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	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hall Wise	9434 Coeburn Mountain Road Wise, VA 24293

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 28567 Based on staff interview and clinical record review, the facility staff failed to accurately complete Minimum Data Set (MDS) assessments for 2 of 23 residents (Residents #32 and #85). The findings included: 1. For Resident #32, the facility staff coded the MDS assessment to indicate this resident was receiving anticoagulant medications when in fact they were receiving antiplatelet medications. Resident #32's diagnoses included hemiplegia and hemiparesis following cerebral infarction and heart failure. Section C (cognitive patterns) of Resident #32's annual MDS assessment with an assessment reference date (ARD) of 05/01/24 included a brief interview for mental status (BIMS) score of 15 out of a possible 15 points. Per the MDS manual a score of 15=cognitively intact. Section N (medications) was coded to indicate Resident #32 was receiving anticoagulant medication and was not receiving antiplatelet medication. Resident #32's clinical record included provider orders dated 12/01/23 for aspirin 81 mg and Plavix 75 mg every morning. Both medications are classified as antiplatelet's. On 07/30/24 at 5:00 p.m., during an end of the day meeting with the Administrator, Administrator in Training, Director of Nursing (DON), Nurse Consultant, and Assistant Director of Nursing the issue with the inaccurate MDS assessment was reviewed. On 07/31/24 at 8:37 a.m., the Nurse Consultant and DON verified the MDS had been coded incorrectly regarding the medication and provided the surveyor with information indicating the MDS had been corrected. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #85, the facility staff coded a discharge MDS to indicate the resident was discharged to a short-term general hospital when in fact they were discharged home. Resident #85's diagnoses included aftercare following surgery for neoplasm and dysphagia. (continued on next page)

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.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Section C (cognitive patterns) of Resident #85's discharge MDS assessment with an assessment reference date (ARD) of 05/06/24 included a brief interview for mental status (BIMS) score of 15 out of a possible 15 points. Per the MDS manual a score of 15=cognitively intact. Section A (identification information) was coded to indicate the resident had a planned discharge and was discharged to a short-term general hospital. Resident #85's clinical record included a progress note dated 05/06/24 that read in part, Resident is being discharged from facility at this time. All paperwork and belongings are signed for. Discharge paperwork sent with resident. On 07/31/24 at 1:30 p.m., the Director of Nursing (DON) reviewed the discharge MDS assessment and progress note with the surveyor and confirmed Resident #85 had been discharged home. The issue with the inaccurate MDS was reviewed with the Administrator, Administrator in Training, DON, Assistant Director of Nursing, and Nurse Consultant on 07/31/24 at 3:30 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 28567 Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan (CCP) for 2 of 23 residents (Residents #35 and #63). The findings included: 1. For Resident #35, the facility staff failed to review and revise the CCP to capture the current treatment orders to the residents lower legs. Resident #35's diagnoses included type 2 diabetes, edema, and hypertension. Section C (cognitive patterns) of Resident #35's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 07/03/24 included a brief interview for mental status (BIMS) score of 8 out of a possible 15 points. Per the MDS manual a score of 8=moderately impaired. Section M (skin) was coded to indicate Resident #35 was receiving application of nonsurgical dressings (with or without topical medications) other than to feet and applications of ointments/medications other than to feet. Resident #35's current medication summary included a provider order dated 06/19/24 to cleanse bilateral lower extremities with soap and water, then apply Unna boots from toes to knees (calamine/zinc) every day shift every 7 day(s) for Edema/Weeping. Resident #35's CCP included the focus area of skin the facility staff had documented the following interventions. Cleanse venous ulcer on right inner shin with wound cleanser, apply Iodosorb gel with calcium alginate. Cover with bordered gauze. Every day shift for Venous ulcer. Date Initiated: 03/26/2024 Cleanse venous ulcer on right inner shin with wound cleanser. Apply Calcium alginate. cover with bordered gauze every day shift for venous ulcer. Date Initiated: 03/13/24. This CCP did not include any information regarding the Unna boots. On 07/30/24 at 1:39 p.m., during an interview with the MDS coordinator this staff reviewed Resident #35's CCP and confirmed the CCP still included Resident #35's previous treatment orders. The MDS coordinator stated they only knew about changes when the staff made them aware. During an end of the day meeting on 07/30/24 at 5:00 p.m., the issue with Resident #35's CCP not being revised to include their current treatment order was reviewed with the Administrator, Administrator in Training, Director of Nursing (DON), Nurse Consultant, and Assistant Director of Nursing. Prior to the exit conference on 08/01/24 the DON and Nurse Consultant provided the survey team with a copy of an updated CCP that had been revised to include the current Unna boot treatment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this issue was provided to the survey team prior to the exit conference. 2. Resident #63's CCP included the intervention for 6 liters of Oxygen via nasal cannula for shortness of breath. The provider order was for Oxygen at 4 liters per minute. Resident #63's diagnoses included acute respiratory failure with hypoxia and hypercapnia, chronic obstructive pulmonary disease, and history of other malignant neoplasm of bronchus and lung. Section C (cognitive patterns) of Resident #63's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 07/03/24 included a brief interview for mental status (BIMS) score of 4 out of a possible 15 points. Per the MDS manual a score of 4=severe impairment. Section O (special treatments, procedures, programs) was coded to indicate this resident used Oxygen. Resident #63's medication summary report included an order dated 06/24/24 for Oxygen at 4 liters per minute. Resident #63's CCP included the focus area of cardiovascular/respiratory. Interventions included Oxygen at 6 liters per minute via nasal cannula continuous. Diagnosis shortness of breath. Date Initiated: 03/07/24. Throughout the course of the survey the surveyor did not observe Resident #63 with their provider ordered Oxygen in use. During these observations Resident #63 was never observed to have any respiratory issues. On 07/30/24 at 3:15 p.m., during an interview with Licensed Practical Nurse (LPN) #1, this nurse stated they had worked at the facility for 2 years and this resident never wore Oxygen. The Nurse Consultant stated this unit was LPN #1's routine assignment. During an end of the day meeting on 07/30/24 at 5:00 p.m., the issue with Resident #63's CCP not being revised to include their current Oxygen order was reviewed with the Administrator, Administrator in Training, Director of Nursing (DON), Nurse Consultant, and Assistant Director of Nursing. On 07/30/24 the Nurse Consultant transcribed an order for the Oxygen to be discontinued. Prior to the exit conference on 08/01/24 the DON provided the surveyor with a copy of an updated CCP indicating the intervention of Oxygen had been resolved. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28567 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure that 1 of 23 residents were utilizing provider ordered Oxygen (Resident #63). The findings included: The facility staff failed to follow the providers orders for Oxygen administration. Resident #63's diagnoses included acute respiratory failure with hypoxia and hypercapnia, chronic obstructive pulmonary disease, and history of other malignant neoplasm of bronchus and lung. Section C (cognitive patterns) of Resident #63's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 07/03/24 included a brief interview for mental status (BIMS) summary score of 4 out of a possible 15 points. Per the MDS manual a score of 0-7=severe impairment. Section O (special treatments, procedures, programs) was coded to indicate this resident used Oxygen. Resident #63's current medication summary report/physician order summary included a current (active) physician order dated 06/24/24 for Oxygen at 4 liters per minute. During a review of Resident #63's medication administration records (MARs) and treatment administration records (TARs) for July 2024 the surveyor was unable to locate the order for Oxygen. Resident #63's comprehensive care plan (CCP) included the focus area of cardiovascular/respiratory. Interventions included Oxygen at 6 liters per minute via nasal cannula continuous. Diagnosis shortness of breath. Date Initiated: 03/07/24. Per the Nurse Consultant the facility staff failed to update the CCP when the resident was readmitted on [DATE] to the current order of 4 liters a minute. Throughout the course of the survey the surveyor did not observe Resident #63 with their provider ordered Oxygen in use. During these observations Resident #63 was never observed to have any respiratory issues. On 07/30/24 at 3:15 p.m., during an interview with Licensed Practical Nurse (LPN) #1 this nurse reviewed Resident #63's clinical record and confirmed the Oxygen was not on the residents MAR. LPN #1 stated they had worked at the facility for 2 years and this resident never wore Oxygen. The Nurse Consultant stated this unit was LPN #1's routine assignment. On 07/30/24, the nursing staff notified the physician that the resident refused to wear their Oxygen and the physician discontinued the order. On 07/30/24, during an end of the day meeting with the Administrator, Administrator in Training, Nurse Consultant, Director of Nursing (DON), and Assistant Director of Nursing, the issue with the residents' Oxygen not being in place and the order not being on the MAR and/or TAR was reviewed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/31/24 at 8:30 a.m., the DON and Nurse Consultant stated the Oxygen had been discontinued by the provider and the care plan had been updated. The facility administrative staff provided the surveyor with a copy of their policy titled, Oxygen Administration. This policy read in part, .The purpose of this procedure is to provide guidelines for safe oxygen administration .Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident . No further information regarding this issue was provided to the survey team prior to the exit conference.