PRINTED: 10/18/2019
FORM APPROVED

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0119	A. BUILDING: _____ B. WING _____	09/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 9/24/19 through 9/26/19. The facility was in not compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 97 bed facillty was 91 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 3 closed records. There were also 2 complaints invesstigated during this survey. VA 5-371-220 (A), (B) and (D) Please cross reference to F-684 VA 5-371-220 (A), (B) and (D) Please cross reference to F-697 VA 5-371-300 Please cross reference to F-755 VA 5-371-220 (B) Please cross reference to F-760	F 000	POC Cross Reference for Licensure Cross reference POC for F-684 to VA 5-371-220 (A), (B), and (D) Cross reference POC for F-697 to VA 5-371-220 (A), (B), and (D) Cross reference POC for F-755 to VA 5-371-300 Cross reference POC for F-760 to VA 5-371-220 (B)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/1/19

STATE FORM 6899 JVV011 If continuation sheet 1 of 1

LP

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

PRINTED: 10/18/2019
FORM APPROVED
OMB NO. 0938-0391

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 09/24/19 through 09/26/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/24/19 through 9/26/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety survey/report will follow. The census in this 97 certified bed facility was 91 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 3 closed record reviews. There were also 3 complaints investigated during this survey.	F 000		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;	F 563	**F563** **Corrective Action(s)** Resident #20's son has been notified by the administrator that the no trespassing notification that was sent to him has been revoked and he is able to visit his mother as he wishes during established visitation hours. **Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. The Administrator and/or Social Services director will review 100% of all clinical records to identify residents who may have been denied their right to visitation. An incident & accident report has been completed for all negative findings.	

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

Administrator 10/29/19

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 563	Continued From page 1 (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on clinical record review, Resident interview, staff interview, family interview, facility document review, and during the course of a complaint investigation, it was determined that the facility staff failed to allow 1 of 26 Residents in the survey sample to receive visitors of choice, Resident # 20. The findings included The facility staff failed to allow Resident # 20 to visit with her son at the facility. Resident # 20 was an 86-year-old-female who was originally admitted to the facility on 12/10/18 and had a readmission date of 7/70/19. Diagnoses included but were not limited to, major depressive disorder, anxiety, hypertension, and muscle weakness. The clinical record for Resident # 20 was reviewed on 9/25/19 at 10:00 am. The most recent MDS assessment (minimum data set) for	F 563	**Systemic Change(s):** The facility policy and procedures have been reviewed and no changes are warranted at this time. All staff will be inserviced by the administrator on Resident Rights. The inservice will specifically include the residents right to accept or deny visitors throughout the day. **Monitoring:** The Administrator is responsible for maintaining compliance. The Administrator and/or Social Services director will meet with the resident council monthly to review resident rights and to hear any concerns regarding resident rights violations that may have occurred. Any/all negative findings will be corrected at time of discovery. Findings from Resident counsel minutes will be reviewed will be reviewed in QA committee for analysis and recommendation for changes in facility policy, procedure and/or practice. **Completion Date: 11/10/19**	

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F 563	Continued From page 2 Resident # 20 was a quarterly assessment with an ARD (assessment reference date) of 7/31/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 20 had a BIMS (brief interview for mental status) score of 7 out of 15, which indicated that Resident # 20's cognitive status was severely impaired. The current plan of care for Resident # 20 was reviewed and revised on 8/6/19. The facility staff documented a "Problem/Need" for Resident # 20 as, "Resident # 20 is invited and encouraged to attend and participate in activities, however she does refuse on most days. Resident # 20 remains active by music, interacting with others etc. Resident # 20 has very good family support and contact as family visits daily. Her favorite activity is spending time with family." On 9/26/19 at 9:06 am, the surveyor conducted an interview with Resident # 20 in her room. The surveyor asked Resident # 20 if her son (name withheld) had visited her lately. The surveyor observed Resident # 20 as she became tearful. Resident # 20 stated, "No I haven't seen (name withheld) in a while." Maybe about three months or so, maybe even longer than that." "He was my first born." The surveyor asked Resident # 20 why she had not seen her son in a while. Resident # 20 stated, "He and (name withheld) are not allowed to come here." "I guess they got in some trouble and are not allowed to come here." On 9/26/19 at 9:10 am, the surveyor spoke with Resident # 20's son via telephone. The surveyor asked Resident # 20's son if he was allowed to visit Resident # 20 at the facility. Resident # 20's	F 563		

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F 563	Continued From page 3	F 563		

son informed the surveyor that he was not allowed to visit Resident # 20 in the facility. Resident # 20's son stated, "That said I caused trouble and I never opened my mouth." "I am in a wheelchair." "I am paraplegic." "They just sent me a letter and said I can't come to the nursing home or any of their other properties, and if I do, I would be arrested." "I just hate that I am not allowed to see my mother." "She is 86 years old." "She won't be here much longer."

On 9/26/19 at 9:22 am, the surveyor interviewed the facility administrator. The surveyor asked the facility administrator if Resident # 20's son and daughter had been banned from the facility. The facility administrator informed the surveyor that Resident # 20's son and daughter had been banned from the facility. The surveyor asked the facility administrator what happened that warranted the decision. The facility administrator explained that Resident # 20's son and daughter would visit Resident # 20 around 7:30pm or 8:00pm when she would be getting ready to go to sleep for the night. The administrator stated they would come in threatening the nurses, and that one of the nurses brought pepper spray. The surveyor asked if both Resident # 20's son and daughter threatened the nurses. The administrator stated that Resident # 20's daughter would. The administrator stated that Resident # 20's daughter would want information on Resident # 20. The administrator stated the facility would provide information to Resident # 20's other daughter who was the responsible party. The administrator stated that the facility explained the process, offered social work assistance, and set up a special care plan meeting for all of the children. The administrator stated, "(Daughter's name withheld) took the

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F 563	Continued From page 4 meeting and turned it into a bashing session." The administrator informed the surveyor that after the care plan meeting Resident # 20's daughter continued to come in making threats, which caused the facility nurses to cry. The administrator stated, "After several discussions with them I decided to go the route to ask them to leave and they would not." The facility then contacted the police to have Resident # 20's son and daughter escorted out of the facility. The administrator stated that Resident # 20's son and daughter asked if they could visit Resident # 20 one last time and were allowed to, but that Resident # 20's daughter got Resident # 20 upset. The surveyor informed the administrator following the interview that the information that he provided during the interview supported that Resident # 20's daughter caused issues within the facility, but none of the information provided by the administrator reflected that Resident # 20's son had caused any issues that would support him being banned from the facility. The surveyor asked the administrator to provide documentation of any incidents that occurred when Resident # 20's family had caused any disturbances within the facility to create an unsafe environment. On 9/26/19 at 4:30 pm, the administrator provided the surveyor with a copy of the "Care Plan Meeting Summary" that was held on 3/5/19. The surveyor observed documentation on the care plan meeting summary that Resident # 20's son was "Unable to attend" the meeting. The administrator also provided the surveyor with copies of two "Resident/Visitor Incident Witness Statement" sheets that were documented on 5/17/19. After the surveyor reviewed the resident/visitor incident witness statement sheets, the surveyor did not observe any documentation	F 563		

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F 563	Continued From page 5	F 563		

that supported that Resident # 20's son caused any disturbances that would warrant him being banned from the facility.

The administrator also provided the surveyor with a copy of a "No Trespassing Notification" that had been sent to Resident # 20's son that was dated 5/20/19. The no trespassing notification contained documentation that included but was not limited to,
..."You are hereby notified pursuant to Virginia Code §18.2-119 that you are forbidden to entering upon the building or grounds of any (Facility name withheld) Nursing Center for any reason whatsoever.

You are further notified that violation of this notice will subject you to immediate arrest as a trespasser or a warrant will be sworn for your arrest and prosecution." ...

Court appointed guardianship papers in the clinical Record for Resident # 20 contained documentation that included but was not limited to,
..."Ordered that all of the other children of the Respondent being (four of Resident # 20's children's name withheld) shall have reasonable access to the care providers and health care records of the Respondent. In addition said adult children shall have access to and visitation with the Respondent which shall be exercised only in accordance with any instructions and/or limitations or restrictions imposed by the Respondent's health care providers." ...

The facility "Visitation" policy contained documentation that included but was not limited to,

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F 563	Continued From page 6 ..."Policy statement Our facility permits residents to receive visitors subject to the resident's wishes and the protection of the rights of the other residents in the facility. Policy Interpretation and Implementation 1. We recognize the resident's need to maintain contact with the community in which he or she has lived or is familiar. Therefore, the resident is permitted to have visitors as he/she wishes. 13. Incidents of any visitor's disruptive behavior must be documented in the resident's medical record or other facility approved form." ... On 9/26/19 at 5:01 pm, the administrator, director of nursing, and corporate nurse consultant were informed that after the interview with the administrator, review of Resident # 20's clinical record, the facility policy, and statements that had been provided by the facility, there was no documentation that supported the facility banning Resident # 20's son from the facility, which violated Resident # 20 right to have her son visit. The surveyor provided the administrative team with the opportunity to ask questions and to provide any additional information to support banning the son from entering the facility. The administrative team stated they had no further questions to ask. No further information regarding this issue was presented to the survey team prior to the exit conference on 9/26/19.	F 563		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident;	F 580	**F580** **Corrective Action(s)** Resident #85's attending physician has been notified that the facility failed to notify the physician that resident #85's pain was not relieved with the ordered pain medication.	

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F 580	Continued From page 7 consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility	F 580	LPN #1 that failed to assess resident #85 after being notified of her unrelieved pain and failed to notify the MD in a timely manner of resident #85's unrelieved pain is no longer employed at the facility. A Facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents with physician ordered pain medications may have potentially been affected. The DON, ADON, Unit Manager, and/or designee will complete a 100% review of all residents with physician ordered pain medications to identify resident at risk. All negative findings will be corrected at the time of discovery and the attending physician will be notified. A facility Incident & Accident form has been completed for this incident. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The 24 Hour Report serves as the source document for communicating changes in condition, status, proper notification to the attending physicians and the responsible parties and revision/updates to the comprehensive plan of care. The 24 Hour Report will be reviewed and initialed daily by the Administrator, DON and Unit Manager. The Licensed staff will be inserviced by the DON and/or Regional nurse consultant on the Notification of Rights & Services and issued a copy of the facility policy and procedure. The inservice will include staff education on Physician and RP notification for any change in resident status, medications, treatments.	

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F 580	Continued From page 8 that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, the facility staff failed to notify the physician of a change in the status concerning pain management for 1 of 23 residents in the survey sample (Resident #85). The findings included: Resident #85 reported to the surveyor that she was experiencing increased pain that was not relieved by medication that was previously given to the resident. LPN (licensed practical nurse) #1 did not notify the physician in a timely manner after notification of pain not being relieved by medication given and the resident having increased pain. Resident #85 was readmitted to the facility on 9/16/18 with the following diagnoses of, but not limited to anemia, high blood pressure, Peripheral Vascular Disease, diabetes, Parkinson's disease and depression. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/18/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. Resident #85 was also coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene and was totally dependent on 2 staff members for bathing.	F 580	**Monitoring:** The DON and Unit Managers are responsible for maintaining compliance. The DON and/or Designee will complete MAR audits weekly for residents with physician ordered pain medication to monitor compliance. All Any/all negative findings will be corrected at time of discovery and appropriate disciplinary action taken. Aggregate findings will be reported to the QA Committee for review, analysis and recommendation for changes in facility policy, procedure and/or practice. **Completion Date: 11/10/19**	

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F 580	Continued From page 9 On 9/25/19 at 9:25 am, the surveyor went into the resident's room. Resident #85 stated to the surveyor at 9:30 am that she was in pain and it was constant. Surveyor asked if she had let the nurse know about this and she stated, "I have and I took something earlier but it just still hurts, nothing relieves it." Surveyor spoke to the LPN (licensed practical nurse) #1 and notified her of the statements that the resident just made to the surveyor. LPN #1 stated, "She gets Lortab every 6 hours and the next time she gets it is 12 noon. They increased her Gabapentin for that reason of break through pain. I guess if she keeps hurting, I can call the doctor." At 10:10 am, the Surveyor went back in to resident's room and asked if the nurse had come to assess her pain since the surveyor was here earlier. The resident stated, "No, no one has been in here except for you. I thank you for checking on me. And if you pray please pray for me." At approximately 10:20 am, the surveyor requested the following: Resident's current physician orders, current care plan, September MAR (medication administration record), and nursing notes from 6 am this morning (9/25/19) to the present time of this request and facility policy on pain management from the administrator. At 10:24 am, the surveyor reviewed the clinical record of Resident #85. It was noted by the surveyor that Resident #85 had the following physician orders for pain which included: Norco 7.5 mg (milligram) every 6 hours that had been in effect since the physician ordered the medication on 1/1/19 and Gabapentin 300 mg TID (three times a day) which was noted to had been increased to this dosage on 9/23/19 by the	F 580		

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F 580	Continued From page 10	F 580		

physician. There was no nursing documentation in the resident's clinical record dated for 9/25/19 concerning the resident being assessed for increased pain or the physician being notified of the findings of this assessment. The last nursing documentation was documented for 9/25/19 at 3:10 AM.

At 10:45 am, the surveyor interviewed LPN #1. The surveyor asked LPN #1 if she had assessed the pain of Resident #85 since the surveyor had notified her of the resident having complaints of pain and no relief of pain from pain medication as documented per the surveyor's interview with the resident at 9:25 am. LPN #1 stated, "No, but I can." The surveyor then asked if the doctor had been notified of the above documented findings. LPN #1 stated, "No, he hasn't. I will call him after I assess the resident if needed."

At 11:22 am, the surveyor interviewed the unit manager of the above documented findings and asked when is the staff to assess and notify the physician for a resident experiencing increased pain with no relief received from prescribed medication as voiced by the resident to a nurse. Unit manager replied, "You go and assess the pain right when you are notified of anyone having pain. If there is a change in pain levels or the resident is not having pain control with medications already administrated to the resident then the nurse should call the physician and notify him of this." The unit manager then stated, "The nurse has called the doctor and has received orders for Tramadol 50 mg (milligram) to be given twice a day for pain. I have also put a corrective action in place concerning this issue."

On 9/25/19 at 4:14 pm, the surveyor notified 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 _____	C 09/26/2019

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 580	Continued From page 11 administrative team, which consisted of the administrator, DON and the regional nurse consultant of the above documented findings. The surveyor again notified the administrative team of the above documented findings and issues concerning Resident #85 on 9/26/19 at 1:00 pm. No further information was provided to the surveyor or the survey team prior to the exit conference on 9/26/19.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review, the facility staff failed to provide services maintaining professional standards of practice for one of 26 Residents in the survey sample, Resident # 28. The findings included The facility staff documented administration of Marinol for Resident # 28 that had not arrived in the facility.	F 684	**F684** **Corrective Action(s):** Residents #28's attending physician was notified that the facility had documented the administration of a medication that was not available from the pharmacy and that the facility failed to ensure that physician ordered Marinol was available for administration from the pharmacy. A facility Incident and Accident form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents receiving medications may have been potentially affected. The DON, ADON, Unit Managers and/or designee will conduct a 100% audit of all residents MAR's to identify resident at risk. Residents identified at risk for not having medications available 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.	

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F 684	Continued From page 12 Resident # 28 was an 81-year-old-female that was originally admitted to the facility on 3/8/12, and had a readmission date of 2/22/19. Diagnoses included but were not limited to, dementia, muscle weakness, vitamin D deficiency, and hypothyroidism. The clinical record for Resident # 28 was reviewed on 9/25/19 at 9:43 am. The most recent MDS (minimum data set) assessment for Resident # 28 was a quarterly assessment with an ARD (assessment reference date) of 8/7/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 28 had a BIMS (brief interview for mental status) score of 7 out of 15, which indicated that Resident # 28's cognitive status was severely impaired. Section K of the MDS assesses swallowing and nutritional status. In Section K0300, the facility staff documented that Resident # 28 had weight loss and was not on physician prescribed weight loss regimen. The current plan of care for Resident # 28 was reviewed and revised on 8/12/19. The facility staff documented a problem area for Resident # 28 as, "Resident # 28 has no problems at this time with chewing/swallowing. She is fed by staff. She has top and bottom dentures but doesn't wear them at all times. Resident # 28 has fair intake and her weight is within normal range at this time. DX: (diagnoses) hypothyroidism, hypokalemia, dementia, depression, old MI (heart attack), GERD (gastroesophageal reflux disease)." Interventions included but were not limited to, "Meds/Labs as ordered inform MD/RP (medical doctor/responsible party) of wt (weight) changes." Resident # 28 had orders that included but were	F 684	**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 medications per physician orders. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for following and administering medications per physician order to include the procedure for obtaining medications from pharmacy to ensure availability. The inservice will also address the proper documentation procedures to be implemented when medications are not available for administration. **Monitoring:** The DON will be responsible for maintaining compliance. The DON, and/or Designee will audit resident MAR's weekly to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 11/10/19**	

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F 684	Continued From page 13 not limited to, "Marinol 5 mg (milligram) capsule give one po (by mouth) Q (every) day DX decreased appetite," which was initiated by the physician on 8/16/19. The surveyor reviewed the August 2019 medication administration record for Resident # 28. The surveyor observed documentation of "N" on the medical record, which meant not administered on the following dates: On 8/21/19 documentation in the clinical record reflected that Marinol "was refused by resident." On 8/25/19 documentation in the clinical record reflected that Marinol "was not administered-Other. Pending provider clarification." On 8/31/19 documentation in the clinical record reflected that Marinol was "unavailable." The surveyor observed that facility staff documented Marinol 5 mg as having been administered to Resident # 28 on 8/22/19, 8/23/19, 8/24/19, 8/26/19, 8/27/19, 8/28/19, 8/29/19, and 8/30/19. The surveyor reviewed the September 2019 medication administration record for Resident # 28. The surveyor observed documentation of "N" on the medical record, which meant not administered on the following dates: On 9/5/19 documentation in the clinical record reflected that Marinol was "not available." On 9/8/19 documentation in the clinical record reflected that Marinol was not administered "Pending Rx (prescription)." On 9/9/19 documentation in the clinical record reflected that Marinol "was refused by resident. Refused x3."	F 684		

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F 684	Continued From page 14 The surveyor observed that the facility staff documented that Marinol 5 mg as having been administered to Resident # 28 on 9/1/19, 9/2/19, 9/3 /19, 9/4/19, 9/6/19, 9/7/19. On 9/26/19 at 11:53 am, the surveyor informed the director of nursing that Marinol 5 mg had been documented as being unavailable on the dates listed above. The surveyor requested additional information as to why the Marinol 5 mg was unavailable for Resident # 28 and requested to see the Marinol controlled substance log from August and September 2019 for Resident # 28. On 9/26/19 at 2:00 pm, the director of nursing informed the surveyor that there were no Marinol controlled substance logs for Resident # 28 for August 2019. The director of nursing informed the surveyor that the physician had written a prescription on 8/16/19 for Marinol 5 mg, but did not specify a quantity so the medication never came into the facility. The director of nursing stated that the facility nurses attempted to contact the physician to no avail to get a new prescription with a quantity. The director of nursing provided the surveyor with a copy of a prescription for Marinol 5 mg that was written on 9/9/19 that specified a quantity of 30 capsules to be sent. The director of nursing informed the surveyor that even though the order was written on 8/16/19 the Marinol was not delivered to the facility until 9/10/19. The director of nursing acknowledged that facility staff documented Marinol 5 mg as having been administered to Resident # 28 when the medication was not in the building available for administration. The facility policy and standard of practice on	F 684		

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	495350	A. BUILDING _____ B. WING _____	C 09/26/2019

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F 684	Continued From page 15 "Administering Medications" contained documentation that included but was not limited to, ..."Policy Interpretation and Implementation 19. The individual administering the medication must initial the resident's MAR (medication administration record) on the appropriate line after giving each medication and before administering the next ones." ... On 9/26/19 at 5:01 pm, the administrator, the director of nursing, and corporate nurse consultant were made aware of the deficient practice as stated above and provided the opportunity to ask questions and submit additional information to dispute the deficient practice. The administrative team had no further questions and no further information regarding this issue was presented to the survey team prior to the exit conference on 9/26/19.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the	F 695	**F695** **Corrective Action(s):** The attending physician has been notified that Resident #84 did not receive oxygen at the correct flow rate as ordered by the physician. Resident #84 has had their oxygen administration orders clarified with the attending physician. A facility Incident & Accident form has been completed for this incident.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 16 facility staff failed to administer oxygen as ordered by the physician for 1 of 23 residents in the survey sample (Resident #84). The findings included: The facility staff failed to administer Resident #84's oxygen at 3 l/min (liters/minute) as ordered by the physician. Resident #84 was readmitted to the facility on 9/10/19 with the following diagnoses of, but not limited to heart failure, high blood pressure, depression, respiratory failure and chronic obstructive pulmonary disease. On the admission MDS (Minimum Data Set) with an ARD (assessment reference date) of 9/17/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #84 was also coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene and being totally dependent on 2 staff members for bathing. On 9/25/19 at 9:02 am, the surveyor observed that the resident's oxygen concentrator was set to deliver oxygen at 4 to 4 ½ l/min by nasal cannula. The surveyor observed the resident lying in bed with her nasal cannula in place and receiving oxygen at this time on this setting. CNA (certified nursing assistant) #1 was asked if she knew what the resident's oxygen should be setting on for Resident #84. CNA #1 replied, "I don't really know, ask _____ (name of nurse that was assigned to this resident)." The surveyor went and asked RN (registered nurse) #1 to come into the resident's room with the surveyor. RN #1 went into room with surveyor and stated after she	F 695	**Identification of Deficient Practices & Corrective Action(s):** All residents receiving oxygen therapy may have potentially been affected. A 100% review of all resident's oxygen orders will be conducted by the DON, ADON and/or Unit Managers to identify residents at risk. Residents found to be at risk will be corrected at the time of discovery. A facility Incident & Accident form will be completed for each item discovered. **Systemic Change(s):** The facility policy and procedure for Oxygen administration has been reviewed and no changes were warranted at this time. All licensed nursing staff will be inserviced on the facility policy and procedure for accurate oxygen administration and monitoring per physician order. Inservices will include the delivery of oxygen per physician order. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or Designee will perform three audits weekly of all residents using oxygen to monitor for compliance. All negative findings will be corrected at time of discovery and appropriate disciplinary action will be taken as needed. All negative findings will reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 11/10/19**	

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	495350	A. BUILDING _____ B. WING _____	C 09/26/2019

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HERITAGE HALL WISE	9434 COEBURN MOUNTAIN ROAD WISE, VA 24293

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F 695	Continued From page 17 observed the oxygen setting on the contractor and stated, "This is on between 4 and 4 and 1/2 instead of 3 like it is ordered." The surveyor reviewed the clinical record for Resident #84 at approximately 11:50 am. The surveyor noted a physician's order, which was for Oxygen to be administrated at 3 l/min by nasal cannula continuous. On 9/25/19 at 09/25/19 3:15 pm and the surveyor requested and received the facility's policy titled "Oxygen Administration" from the DON (director of nursing). This policy read in part " ...Verify that there is a physician's order for this procedure. Review the physician's orders ...for oxygen administration ..." At 4:14 pm, the surveyor notified the administrative team, which consisted of the administrator, DON and the regional nurse consultant, of the above documented findings. The surveyor notified the administrative team of the above documented findings again on 9/26/19 at 1:00 pm. No further information was provided to the surveyor or survey team prior to the exit conference on 9/26/19.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(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.	F 697	**F697** **Corrective Action(s):** Residents #85's attending physician was notified that facility staff LPN #1 failed to assess the residents pain levels or the residents pain management plan after being notified of Resident #85's unrelieved pain after the administration of her physician ordered pain medication. A facility Incident & Accident form was completed for this incident.	

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	495350	A. BUILDING _____ B. WING _____	C 09/26/2019

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F 697	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview and clinical record review, the facility staff failed to ensure that pain management is provided to a resident by assessing and managing the pain for 1 of 23 residents in the survey sample (Resident #85). The findings included: Resident #85 was readmitted to the facility on 9/16/18 with the following diagnoses of, but not limited to anemia, high blood pressure, Peripheral Vascular Disease, diabetes, Parkinson's disease and depression. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/18/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. Resident #85 was also coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene and was totally dependent on 2 staff members for bathing. On 9/25/19 at 9:25 am, the surveyor went into the resident's room. Resident #85 stated to the surveyor at 9:30 am that she was in pain and it was constant. Surveyor asked if she had let the nurse know about this and she stated, "I have and I took something earlier but it just still hurts, nothing relieves it." Surveyor spoke to the LPN (licensed practical nurse) #1 and notified her of the statements that the resident just made to the surveyor. LPN #1 stated, "She gets Lortab every 6 hours and the next time she gets it is 12 noon. They increased her Gabapentin for that reason of break through pain. I guess if she keeps hurting, I can call the doctor."	F 697	**Identification of Deficient Practices & Corrective Action(s):** All other residents receiving scheduled or PRN pain medication may have potentially been affected. A 100% review of all residents receiving PRN or scheduled pain medications will be conducted by the DON, RCC and/or designee to verify a resident centered care plan is in place to address the residents pain levels and the residents pain management plan. All negative findings will be corrected at time of discovery, the attending physician will be notified of any pain management issues and a facility Incident & Accident form will be completed. **Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for following and administering medications per physician order. This includes reassessing residents after the administration of routine or PRN pain medications.	

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	495350	A. BUILDING _____ B. WING _____	C 09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 697	Continued From page 19 At 10:10 am, the surveyor went back in to resident's room and asked if the nurse had come to assess her pain since the surveyor was here earlier. The resident stated, "No, no one has been in here except for you. I thank you for checking on me. And if you pray please pray for me." At approximately 10:20 am, the surveyor requested the following: Resident's current physician orders, current care plan, September MAR (medication administration record), and nursing notes from 6 am this morning (9/25/19) to the present time of this request and facility policy on pain management from the administrator. At 10:24 am, the surveyor reviewed the clinical record of Resident #85. It was noted by the surveyor that Resident #85 had the following physician orders for pain which included: Norco 7.5 mg (milligram) every 6 hours that had been in effect since the physician ordered the medication on 1/1/19 and Gabapentin 300 mg TID (three times a day) which was noted to had been increased to this dosage on 9/23/19 by the physician. At 10:45 am, the surveyor interviewed LPN #1. The surveyor asked LPN #1 if she had assessed the pain of Resident #85 since the surveyor had notified her of the resident having complaints of pain and no relief of pain from pain medication as documented per the surveyor's interview with the resident at 9:25 am. LPN #1 stated, "No, but I can." The surveyor reviewed the September MAR (medication administration record) and the nursing notes for Resident #85 at 10:55 am. On the MAR, Lortab had been documented as last	F 697	**Monitoring:** The DON will be responsible for maintaining compliance. The DON, and/or Designee will audit resident Care Plan weekly coinciding with the Care Plan schedule to monitor for compliance . Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 11/10/19**	

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F 697	Continued From page 20 dose being given was at 6 am on 9/25/19 and Gabapentin had been documented as last being given at 6 am on 9/25/19. The next scheduled dose of Lortab was scheduled to be given to the resident at 12 noon and the Gabapentin was scheduled to be given at 2 pm on 9/25/19. According to the MAR, the surveyor did not note documentation of the resident receiving any other pain medication since the 2 above medications were administrated. The last nursing note in the clinical record was documentation at 3:10 am on 9/25/19. At 11:22 am, the surveyor interviewed the unit manager of the above documented findings and asked when is the staff to assess a resident for pain. Unit manager replied, "You go and assess the pain right when you are notified of anyone having pain." The surveyor requested copies of the facility policy regarding pain management. The unit manager stated, "The nurse has called the doctor and has received orders for Tramadol 50 mg (milligram) to be given twice a day for pain. I have also put a corrective action in place concerning this issue." The DON (director of nursing) provided copies of the facility's policy titled "Administering Pain Medications" to the surveyor. This policy read in part: " ...4. Conduct an abbreviated pain assessment if there has been no change in condition since the previous assessment ..." On 9/25/19 at 4:14 pm, the surveyor notified the administrative team, which consisted of the administrator, DON and the regional nurse consultant of the above documented findings.	F 697		

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F 697	Continued From page 21 The surveyor again notified the administrative team of the above documented findings and issues concerning Resident #85 on 9/26/19 at 1:00 pm. No further information was provided to the surveyor or the survey team prior to the exit conference on 9/26/19.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(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 and clinical record review, the facility staff failed to ensure that a resident who require dialysis receive such services through collaborating with the dialysis care for 1 of 23 residents in the survey sample (Resident #87). The findings included: The facility staff failed to have communication sheets for Resident #87 that collaborated the resident's dialysis care. Resident #87 was admitted to the facility on 9/7/19 with the following diagnoses of, but not limited to anemia, diabetes, anxiety disorder and end stage renal disease. On the admission MDS (Minimum Data Set) with an ARD (assessment	F 698	**F698** **Corrective Action(s):** Residents #87's attending physician was notified that the facility failed to put communication sheets in place to collaborate with the Dialysis clinic for delivering care to resident #87. A facility Incident and Accident form has been completed. **Identification of Deficient Practices/Corrective Action(s):** All other residents receiving dialysis may have been potentially affected. The DON, ADON, and/or Unit Managers will conduct a 100% audit of all Dialysis residents' physician orders and MAR's to identify residents at risk for not receiving physician ordered pre and post dialysis monitoring and communication from the dialysis center for all residents receiving dialysis. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.	

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	495350	A. BUILDING _____ B. WING _____	C 09/26/2019

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 698	Continued From page 22 reference date) of 9/19/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #87 was also coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene and bathing. On 9/25/19 and 9/26/19, the surveyor reviewed the clinical record for Resident #87. During this review, the surveyor reviewed the dialysis communication sheet and nursing notes for the month of September 2019. There was a dialysis communication sheet missing for 9/25/19. The surveyor noted that on a dialysis communication sheet dated for 9/11/19, the sheet was not completed by the dialysis center to communicate back to facility how and what occurred with the resident while on dialysis for this date. On 9/26/19 at 11:45 am, the DON (director of nursing) provided the surveyor the nurses' notes for this resident concerning dialysis. The DON stated, "Staff are to make an assessment of the shunt when she returns from dialysis and make a notation that she has returned from dialysis." The surveyor asked the DON, "Was this done for this resident?" The DON replied, "Not for every time that she had returned back to the facility from dialysis." At 1:00 pm, the surveyor notified the administrative team of the above documented findings as documented above. No further information was provided to the surveyor or to the survey team prior to the exit conference on 9/26/19.	F 698	**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, obtaining, transcribing and completing physician medication orders, treatment orders as well as pre and post dialysis monitoring and communication. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. This inservice will also include pre and post dialysis monitoring and communication sheets to coordinate the residents care between the facility and the dialysis centers. **Monitoring:** The DON will be responsible for maintaining compliance. The DON, and/or Designee will audit all dialysis residents Pre and Post dialysis monitoring and communication sheets weekly to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 11/10/19**	
F 755	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		

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	495350	A. BUILDING _____ B. WING _____	C 09/26/2019

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F 755 SS=D	Continued From page 23 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review, the facility staff failed to provide routine drugs by ensuring medications	F 755	**F755** **Corrective Action(s):** Resident 28's attending physician has been notified that the facility failed to ensure that the physician ordered Marinol medication was available from pharmacy for administration to Resident #28. A facility Incident and Accident form has been completed for this incident. Resident 193's attending physician has been notified that the facility failed to ensure that the physician ordered Memantine medication was available from pharmacy for administration to Resident #193. 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 orders has been conducted by the DON, ADON 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.	

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	495350	A. BUILDING _____ B. WING _____	C 09/26/2019

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F 755	Continued From page 24 were available in the facility for administration for two of 26 Residents in the survey sample, Resident # 28, # 193. The findings included 1. The facility staff failed to ensure that Marinol was available in the facility for administration for Resident # 28. Resident # 28 was an 81-year-old-female that was originally admitted to the facility on 3/8/12, and had a readmission date of 2/22/19. Diagnoses included but were not limited to, dementia, muscle weakness, vitamin D deficiency, and hypothyroidism. The clinical record for Resident # 28 was reviewed on 9/25/19 at 9:43 am. The most recent MDS (minimum data set) assessment for Resident # 28 was a quarterly assessment with an ARD (assessment reference date) of 8/7/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 28 had a BIMS (brief interview for mental status) score of 7 out of 15, which indicated that Resident # 28's cognitive status was severely impaired. Section K of the MDS assesses swallowing and nutritional status. In Section K0300, the facility staff documented that Resident # 28 had weight loss and was not on physician prescribed weight loss regimen. The current plan of care for Resident # 28 was reviewed and revised on 8/12/19. The facility staff documented a problem area for Resident # 28 as, "Resident # 28 has no problems at this time with chewing/swallowing. She is fed by staff. She has top and bottom dentures but doesn't wear them at	F 755	**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 timely from the pharmacy for administration. The inserviice 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, and/or Designee 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: 11/10/19**	

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F 755	Continued From page 25	F 755		

all times. Resident # 28 has fair intake and her weight is within normal range at this time. DX: (diagnoses) hypothyroidism, hypokalemia, dementia, depression, old MI (heart attack), GERD (gastroesophageal reflux disease)." Interventions included but were not limited to, "Meds/Labs as ordered inform MD/RP (medical doctor/responsible party) of wt (weight) changes."

Resident # 28 had orders that included but were not limited to, "Marinol 5 mg (milligram) capsule give one po (by mouth) Q (every) day DX decreased appetite," which was initiated by the physician on 8/16/19.

The surveyor reviewed the August 2019 medication administration record for Resident # 28. The surveyor observed documentation of "N" on the medical record, which meant not administered on the following dates:
On 8/21/19 documentation in the clinical record reflected that Marinol "was refused by resident."
On 8/25/19 documentation in the clinical record reflected that Marinol "was not administered-Other. Pending provider clarification."
On 8/31/19 documentation in the clinical record reflected that Marinol was "unavailable."

The surveyor observed that facility staff documented Marinol 5 mg as having been administered to Resident # 28 on 8/22/19, 8/23/19, 8/24/19, 8/26/19, 8/27/19, 8/28/19, 8/29/19, and 8/30/19.

The surveyor reviewed the September 2019 medication administration record for Resident # 28. The surveyor observed documentation of "N" on the medical record, which meant not

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	495350	A. BUILDING _____ B. WING _____	C 09/26/2019

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 755	Continued From page 26 administered on the following dates: On 9/5/19 documentation in the clinical record reflected that Marinol was "not available." On 9/8/19 documentation in the clinical record reflected that Marinol was not administered "Pending Rx (prescription)." On 9/9/19 documentation in the clinical record reflected that Marinol "was refused by resident. Refused x3." The surveyor observed that the facility staff documented that Marinol 5 mg as having been administered to Resident # 28 on 9/1/19, 9/2/19, 9/3 /19, 9/4/19, 9/6/19, 9/7/19. On 9/26/19 at 11:53 am, the surveyor informed the director of nursing that Marinol 5 mg had been documented as being unavailable on the dates listed above. The surveyor requested additional information as to why the Marinol 5 mg was unavailable for Resident # 28 and requested to see the Marinol controlled substance log from August and September 2019 for Resident # 28. On 9/26/19 at 2:00 pm, the director of nursing informed the surveyor that there were no Marinol controlled substance logs for Resident # 28 for August 2019. The director of nursing informed the surveyor that the physician had written a prescription on 8/16/19 for Marinol 5 mg, but did not specify a quantity so the medication never came into the facility. The director of nursing stated that the facility nurses attempted to contact the physician to no avail to get a new prescription with a quantity. The director of nursing provided the surveyor with a copy of a prescription for Marinol 5 mg that was written on 9/9/19 that specified a quantity of 30 capsules to be sent.	F 755		

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	495350	A. BUILDING _____ B. WING _____	C 09/26/2019

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F 755	Continued From page 27 The director of nursing informed the surveyor that even though the order was written on 8/16/19 the Marinol was not delivered to the facility until 9/10/19. The director of nursing acknowledged that facility staff documented Marinol 5 mg as having been administered to Resident # 28 when the medication was not in the building available for administration. The facility policy and standard of practice on "Administering Medications" contained documentation that included but was not limited to, ..."Policy Interpretation and Implementation 19. The individual administering the medication must initial the resident's MAR (medication administration record) on the appropriate line after giving each medication and before administering the next ones." ... The facility policy on "Medication Shortages/Unavailable Medications" contained documentation that included but was not limited to, ..."Procedure 7. If facility nurse is unable to obtain a response from the attending physician/prescriber in a timely manner, facility nurse should notify the nursing supervisor and contact the facility's Medical Director for orders/direction making sure to explain the circumstances of the medication shortage." ... On 9/26/19 at 5:01 pm, the administrator, the director of nursing, and corporate nurse consultant were made aware of the deficient practice as stated above and provided the opportunity to ask questions and submit additional information.	F 755		

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	495350	A. BUILDING _____ B. WING _____	C 09/26/2019

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F 755	Continued From page 28 The administrative team had no further questions and no further information regarding this issue was presented to the survey team prior to the exit conference on 9/26/19. 2. The facility staff failed to ensure that Memantine was available in the facility for administration for Resident # 193. Resident # 193 was an 85-year-old-female who was admitted to the facility on 9/23/19. Diagnoses included but were not limited to, Alzheimer's disease, hypertension, pneumonia, and heart disease. The clinical record for Resident # 193 was reviewed on 9/25/19 at 10:23 am. There was no complete MDS (minimum data set) assessment during the time of the survey. The baseline plan of care for Resident # 193 that was initiated on 9/24/19 had a focus area of "Medication/Treatment Orders" The surveyor observed a handwritten mark next to "See MAR/TAR (medication administration record/treatment administration record)." Resident # 193 had orders that included but were not limited to, "Memantine HCL 10 mg (milligram) tablet 1 tablet via peg tube BID (two times a day) every morning and at bedtime." The surveyor reviewed the September 2019 medication administration record for Resident # 193. The surveyor observed documentation on Resident # 193's medication administration record that Memantine was not administered on 9/24/19 at 9:00 am and 5:00 pm.	F 755		

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F 755	Continued From page 29 On 9/26/19 at 11:11 am, the surveyor spoke with RN (registered nurse) unit manager #1 and asked why Mamantine had not been administered to Resident # 193 on 9/24/19 at 9:00 am and 5:00. RN unit manager #1 stated that the Mamantine for Resident # 193 had not arrived from the pharmacy and was not in the stat box. The surveyor asked RN unit manager # 1 if the facility usually notified a backup pharmacy if meds are not available. RN unit manager # 1 stated that the facility used a backup pharmacy but did not utilize the backup pharmacy to obtain Memantine for Resident # 193. The facility policy on "Medication Shortages/Unavailable Medications" contained documentation that included but was not limited to, ..."Procedure 1. Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from the pharmacy. If the medication shortage is discovered at the time of medication administration, facility staff should immediately take the action specified in Sections 2 or 3 of this Policy 7.0 as applicable. 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, facility nurse should obtain the	F 755		

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	495350	A. BUILDING _____ B. WING _____	C 09/26/2019

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 755	Continued From page 30 medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy to arrange for an emergency delivery. 3. If a medication shortage is discovered after normal pharmacy hours: 3.1 A licensed facility nurse should obtain the ordered medications from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan to action. Action may include: 3.2.1 Emergency delivery; or 3.2.2 Use of an emergency (back-up) third party pharmacy." ... On 9/26/19 at 5:01 pm, the administrator, the director of nursing, and corporate nurse consultant were made aware of the deficient practice as stated above and provided the opportunity to ask questions and submit additional information. The administrative team had no further questions and no further information regarding this issue was presented to the survey team prior to the exit conference on 9/26/19.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760	**F760** **Corrective Action(s):** Resident #28's attending physician has been notified that the facility staff failed to administer Marinol per physician order from 8/16/19 through 9/9/19. A facility Medication error form was completed for each incident.	

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	495350	A. BUILDING _____ B. WING _____	C 09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review, the facility staff failed to ensure that one of 26 Residents were free of significant medication errors, Resident # 28. The findings included: The facility staff failed to administer physician ordered Marinol to Resident # 28 from 8/16/19 through 9/9/19. Resident # 28 was an 81-year-old-female that was originally admitted to the facility on 3/8/12, and had a readmission date of 2/22/19. Diagnoses included but were not limited to, dementia, muscle weakness, vitamin D deficiency, and hypothyroidism. The clinical record for Resident # 28 was reviewed on 9/25/19 at 9:43 am. The most recent MDS (minimum data set) assessment for Resident # 28 was a quarterly assessment with an ARD (assessment reference date) of 8/7/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 28 had a BIMS (brief interview for mental status) score of 7 out of 15, which indicated that Resident # 28's cognitive status was severely impaired. Section K of the MDS assesses swallowing and nutritional status. In Section K0300, the facility staff documented that Resident # 28 had weight loss and was not on physician prescribed weight loss regimen. The current plan of care for Resident # 28 was reviewed and revised on 8/12/19. The facility staff	F 760	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving Physician ordered Marinol may have potentially been affected. A 100% review of all resident's medication orders will be conducted to identify residents at risk by DON and/or Designee. All residents identified at risk will be corrected at time of discovery and appropriate disciplinary action taken. An Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed staff will be inserviced on the facility Medication Administration policy and procedure by the DON regarding the administration of medications per physician orders to include the steps the nurses should take should a medication not be delivered timely from the pharmacy. **Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON and/or designee will do weekly MAR audits to monitor for compliance. Any negative findings will be addressed at the time of discovery and appropriate disciplinary action taken. Detailed findings of these results will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 11/10/19**	

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	495350	A. BUILDING _____ B. WING _____	C 09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 32	F 760		

documented a problem area for Resident # 28 as, "Resident # 28 has no problems at this time with chewing/swallowing. She is fed by staff. She has top and bottom dentures but doesn't wear them at all times. Resident # 28 has fair intake and her weight is within normal range at this time. DX: (diagnoses) hypothyroidism, hypokalemia, dementia, depression, old MI (heart attack), GERD (gastroesophageal reflux disease)." Interventions included but were not limited to, "Meds/Labs as ordered inform MD/RP (medical doctor/responsible party) of wt (weight) changes."

Resident # 28 had orders that included but were not limited to, "Marinol 5 mg (milligram) capsule give one po (by mouth) Q (every) day DX decreased appetite," which was initiated by the physician on 8/16/19.

The surveyor reviewed the August 2019 medication administration record for Resident # 28. The surveyor observed documentation of "N" on the medical record, which meant not administered on the following dates:
On 8/21/19 documentation in the clinical record reflected that Marinol "was refused by resident."
On 8/25/19 documentation in the clinical record reflected that Marinol "was not administered-Other. Pending provider clarification."
On 8/31/19 documentation in the clinical record reflected that Marinol was "unavailable."

The surveyor observed that facility staff documented Marinol 5 mg as having been administered to Resident # 28 on 8/22/19, 8/23/19, 8/24/19, 8/26/19, 8/27/19, 8/28/19, 8/29/19, and 8/30/19.

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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 760	Continued From page 33 The surveyor reviewed the September 2019 medication administration record for Resident # 28. The surveyor observed documentation of "N" on the medical record, which meant not administered on the following dates: On 9/5/19 documentation in the clinical record reflected that Marinol was "not available." On 9/8/19 documentation in the clinical record reflected that Marinol was not administered "Pending Rx (prescription)." On 9/9/19 documentation in the clinical record reflected that Marinol "was refused by resident. Refused x3." The surveyor observed that the facility staff documented that Marinol 5 mg as having been administered to Resident # 28 on 9/1/19, 9/2/19, 9/3 /19, 9/4/19, 9/6/19, 9/7/19. Upon review of Resident # 28's weights in the clinical record, Resident # 28 has a 14.20% weight loss over a six month period. Resident # 28 had a weight on 8/6/19 of 148.6 and a weight on 9/4/19 of 142.6. On 9/26/19 at 11:53 am, the surveyor informed the director of nursing that Marinol 5 mg had been documented as being unavailable on the dates listed above. The surveyor requested additional information as to why the Marinol 5 mg was unavailable for Resident # 28 and requested to see the Marinol controlled substance log from August and September 2019 for Resident # 28. On 9/26/19 at 2:00 pm, the director of nursing informed the surveyor that there were no Marinol controlled substance logs for Resident # 28 for August 2019. The director of nursing informed the	F 760		

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F 760	Continued From page 34 surveyor that the physician had written a prescription on 8/16/19 for Marinol 5 mg, but did not specify a quantity so the medication never came into the facility. The director of nursing stated that the facility nurses attempted to contact the physician to no avail to get a new prescription with a quantity. The director of nursing provided the surveyor with a copy of a prescription for Marinol 5 mg that was written on 9/9/19 that specified a quantity of 30 capsules to be sent. The director of nursing informed the surveyor that even though the order was written on 8/16/19 the Marinol was not delivered to the facility until 9/10/19. The director of nursing acknowledged that facility staff documented Marinol 5 mg as having been administered to Resident # 28 from 8/16/19 through 9/9/19, when the Marinol was not in the building available for administration. The facility policy and standard of practice on "Administering Medications" contained documentation that included but was not limited to, ..."Policy Interpretation and Implementation 19. The individual administering the medication must initial the resident's MAR (medication administration record) on the appropriate line after giving each medication and before administering the next ones." ... On 9/26/19 at 5:01 pm, the administrator, the director of nursing, and corporate nurse consultant were made aware of the deficient practice as stated above and provided the opportunity to ask questions and submit additional information. The administrative team had no further questions and no further information regarding this issue	F 760		

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F 760	Continued From page 35 was presented to the survey team prior to the exit conference on 9/26/19.	F 760		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842	**F842** **Corrective Action(s):** Resident #21's attending physician has been notified that the facility failed to accurately transcribe the physician medication order for Ferrous Sulfate. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents receiving Ferrous Sulfate medication may have potentially been affected. A 100% review of all resident Physician Orders will be conducted by the DON, ADON, and/or designee to identify residents at risk. All negative findings will be clarified and/or correct as applicable at time of discovery. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the Regional Nurse Consultant or DON on obtaining, transcribing, and completing physician medication and treatment orders.	

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F 842	Continued From page 36 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility failed to ensure a complete and accurate clinical record for 1 of 23 Residents, Resident #21. The findings included:	F 842	**Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or designee will conduct weekly chart audits coinciding with the Care Plan schedule to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 11/10/19**	

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F 842	Continued From page 37 For resident #21, the facility staff failed to accurately transcribe a physician's order correctly. Resident #21's face sheet listed an admission date of 12/16/10 and a readmission date of 1/18/19. The Resident's diagnosis list indicated diagnoses, which included, but not limited to Multiple Sclerosis, Anemia, Hypothyroidism, Type 2 Diabetes Mellitus, Major Depressive Disorder, Anxiety Disorder, Hemiplegia, Essential Hypertension and Gastro-esophageal Reflux Disease. The most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 8/01/19 assigned the Resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns. The discharge medications list from the 1/18/19 hospital discharge summary was reviewed and contained a physician's order for "Ferrous Sulfate 325 mg (65 mg iron) Tablet: 1 tablet oral twice a day for anemia". The resident's physician order entered in the medical record dated 1/18/19 stated "Ferrous Sulf EC 324 mg tablet, one PO BID". On 8/26/19 at approximately 8:29 am, surveyor observed RN #1 administer Ferrous Sulfate 325 mg to Resident #21. The surveyor spoke with pharmacist #1 on 9/26/19 at approximately 11:09 am regarding Resident #21's order for Ferrous Sulfate. Pharmacist #1 stated the order received by the pharmacy on 1/18/19 was transcribed for Ferrous Sulfate 324 mg twice daily and the medication is	F 842		

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F 842	Continued From page 38 an OTC (over the counter) medication and is not supplied by the pharmacy. The concern of not transcribing a physician's order correctly was discussed with the administrative staff (administrator, director of nursing, and regional nurse consultant) during a meeting on 9/26/19 at approximately 5:30 pm. No further information was provided prior to exit.	F 842		