F 441	Continued From p	age 24	۲	rela	ited to isolation precau	itions and	
• • • •	in the standa	rds policies and procedures		infe	ection control tracking	and trending	
	for the program. W	which must include, but are not		will be corrected at time of discovery and			
	limited to:				ncility Incident & Acci	dent form will	
		. بالمنافق المنافق الم		be	completed.		
	(i) A system of sur	rveillance designed to identify		Cv.	stemic Change(s):		
	- ible commun	icable diseases of infections		Sys The	e facility Infection Cor	ntrol policy and	
	before they can s	pread to other persons in the		pro	cedure has been review	wed and no	
	facility:			cha	anges are warranted at	this time. The	
		them possible incidents of		DC	N will be inserviced b	by the Regional	
	(ii) When and to v	whom possible incidents of sease or infections should be		Nu	rse Consultant on the	facility's	
	communicable di	sease of infections over		inf	ection control policy a	nd procedure	
	reported;			and	d the infection tracking	g logs for	
	(iii) Standard and	transmission-based precaution	ns	ma	intaining proper infect indards and prevention	in the facility	
	to be followed to	prevent spread of infections;		sta	ndards and prevention I staff will be inservice	ed by the DON	
				AI.	d/or Regional Nurse C	onsultant on the	
	(iv) When and ho resident; including	ow isolation should be used for g but not limited to:	а	inf	fection Control Policy fluenza Prevention and	to include the	
	(A) The type and	duration of the isolation,		M	onitoring:		
	(A) The type and	the infectious agent or organis	m	IVI Th	ne DON is responsible	for maintaining	
				co	mpliance. The facility	has an infection	1
	(m) aimamanar	nt that the isolation should be the	ne	co	ntrol tracking log for r	nonitoring and	
	least restrictive p	possible for the resident under	the	tra	ncking infections and in	nfectious	
	circumstances.			111	nesses to maintain con	npliance. The	
					ON will review the inf		1
	(v) The circumst	ances under which the facility		tra	acking log weekly and	review/report al	1
	and archibit on	Indivees with a communication		fir	ndings to the Risk Mar ommittee for review ar	iagement	
	ri or intoc	tad skin iesiūlis libili dii ooc		Co	ommittee for review at commendations. Aggre	iu egate findings o	f
	contact with res	idents or their food, if direct		re +h	e reports will be subm	itted to the	
	contact will trans	smit the disease; and		O	uality Assurance Com	mittee quarterly	
	الله الاستوادي ال	ygiene procedures to be followed	ed	fo	or review, analysis, and	1	
	by staff involved	In direct resident contact.		re	ecommendations for chacility policy and proce	ange in the	
	(4) A system for	r recording incidents identified			ompliance Date: May		
	under the facilit	y's IPCP and the confective		C	omphance Date: May	/ 11, WUI/	
	i' Inlian b	v the facility					

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actions taken by the facility.

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Facility ID VA0119

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DEPARIMENT OF DEALITY	71110 11011						
CENTERS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A BUILDI	NG				
	495350	B WING	OTATE ZIO CODE	04/06/2017			
			STREET ADDRESS, CITY, STATE, ZIP CODE				
NAME OF PROVIDER OR SUPPLIER			9434 COEBURN MOUNTAIN ROAD				
HERITAGE HALL WISE			WISE, VA 24293				
(X41E) SUMMARY ST.	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	COOCC. DEFERENCED TO THE ACTION) BE			
		<u> </u>					

F 441 Continued From page 25

- (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.
- (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow infection control guidelines for 1 of 20 residents in the survey sample (Resident #13).

The findings included:

1. The facility staff failed to follow infection control guidelines concerning Resident #13 that had Influenza A.

Resident #13 was readmitted to the facility on 1/3/17 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, urinary tract infection, depression, atrial fibrillation, and generalized edema. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/24/17 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 10 out of a possible score of 15. Resident #13 was also coded as requiring set up supervision for eating and personal hygiene. However, Resident #13 requires extensive assistance from 1 staff member for bathing.

During the initial tour on Hall 1 with unit manager #1 on 4/4/17 at approximately 1:45 pm, the

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DEPARTMENT OF HEA	ARE & MEDICAID SERVICES	and the second seco		(X3) DATE SURVEY	
CENTERS FOR MEDIC	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A BUILDING _			
		D MUNG		04/06/2017	
	495350		REET ADDRESS, CITY, STATE, ZIP CODE		
	HED	51	REET ADDITEDO.		
NAME OF PROVIDER OR SUPP	Lien	94	34 COEBURN MOUNTAIN ROAD		
HERITAGE HALL WISE		W	ISE, VA 24293		
1			PROVIDER'S PLAN OF CORRECTION	ON (X5.	
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES SIENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	.U DE """,	
TAG		Company of the Compan			

F 441 Continued From page 26

surveyor was given a report that "This resident has Influenza A and is in isolation, but he does not comply with that. He comes out of his room and we have to tell him to put on his face mask or the staff will go and get it and put it on him. He will sometimes become mad and curse the staff. We also have another case of Influenza A on this hallway too."

At approximately 2:30 pm, the surveyor notified the team leader for the survey of the above documented findings.

At 3 pm, this surveyor accompanied by another surveyor went to Hall 1 to the nurses' station and it was observed that Resident #13 was sitting in the front of the nurses' station with 10 other residents laughing and talking. Resident #19 did have a face mask on but the other residents that were sitting near Resident #13 were less than 3 feet away from Resident #13.

The survey team met with the administrative team at approximately 3:30 pm in the conference room. The surveyor notified the administrative team of the above documented findings and the concerns of the survey team of Resident #13 at the nurses' station as described above. The DON (director of nursing) stated that the resident had been treated with Tamiflu since 4/1/17 and he no longer had a fever. The staff has taken the proper precautions when giving care to this resident and no one else besides these 2 are the only ones that have Influenza A. The surveyor requested the facility's policy concerning Influenza.

The surveyor was provided a copy of the policy titled "Influenza, Prevention and Control of Event ID: 37XF11

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ENTER	S FOR MEDICARE	& MEDICAID SERVICES	T	TIPLE CONSTRUCTION	(X3) DATE SURVEY
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		495350	B WING	and a substitute of the first of the substitute	04/06/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 9434 COEBURN MOUNTAIN RO WISE, VA 24293	ZIP CODE DAD
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	PROVIDER'S PLAN OF	THE APPROPRIATE DATE
F 441	"Influenza Modes 1a. Transmis requires close col (approximately siz air 2. During per activity steps will visits by individual influenza 3c. Individual infections will be from others as po	17 at 8 am by the corporate cy it stated the following: of Transmission ssion via large-particle droplets that between distances (6) feet or less) through the liods of increased influenza be taken to minimize elective als with suspected or confirmed is with symptoms of respiratory encouraged to sit as far as awayssible " review was performed by the table to the surveyor. The		441	
	physician had ord 4/1/17 which the A. The physician mouth) BID (twice According to the comprehensive of placed in Contact received on 4/1/ comprehensive in Droplet Precase On 4/6/17 at app asked the unit manufacture.	dered a flu swab to be done on result was positive for Influenza or ordered "Tamiflu 75 mg po (by se a day) X (times) 5 days". Inurses' notes and the resident's care plan, the resident was set Isolation after the results were 17. Then according to the care plan the resident was place utions on 4/4/17. Proximately 3:30 pm, the survey manager for Hall1 how many and on Hall 1. The unit manager is 58 residents on this hallway."	s ed or		

The surveyor also asked the unit manager how many residents were positive for Influenza A. The unit manager replied "only 2". The unit manager also stated "all the other residents on this hall have been started on Tamiflu as a

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STOADTAN	ENT OF HEALTH	AND HUMAN SERVICES				OMB NO. 0938	
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		and the state of t	B WING			04/06/20	317
		495350	T	CTDEF	T ADDRESS, CITY, STATE, ZIP CODE		
JAME OF PRO	OVIDER OR SUPPLIER	***************************************		9434 (COEBURN MOUNTAIN ROAD		
					, VA 24293		
HERITAGE	HALL WISE				DECLYDER'S PLAN OF CORREC	HON	IX5) APLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD DL	DATE
		age 28	F4	441			
F 441	Continued From p	n approximately 6 pm".					
	concerns docume Resident #13 hav nursing station in residents even th mask on. This or approximately 5 papproximately 3: conference room No further inform surveyor prior to 483.50(a)(1) ADI (a) Laboratory S (1) The facility maservices to meet facility is respon-	nation was provided to the the exit conference on 4/6/17. MINISTRATION ervices must provide or obtain laboratory the needs of its residents. The sible for the quality and timeline	F	502	F502 Corrective Action(s): Resident #4's attending phy been notified that the facilit obtain an Iron Profile as orc physician. A Facility Incide Accident form has been corthe missing labs.	y failed to lered by the ont &	
	This REQUIRE! by: Based on staff review, the facil ordered laborat (Resident #4, R #3).	MENT is not met as evidenced interview and clinical record ity staff failed to obtain physiciar ory tests for 4 of 20 residents tesident #5, Resident #9, Resident			Resident #5's attending phybeen notified that the facility obtain a Lipid Panel as order physician. A Facility Incide Accident form has been couthe missing labs. Resident #9's attending phy	ty failed to ered by the ent & mpleted for	
	for Resident #4	staff failed to obtain an iron profi			been notified that the facili obtain a CBC & CMP as o physician. A Facility Incid Accident form has been co the missing labs.	ty failed to rdered by the ent &	

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facility 5/17/16 and readmitted 5/25/16 with

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DEPARTMENT OF HEA	LTH AND HUMAN SERVICES			OMB NO. 0938-0391
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	1 '		COMPLETIES
	495350	B WING		04/06/2017
NAME OF PROVIDER OR SUPE	I IFR		EET ADDRESS, CITY, STATE, ZIP C	CODE
			4 COEBURN MOUNTAIN ROAD	
HERITAGE HALL WISE		Wis	SE, VA 24293	RRECTION (X5)
(A4) III	RY STATEMENT OF DEFICIENCIES RIENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	A SHOULD BE
failure, chronic dysphagia, co	m page 29 t included but not limited to heart b obstructive pulmonary disease, nstipation, dementia with behaviora anemia, and insomnia.	F 502	Resident #3's attending been notified that the fac obtain a BMP as ordered physician. A Facility Inc Accident form has been the missing labs.	cility failed to I by the cident &
data set (MDS reference data resident to ha memory prob cognitive skill The clinical resident telephone ord "Ferrous Sulf mouth) bid (to (every day), I	Resident #4's most recent quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/9/17 assessed the resident to have both short and long term memory problems and moderately impaired cognitive skills for daily decision making. The clinical record of Resident #4 contained a telephone order dated 11/23/16 that read "Ferrous Sulfate 325 mg (milligrams) po (by mouth) bid (twice a day), Vitamin C 500 mg po qo (every day), Iron profile, hemmocults (sic) x2."		Identification of Defici & Corrective Action(s) All other residents who ordered lab tests may habeen affected. A 100% resident's lab orders will identify residents at risk findings will be corrected discovery. The attending be notified of the missing not obtained timely. A faccident Form will be	had physician we potentially audit of all be completed to All negative at the time of physicians will glabs and labs acility Incident
The surveyor reviewed the laboratory section of the clinical record but was unable to locate the results of the iron profile. The surveyor informed the director of nursing that the results of the iron profile ordered on 11/23/16 were not located in the clinical record. The surveyor informed the administrative staff of the inability to locate the results of the iron profile in the end of the day meeting on 4/5/17 at 5:40 p.m.		f e	Systemic Changes: The facility policy and been reviewed and no c warranted at this time. tracking system has bee implemented to track as required lab work has been per physician order and procedure. The DON a Consultant will inservice staff on physician order.	hanges are The laboratory on reviewed and nd validate that been completed policy and und/or Nurse oe all licensed red laboratory-
4/6/17 that the as ordered.	of nursing informed the surveyor or the iron profile had not been obtained formation was provided prior to the lace on 4/6/17.	u	testing, protocols, & tra	teking system

for Resident #5. FORM CMS-2567(02-99) Previous Versions Obsolete

2. The facility staff failed to obtain a lipid panel

Event ID: 37XF11

Facility ID: VA0119

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Dime (7 to t	TENIO TENENT	MEDICAID SERVICES			OWR NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495350	B WING		04/06/2017
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 9434 COEBURN MOUNTAIN RO	
HERITAG	E HALL WISE			WISE, VA 24293	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE COMPLETION THE APPROPRIATE DATE
	4/5/17. Resident # 2/28/96 and readm that included but no disabilities, legal bl cellulitis, and Vitam Resident #5's anno assessment with a (ARD) of 7/13/16 at term memory prob problems, and sev for daily decision in The March 2017 p was reviewed. Re lipid panel every 6 6/24/16. The labo record held the res 12/22/16. The surveyor requ assistance on 4/5/ lipid panel done th DON provided a li 2/22/16. The DON locate the results of The surveyor infor the above concern No further informate exit conference or 3. The facility staff ordered laborator	of Resident #5 was reviewed 5 was admitted to the facility itted 1/10/12 with diagnoses of limited to intellectual indness, hyperlipidemia, nin D deficiency. Ital minimum data set (MDS) in assessment reference date issessed the resident with short lems, long term memory erely impaired cognitive skills making. hysician order sheet (POS) sident #5 had orders for fasting months with a start date of ratory section of the clinical sults of a lipid panel obtained ested the director of nursing's 17 at 1:30 p.m. to locate the e previous 6 months. The bid panel that was obtained stated she was unable to of a lipid panel for June 2016. Immed the administrative staff of a no 4/5/17 at 5:40 p.m.		Monitoring: The DON is responsi compliance. The DON will complete the Fact weekly to monitor for negative findings will attending physician a action will be taken a results of these audits the Quality Assurance review, analysis, & rehange in facility poland/or practice. Completion Date: M	N and/or designee cility Lab audit tool r compliance. Any l be reported to the and disciplinary as warranted. The s will be reported to be Committee for ecommendations for licy, procedure,

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panel) lab test for Resident #9.

Resident #9 was admitted to the facility 5/16/11 Event ID: 37XF11

Facility ID. VA0119

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APR 28 2017 *OH/OLC

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					O. 0938-0391
		& MEDICAID SERVICES	(X2) MUI	TIPLE COI	NSTRUCTION	(X3) D.	ATE SURVEY
STATEMENT AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER					OMPLETED
		495350	B WING			1	4/06/2017
	PROVIDER OR SUPPLIER	1 43500	1		T ADDRESS, CITY, STATE, Z		
					COEBURN MOUNTAIN RO	AD	
HERITA	SE HALL WISE			WISE	, VA 24293	- ADDEOTION	(X5)
(X4) ID PREFIX TAG	CACH DEDOEND	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
r ena	Continued From p	age 31	F 5	502			
F 502	and readmitted on	3/31/15 with diagnoses that					
	included but not life	nited to high blood pressure, ire, and bronchitis.					
	on the most recen an assessment re facility staff asses	ent #9's clinical record revealed t minimum data set (MDS) with ference date of 2/1/17, the sed the resident to usually usually be understood. He wa a cognitive summary score of	1				
	record revealed th	w of Resident #9's clinical nat the physician had given an for a CBC every 3 months and other.	а				
	clinical record rev	poratory reports in Resident #9 ealed no results for the the CBC due in December P due in September 2016.	's				
	consultant was as	pm, the regional nurse sked to assist with locating the He said he would check.					
	administrator, reg	a meeting with the gional nurse consultant and they were informed of the I CMP laboratory tests.					
	On 4/5/17 at 2:40 the surveyor "we) pm the regional nurse informe don't have the labs."	ed				
	information was a	6/17 at 3:40 pm, the above again discussed with the iional nurse consultant and the					

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director of nurses.

4. The facility staff failed to obtain a physician Event ID: 37XF11

Facility ID VA0119

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DEPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES

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DEPARIMENT OF HEALIT	AND HOW WO		*	JIVID 140. 0930-000 1
CENTERS FOR MEDICARE	& MEDICAID SERVICES	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			ING	COMPLETED
AND PLAN OF CORRECTION		1, 23,2		
	495350	B WING		04/06/2017
			STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER			9434 COEBURN MOUNTAIN ROAD	
HERITAGE HALL WISE			WISE, VA 24293	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	ADACE DESERVED TO THE ALL IN	JLD BE
F 502 Continued From porder laboratory te	age 32	F	502	

Resident #3 was readmitted to the facility on 12/21/16 with the following diagnoses of, but not limited to anemia, high blood pressure, high cholesterol, Alzheimer's disease, stroke. anxiety disorder, depression, and psychotic disorder. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/14/17 coded the resident as having short term and long term memory problems and was severely impaired to make daily decisions. Resident #3 was also coded as being totally dependent on 2 or more staff members for personal hygiene and bathing.

The surveyor conducted a clinical record review of Resident #3's chart on 4/5/17. In performing this review, the surveyor noted that on 12/22/16, the physician wrote an order which stated "...Weekly BMP (Basic Metabolic Panel)."

The surveyor could not locate the results of the BMP for 1/23/17 that was ordered by the physician to be obtained weekly on 12/22/16.

On 4/5/17 at approximately 5:00 pm, the administrative team was notified of the above documented findings by the surveyor in the conference.

On 4/6/17 at 9 am, the DON (director of nursing) stated to the surveyor "We have looked into the missing lab for this resident and we did not get the BMP on 1/23/17."

No further information was provided to the surveyor prior to the exit conference on 4/6/17.

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Event ID: 37XF11

Facility ID: VA0119

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