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

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HERITAGE HALL
HEALTHCARE AND REHABILITATION CENTERS
Managed by AMERICAN HEALTHCARE, LLC

Heritage Hall of Wise • 9434 Coeburn Mountain Road • Wise, VA 24293 • (P) 276.328.2721 • (F) 276.328.1463

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

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 _____	04/06/2017

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

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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 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE 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. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions.	F 272	**F272** **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):** 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	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4-25-17

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

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F 272	Continued From page 1 (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure accurate minimum data set assessments for 1 of 20 residents (Resident #4). The findings included: The facility staff failed to accurately code Resident #4's physical restraint and restorative nursing. Resident #4's clinical record was reviewed 4/5/17 and 4/6/17. Resident #4 was admitted to the facility 5/17/16 and readmitted 5/25/16 with	F 272	Care Plan Team on accurately coding all sections of the MDS. This will include accurate coding of section P for restraints and section O for restorative nursing. **Monitoring:** The RCC is responsible for maintaining compliance. The RCC will complete MDS audit tool weekly coinciding with the MDS calendar to monitor for compliance. Any/all negative findings will be reported to the RCC and the DON at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date**: May 11, 2017	

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F 272	Continued From page 2	F 272		

diagnoses that included but not limited to heart failure, chronic obstructive pulmonary disease, dysphagia, constipation, dementia with behavioral disturbances, anemia, and insomnia.

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. Resident #4's decisions were identified to be poor with cues and supervision required.

(a). The facility staff failed to accurately code Resident #4's seatbelt on two (2) MDSs- a quarterly MDS with an ARD of 8/25/16 and a quarterly MDS with an ARD of 11/17/16.

The surveyor observed Resident #4 on 4/5/17 at 9:45 a.m. Resident #4 was sitting at the nurse's station in a wheelchair. The surveyor observed an alarming seatbelt on the wheelchair and asked the resident if she could unfasten the belt. Resident #4 was able to unfasten the seatbelt with some difficulty but did manage to accomplish the task.

Resident #4's clinical record contained a physician order dated 6/13/16 with a signed consent for the use of an alarming seatbelt to wheelchair and orders to check every 30 minutes and release for 10 minutes every hour.

The quarterly MDS with an ARD of 8/25/16 assessed Resident #4 to have impairments for both short and long term memory and severely impaired cognitive skills for daily decision making. Section P (Restraints) was reviewed. There was

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F 272	Continued From page 3	F 272		

no documentation of restraint use for Resident #4. The surveyor reviewed the "Restraint Need Assessment Form" dated 8/25/16 and completed by registered nurse #3.

The quarterly MDS with an ARD of 11/17/16 assessed Resident #4 to have impairments for both short and long term memory and moderately impaired cognitive skills for daily decision making. Section P (Restraints) was reviewed. There was no documentation of restraint use for Resident #4. The surveyor reviewed the "Restraint Need Assessment Form" dated 11/17/16 and completed by registered nurse #3. The surveyor interviewed R.N. #3 on 4/5/17 at 2:45 p.m. R.N. #3 stated she missed coding the restraint. The surveyor also interviewed the director of nursing on 4/5/17 at 3:30 p.m. The DON stated since Resident #4 had the order for the seatbelt from June 2016, the facility had used the seatbelt. The DON provided the March 2017 completed tasks that included seatbelt monitoring.

(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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F 272	Continued From page 4	F 272		

cognitive skills for daily decision making. Section O Special Treatments. Procedures and Programs was reviewed. Restorative nursing programs (Section O0500) was reviewed for accuracy. There were no recorded number of days Resident #4 had participated in the restorative nursing program. The October 2016 through November 2016 rehabilitative/restorative flowsheets were reviewed. During the look back period of 7 days (11/11/16 through and including 11/17/16) Resident #4 was checked that bilateral upper extremity exercises, transfers and sit to stand transfers (11/15/16 and 11/16/16 and refused on 11/17/16) were completed. Resident #4's participation in restorative nursing was not marked on the quarterly MDS. The coding for these boxes was a 0 (zero).

The quarterly MDS with an ARD of 2/9/17 was also reviewed as well as the February 2017 restorative flowsheets. Resident #4 received restorative nursing for bilateral upper extremity exercises 2/3/17 through 2/9/17 (7 days), 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 these boxes was a 0 (zero).

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

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F 272	Continued From page 5 stated that the restorative nursing coding was not done correctly-it was misssed. The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the administrator in training of the above inaccurate coding for restraints and restorative nursing on Resident #4's MDSs in the end of the day meeting on 4/5/17 and on 4/6/17. No further information was provided prior to the exit conference on 4/6/17.	F 272		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. 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 professional nursing practice in regards to infection control for 1 of 20 residents with Influenza A. 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	F 281	**F281** **Corrective Action(s):** Resident #13's attending physician has been notified that the facility staff failed to follow infection control practices for resident #13 who had Influenza A. A Facility Incident & Accident Form was completed for these incidents. **Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON or Unit Manager will conduct a 100% review of all resident's with Influenza A and the infection control practices in place to identify any residents at risk. All residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each improper infection control practice noted. A facility Incident & Accident form will be completed for each negative finding.	

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F 281	Continued From page 6 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 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	F 281	**Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, proper infection control practices to prevent the spread of Influenza A and administering physician ordered medications per physician order. Licensed staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for Infection control to include proper controls to prevent the spread of Influenza A. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or Unit Manager will review physician orders and the care plans of residents diagnosed with Influenza A to ensure proper Infection Control precautions are being instituted in order to maintain compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action 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 11, 2017	

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F 281	Continued From page 7	F 281		

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 Seasonal" on 4/5/17 at 8 am by the corporate nurse. In this policy it stated the following:

"Influenza Modes of Transmission
1a. Transmission via large-particle droplets requires close contact between distances (approximately six (6) feet or less) through the air
...
2. During periods of increased influenza activity steps will be taken to minimize elective visits by individuals with suspected or confirmed influenza
...
3c. Individuals with symptoms of respiratory infections will be encouraged to sit as far as away from others as possible ... "

A clinical record review was performed by the surveyor on 4/6/17 by the surveyor. The physician had ordered a flu swab to be done on 4/1/17 which the result was positive for Influenza A. The physician ordered "Tamiflu 75 mg po (by mouth) BID (twice a day) X (times) 5 days". According to the nurses' notes and the resident's comprehensive care plan, the resident was

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F 281	Continued From page 8 placed in Contact Isolation after the results were received on 4/1/17. Then according to the comprehensive care plan the resident was placed in Droplet Precautions on 4/4/17. On 4/6/17 at approximately 3:30 pm, the surveyor asked the unit manager for Hall1 how many residents resided on Hall 1. The unit manager stated "there are 58 residents on this hallway." 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 precautionary measure". The surveyor asked the unit manager when approximately 6 pm". The administrative team was notified of the concerns documented above concerning Resident #13 having Influenza A and was at the nursing station in close proximity of other residents even though the resident had a face mask on. This occurred on 4/5/17 at approximately 5 pm and then again on 4/6/17 at approximately 3:45 pm by the surveyor in the conference room. No further information was provided to the surveyor prior to the exit conference on 4/6/17.	F 281		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest	F 309	**F309** **Corrective Action(s):** Residents #2, #4, #7 & #11's attending physicians were notified that the facility failed to administer or follow the bowel protocol as ordered by the physician standing prders. A facility Incident and Accident form was completed for this incident.	

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F 309	Continued From page 9 practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow the established bowel protocol for 4 of 20 residents (Resident #4, Resident #7, Resident #2, and Resident #11). The findings included: 1. The facility staff failed to follow the bowel	F 309	**Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON, ADON, and Unit Managers will conduct a 100% audit of all resident bowel reports to identify residents at risk. Residents identified at risk will be corrected at time of discovery and their attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes following and administering the bowel protocol per physician standing orders. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for following and administering the bowel protocol per physician order. **Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform daily audits of the bowel report to monitor for bowel protocol 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	

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F 309	Continued From page 10 protocol for Resident #4. The facility staff failed to follow the physician's standing orders for constipation [MOM (Milk of Magnesia) PO (by mouth) 1 oz (ounce) q (every) day PRN (as needed) Not to exceed 2 days in a row], Dulcolax sup (suppository) 10 mg (milligrams) q day prn (not to exceed 2 days in a row), fleets enema q day prn. Resident #4's clinical record was reviewed 4/5/17 and 4/6/17. Resident #4 was admitted to the facility 5/17/16 and readmitted 5/25/16 with diagnoses that included but not limited to heart failure, chronic obstructive pulmonary disease, dysphagia, constipation, dementia with behavioral disturbances, anemia, and insomnia. 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. Resident #4's decisions were identified to be poor with cues and supervision required. Resident #4 required extensive assistance of 2 people for transfers and toileting. Resident #4 was coded to always be incontinent of bladder and bowel. Resident #4's current comprehensive care plan dated 2/10/17 identified ADLs (activities of daily living) as a problem and read Resident #4 was incontinent of bladder and bowel. Resident #4's current comprehensive care plan also identified the problem titled "elimination status" and read "assist with toileting and transfers. She is incontinent of bladder and bowel. Has dx (diagnosis): bladder spams, constipation. Approaches: Monitor for s/s (signs or symptoms)	F 309	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 11, 2017	

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	495350	A. BUILDING _____ B. WING _____	04/06/2017

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

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F 309	Continued From page 11	F 309		

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 movements from 7/1/16 through 7/4/16 (4 days) and 7/17/16 through 7/21/16 (5 days). The July 2016 progress notes for these days were reviewed and there was no documentation that Resident #4 had been incontinent of bowel.

The July 2016 electronic medication administration records (eMARs) were reviewed. The eMARs had no documentation that the physician's standing order for constipation had been implemented. There was documentation on 7/22/16 that the resident received a fleets enema. The fleets enema was administered on the 6th day that Resident #4 had no bowel movement.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 12	F 309		

between 12/5/16 through 12/8/16 (4 days) and from 12/10/16 through 12/15/16 (6 days) or received medications for constipation. The December 2016 eMAR did not have documentation that Resident #4 received MOM or a fleets enema.

The surveyor informed the administrative staff of the above finding on 4/5/17 at 5:40 p.m. and requested the facility bowel protocol.

The surveyor interviewed the unit manager licensed practical nurse #1 on 4/6/17 at 9:20 a.m. L.P.N. #1 stated the unit managers are supposed to pull a "No BM for 3 days" report each morning and then per the standing orders give MOM, a suppository and then a fleets enema. The surveyor reviewed the dates Resident #4 did not have a bowel movement and no interventions for those dates. L.P.N. #1 stated she had only been in her position since October 2016 but had no comment about the December 2016 bowel movement concern.

The administrator provided the facility bowel protocol to the surveyor on 4/6/17. The bowel protocol titled "Bowel Evacuation Program and Protocol" read as follows under procedure:
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 x3 days so bowel protocol can be started. The shift nurses will also check the 24-hour report to add to the list anyone who needs next step in the bowel protocol.
The bowel protocol will be initiated on Day 3 of no Bowel Movement (on the day shift unless the resident wishes to wait until the evening shift of

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	495350	A. BUILDING _____ B. WING _____	04/06/2017

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F 309	Continued From page 13	F 309		

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.

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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 _____	04/06/2017

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

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F 309	Continued From page 14	F 309		

The March 2017 signed physician orders were reviewed 4/6/17. Included in the orders were the routine standing orders. The routine standing orders dated 3/17/17 read, "Constipation: MOM 1 oz. (ounce) Q (every) day PRN (as needed) not to exceed 2 days in a row: Dulcolax suppository 10 mg Q day PRN, fleets Q day PRN.

A review of the electronic bowel report roster for January and March 2017 revealed Resident #7 had no bowel movements from 1/23/17 through 1/27/17 and 3/7/17 through, 3/10/17. Review of the medication administration record did not reveal that the bowel protocol had been followed. The resident did not receive any of the bowel standing order medications during the entire months of January or March.

On 4/5/17 during a meeting with the administrator, director of nurses and the regional nurse consultant the above information was discussed. The facility bowel protocol was requested and provided to the surveyor by the director of nurses.

The director of nurses provided the facility bowel protocol to the surveyor on 4/5/17. The bowel protocol titled "Bowel Evacuation Program and Protocol" read as follows under procedure: Unit manager will check bowel movement (BM) or Activities of Daily Living (ADL) sheets-the nurses will be responsible for making sure that the day shift has a list of anyone not having BM x 3 days so bowel protocol can be started. The shift nurses will also check the 24-hour report to add to the list anyone who needs next step in the bowel protocol.

The bowel protocol will be initiated on Day 3 of no

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	495350	A. BUILDING _____ B. WING _____	04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 15	F 309		

Bowel Movement (on the day shift unless the resident wishes to wait until the evening shift of 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 by the facility prior to the exit conference.
3. The facility failed to follow the facility's bowel protocol for Resident #2.

Resident #2 was admitted to the facility on 5/22/14 with the diagnoses of, but not limited to anemia, high blood pressure, urinary tract infection, stroke, hemiplegia, seizure disorder, anxiety disorder, depression, psychotic disorder and chronic obstructive pulmonary disease. The resident was coded on the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/7/17 as not being able to complete the BIMS (Brief Interview Mental Status, an assessment tool) interview. Resident #2 was also coded as requiring only set up supervision with personal hygiene. The resident requires extensive assistance by 1 staff member for bathing.

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 _____	04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 16	F 309		

Resident #2's clinical record was reviewed by the surveyor on 4/5/17. The surveyor noted that on the bowel report the following documentation stated that the resident had no bowel for these dates: 1/3/17 to 1/11/17, 2/9/17 to 2/12/17, and 3/13/17 to 3/18/17. There was no documentation noted in the nurses' notes for these days regarding if the resident had a bowel movement.

On 4/5/17at approximately 5 pm, the administrative team was notified of the above documented findings by the surveyor in the conference room. 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 bowel protocol titled "Bowel Evacuation Program and Protocol". The protocol stated the following:
" " ...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).
2. Dulcolax Suppository 1 per rectum (PR) prn on day 5 of no bowel movement (not to exceed 2 days in a row).
" Fleets enema 1 per rectum (PR) prn on day 7 of no bowel movement.
" Call medical doctor (MD) if no bowel movement within 24 hours of initiation of above protocol ..."

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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 _____	04/06/2017

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

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F 309	Continued From page 17	F 309		

The surveyor reviewed the resident's MAR for the above documented dates of no bowel movements. The surveyor did not note any of the above medications in the bowel protocol documented as being given in the nurses' notes nor on the MAR (Medication Administration Record) for Resident #2.

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

On 4/6/17 at approximately 3 pm, the corporate nurse and the surveyor reviewed the above documented findings. The corporate nurse could not find that the staff followed the standing orders for the bowel protocol.

No further findings were provided to the surveyor prior to the exit conference on 4/6/17.

4. The facility staff failed to follow the facility's bowel protocol for Resident #11.

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

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

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 _____	04/06/2017

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

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F 309	Continued From page 18	F 309		

personal hygiene and bathing.

Resident #11's clinical record was reviewed by the surveyor on 4/5/17. The surveyor noted that on the bowel report the following documentation stated that the resident had no bowel for these dates of 1/6/17 to 1/11/17, 1/23/17 to 1/27/17, 2/21/17 to 2/25/17 and 3/7/17 to 3/12/17. There was no documentation noted in the nurses' notes for these days regarding if the resident had a bowel movement.

On 4/6/17 at approximately 3 pm, the corporate nurse and the surveyor reviewed the above documented findings. The corporate nurse could not find that the staff followed the standing orders for the bowel protocol.

On 4/5/17at approximately 5 pm, the administrative team was notified of the above documented findings by the surveyor in the conference room. 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 bowel protocol titled "Bowel Evacuation Program and Protocol". The protocol stated the following:

" ...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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	495350	A. BUILDING _____ B. WING _____	04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 19 2. Dulcolax Suppository 1 per rectum (PR) prn on day 5 of no bowel movement (not to exceed 2 days in a row). Fleets enema 1 per rectum (PR) prn on day 7 of no bowel movement. Call medical doctor (MD) if no bowel movement within 24 hours of initiation of above protocol ..." The surveyor reviewed the resident's MAR for the above documented dates of no bowel movements. The surveyor did not note any of the above medications in the bowel protocol documented as being given in the nurses' notes nor on the MAR (Medication Administration Record) for Resident #2. On 4/5/17 at approximately 5 pm, the administrative team was notified of the documented findings by the surveyor in the conference room. No further findings were provided to the surveyor prior to the exit conference on 4/6/17.	F 309		
F 387 SS=D	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by:	F 387	**F387** **Corrective Action(s):** The Attending Physician for Resident #11 has been contacted regarding their delinquent visits and has been in to see resident #11. A facility Incident and Accident form has been completed for each incident. **Identification of Deficient Practice(s)** **Corrective Action(s):** All residents in the facility may have potentially been affected. A 100% audit of all resident clinical records will be completed to identify residents at risk.	

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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 _____	04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 387	Continued From page 20 Based on staff interview and clinical record review, the facility staff failed to ensure timely physician visits for 1 of 20 residents in the survey sample (Resident #11). The findings included: 1. The facility staff failed to ensure timely physician visits for Resident #11. 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	F 387	All negative findings will be addressed at time of discovery. To include notification to the attending Physicians of the tardiness with the residents visit. A facility Incident & Accident form will be completed for each incident identified. **Systemic Change(s):** 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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	495350	A. BUILDING _____ B. WING _____	04/06/2017

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

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F 387	Continued From page 21 could not find a progress notes for November on this resident. No further information was provided to the surveyor prior to the exit conference on 4/6/17.	F 387		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (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 pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a physician ordered medication was available for administration for 1 of 20 residents in the survey sample (Resident #19). The findings included: 1. The facility staff failed to have a physician ordered medication available for administration to Resident #19. Resident #19 was admitted to the facility on 9/23/15 with the following diagnoses of, but not limited to high blood pressure, diabetes, depressive disorder, anemia, and chronic	F 425	**F425** **Corrective Action(s):** Resident #19's attending physician has been notified that the facility failed to ensure that the physician ordered medication Flonase was available from pharmacy for administration to Resident #19. A facility Incident and Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all resident's medication regimes has been conducted by the DON and/ or Unit managers to identify residents at risk. Residents found to be at risk due the medications being unavailable from the pharmacy will be corrected at time of discovery and their attending physicians will be notified. A facility Incident and Accident form has been completed for each. **Systemic Changes:** The Pharmacy Policy and Procedure has been reviewed and no changes are warranted. All licensed nursing staff have been inserviced on the Policy and Procedure for medication administration to included medications that are unavailable or do not arrive at the facility	

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

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 _____	04/06/2017

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 425 Continued From page 22

sinusitis. The MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/20/17 scored the resident as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #19 was also coded as being totally dependent on 1 staff member for personal hygiene and bathing.

During the observation of the medication pass and pour on 4/5/17 at 9:45 am LPN (licensed practical nurse) #1 stated "I don't have the Flonase to give to the resident. Resident #19's clinical record was reviewed by the surveyor on 4/5/17. On the physician orders for the month of March, 2017, the physician had ordered "Flonase allergy RLF (relief) 50 mcgs (micrograms) 1 spray to each nostril BID (twice a day)". LPN #1 documented on the MAR (Medication Administration Record) " ...scheduled for 4/5/17 at 10:00 Am was not administered."

Registered Nurse #1 notified the surveyor that they had received the Flonase to give to the resident and the physician had order the medication to be given at a different time for today.

The administrative team was notified of the above documented findings on 4/5/17 at approximately 5:00 pm by the surveyor in the conference room. The surveyor requested a copy of the policy regarding using the backup pharmacy when a medication was needed to administer to a resident.

On 4/6/27 at approximately 10:30 am, the DON (director of nursing) stated to the surveyor "The procedure to obtain any medications that the nurse does not have to administer to the resident

F 425 timely from the pharmacy for administration. The inservice will include the steps the nurses should take should a medication not be delivered timely from the pharmacy.

Monitoring:
The DON is responsible for maintaining compliance. The DON will conduct weekly audits of resident MAR's each week to confirm the availability of all ordered drugs. All negative findings will be corrected at the time of discovery. Results of the reviews 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 11, 2017

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 425 Continued From page 23

is to notify the pharmacy and the pharmacy will call the backup pharmacy to obtain the medication."
The surveyor was provided a copy of the policy titled " ...Receipt of Interim/STAT/Emergency Deliveries". Under the section of Procedure the following was noted:
2. ..."Facility should arrange either:
2.1 With Pharmacy to include the interim/stat/emergency medication(s) in an earlier scheduled delivery or a special delivery as required, or,
2.2 For delivery by contract courier, or,
2.3 For the medication to be dispensed and delivered by a Third Party Pharmacy to ensure timely receipt ..."

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

F 425

F 441 SS=E 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS

(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

F 441

F 441
Corrective Action(s):
Resident #13's attending physician was notified that the facility failed to implement and follow the Influenza Prevention and control policy for resident #13. A facility Incident & Accident form has been completed for each of these incidents.

Identification of Deficient Practice(s) and Corrective Action(s):
All other residents with confirmed Influenza A may have potentially been affected. A 100% review of all residents with confirmed Influenza will be conducted to identify whether the Influenza prevention and control policy and procedures are being initiated and

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F 441	Continued From page 24 (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441	followed. Any/all negative findings related to isolation precautions and infection control tracking and trending will be corrected at time of discovery and a facility Incident & Accident form will be completed. **Systemic Change(s):** The facility Infection Control policy and procedure has been reviewed and no changes are warranted at this time. The DON will be inserviced by the Regional Nurse Consultant on the facility's infection control policy and procedure and the infection tracking logs for maintaining proper infection control standards and prevention in the facility. All staff will be inserviced by the DON and/or Regional Nurse Consultant on the infection Control Policy to include the Influenza Prevention and control policy. **Monitoring:** The DON is responsible for maintaining compliance. The facility has an infection control tracking log for monitoring and tracking infections and infectious Illnesses to maintain compliance. The DON will review the infection control tracking log weekly and review/report all findings to the Risk Management Committee for review and recommendations. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Compliance Date:** May 11, 2017	

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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 _____	04/06/2017

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F 441	Continued From page 25	F 441		

(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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	04/06/2017

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F 441	Continued From page 26	F 441		

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

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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 _____	04/06/2017

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F 441	Continued From page 27	F 441		

Seasonal" on 4/5/17 at 8 am by the corporate nurse. In this policy it stated the following:

"Influenza Modes of Transmission
1a. Transmission via large-particle droplets requires close contact between distances (approximately six (6) feet or less) through the air ...
2. During periods of increased influenza activity steps will be taken to minimize elective visits by individuals with suspected or confirmed influenza ...
3c. Individuals with symptoms of respiratory infections will be encouraged to sit as far as away from others as possible ... "

A clinical record review was performed by the surveyor on 4/6/17 by the surveyor. The physician had ordered a flu swab to be done on 4/1/17 which the result was positive for Influenza A. The physician ordered "Tamiflu 75 mg po (by mouth) BID (twice a day) X (times) 5 days". According to the nurses' notes and the resident's comprehensive care plan, the resident was placed in Contact Isolation after the results were received on 4/1/17. Then according to the comprehensive care plan the resident was placed in Droplet Precautions on 4/4/17.

On 4/6/17 at approximately 3:30 pm, the surveyor asked the unit manager for Hall1 how many residents resided on Hall 1. The unit manager stated "there are 58 residents on this hallway." 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 precautionary measure". The surveyor asked 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 _____	04/06/2017

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F 441	Continued From page 28 unit manager when approximately 6 pm". The administrative team was notified of the concerns documented above concerning Resident #13 having Influenza A and was at the nursing station in close proximity of other residents even though the resident had a face mask on. This occurred on 4/5/17 at approximately 5 pm and then again on 4/6/17 at approximately 3:45 pm by the surveyor in the conference room. No further information was provided to the surveyor prior to the exit conference on 4/6/17.	F 441		
F 502 SS=E	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain physician ordered laboratory tests for 4 of 20 residents (Resident #4, Resident #5, Resident #9, Resident #3). The findings included: 1. The facility staff failed to obtain an iron profile for Resident #4. Resident #4's clinical record was reviewed 4/5/17 and 4/6/17. Resident #4 was admitted to the facility 5/17/16 and readmitted 5/25/16 with	F 502	**F502** **Corrective Action(s):** Resident #4's attending physician has been notified that the facility failed to obtain an Iron Profile as ordered by the physician. A Facility Incident & Accident form has been completed for the missing labs. Resident #5's attending physician has been notified that the facility failed to obtain a Lipid Panel as ordered by the physician. A Facility Incident & Accident form has been completed for the missing labs. Resident #9's attending physician has been notified that the facility failed to obtain a CBC & CMP as ordered by the physician. A Facility Incident & Accident form has been completed for the missing labs.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	04/06/2017

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

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F 502	Continued From page 29	F 502		

diagnoses that included but not limited to heart failure, chronic obstructive pulmonary disease. dysphagia, constipation, dementia with behavioral disturbances. anemia, and insomnia.

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 qd (every day), Iron profile, hemmocults (sic) x2."

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.

The director of nursing informed the surveyor on 4/6/17 that the iron profile had not been obtained as ordered.

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

2. The facility staff failed to obtain a lipid panel for Resident #5.

Resident #3's attending physician has been notified that the facility failed to obtain a BMP as ordered by the physician. A Facility Incident & Accident form has been completed for the missing labs.

Identification of Deficient Practice(s) & Corrective Action(s):
All other residents who had physician ordered lab tests may have potentially been affected. A 100% audit of all resident's lab orders will be completed to identify residents at risk. All negative findings will be corrected at the time of discovery. The attending physicians will be notified of the missing labs and labs not obtained timely. A facility Incident & Accident Form will be completed.

Systemic Changes:
The facility policy and procedure has been reviewed and no changes are warranted at this time. The laboratory tracking system has been reviewed and implemented to track and validate that required lab work has been completed per physician order and policy and procedure. The DON and/or Nurse Consultant will inservice all licensed staff on physician ordered laboratory-testing, protocols, & tracking system used.

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

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 _____	04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 502	Continued From page 30	F 502	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will complete the Facility Lab audit tool weekly to monitor for compliance. Any negative findings will be reported to the attending physician and disciplinary action will be taken as warranted. 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 11, 2017**	

The clinical record of Resident #5 was reviewed 4/5/17. Resident #5 was admitted to the facility 2/28/96 and readmitted 1/10/12 with diagnoses that included but not limited to intellectual disabilities, legal blindness, hyperlipidemia, cellulitis, and Vitamin D deficiency.

Resident #5's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/13/16 assessed the resident with short term memory problems, long term memory problems, and severely impaired cognitive skills for daily decision making.

The March 2017 physician order sheet (POS) was reviewed. Resident #5 had orders for fasting lipid panel every 6 months with a start date of 6/24/16. The laboratory section of the clinical record held the results of a lipid panel obtained 12/22/16.

The surveyor requested the director of nursing's assistance on 4/5/17 at 1:30 p.m. to locate the lipid panel done the previous 6 months. The DON provided a lipid panel that was obtained 2/22/16. The DON stated she was unable to locate the results of a lipid panel for June 2016.

The surveyor informed the administrative staff of the above concern on 4/5/17 at 5:40 p.m.

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

3. The facility staff failed to obtain physician ordered laboratory tests a CBC (complete blood count) and CMP (comprehensive metabolic panel) lab test for Resident #9.

Resident #9 was admitted to the facility 5/16/11

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APR 28 2017
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 502	Continued From page 31	F 502		

and readmitted on 3/31/15 with diagnoses that included but not limited to high blood pressure, anemia, heart failure, and bronchitis .

A review of Resident #9's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 2/1/17, the facility staff assessed the resident to usually understand and to usually be understood. He was assessed to have a cognitive summary score of 15.

On 2/8/16, a review of Resident #9's clinical record revealed that the physician had given an order on 1/18/17 for a CBC every 3 months and a CMP every 6 months.

A review of the laboratory reports in Resident #9's clinical record revealed no results for the laboratory test for the CBC due in December 2016 and the CMP due in September 2016.

On 2/8/16 at 3:35 pm, the regional nurse consultant was asked to assist with locating the missing lab test. He said he would check.

On 4/5/17, during a meeting with the administrator, regional nurse consultant and director of nurses, they were informed of the missing CBC and CMP laboratory tests.

On 4/5/17 at 2:40 pm the regional nurse informed the surveyor "we don't have the labs."

Prior to exit on 4/6/17 at 3:40 pm, the above information was again discussed with the administrator regional nurse consultant and the director of nurses.

4. The facility staff failed to obtain a physician

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

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 _____	04/06/2017

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HERITAGE HALL WISE	9434 COEBURN MOUNTAIN ROAD WISE, VA 24293

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F 502	Continued From page 32	F 502		

order laboratory test for Resident #3.

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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APR 28 2017
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