State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495300 12/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HERITAGE HALL KING GEORGE 10051 FOXES WAY KING GEORGE, VA 22485 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) F 000 Initial Comments F 000 An unannounced Medicare/Medicaid standard survey and biennial licensure survey was conducted 11/29/16 through 12/2/16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 130 certified bed facility was 94 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents #1 through #16 and #20) and 3 closed record reviews (Residents #17 through #19). F 001 Non Compliance F 001 12 VAC 5-371-220 Nursing Services The facility was out of compliance with the 12 VAC 5-371-220 C. Abuse following state licensure requirements: Cross Reference to F223 This RULE: is not met as evidenced by: Cross Reference to POC for F223 The facility was not in compliance with the 12 VAC 5-371-110 Management and following Virginia Rules and Regulations for the Administration Licensure of Nursing Facilities: 12 VAC 5-371-110 (B. 1-3, C) Cross Reference to F225 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220 C. Abuse Cross Reference to POC for F225 12 VAC 5-371-110 Management and 12 VAC 5-371-250 Resident Assessment Administration and Care planning 12 VAC 5-371-110 (B.1-3, C) Cross Reference to 12 VAC 5-371-250 (B.3) Cross F225 Reference to F275 12 VAC 5-371-250 Resident Assessment and Cross Reference to POC for F275 Care Plan 12 VAC 5-371-250 (B.3) Cross Reference to F275 12 VAC 5-371-250 Resident Assessment and Care planning 12 VAC 5-371-250 Resident Assessment and 12 VAC 5-371-250 (A) Cross Reference to F278 Care Plan LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PNB411

If continuation sheet 1 of 5



State of Virginia (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A BUILDING 495300 B. WING 12/02/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 10051 FOXES WAY HERITAGE HALL KING GEORGE KING GEORGE, VA 22485 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From Page 1 F 001 F 001 Cross Reference to POC for F278 12 VAC 5-371-250 (A) Cross Reference to F278 12 VAC 5-371-200 Nursing Director 12 VAC 5-371-200 (B) Cross Reference 12 VAC 5-371-200 Nursing Director to F281 12 VAC 5-371-200 (B) Cross Reference to F281 Cross Reference to POC for F281 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220 (A, B) Cross Reference to 12 VAC 5-371-220 Nursing Services F323 12 VAC 5-371-220 (A, B) Cross Reference to F323 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220 (B) Cross Reference to F333 Cross Reference to POC for F-323 12 VAC 5-371-340 Dietary and Food Service 12 VAC 5-371-220 Nursing Services Program 12 VAC 5-371-220 (B) Cross Reference 12 VAC 5-371-340 (D) Cross Reference to F367 to F333 12 VAC 5-371-180 Infection Control Cross Reference to POC for F-333 12 VAC 5-371-180 (C) Cross Reference to F441 12 VAC 5-371-180 Infection Control 12 VAC 5-371-180 (C) Cross Reference 12 VAC 5-371-310 Diagnostic Services to F441 12 VAC 5-371-310 (A, B) Cross Reference to F502 Cross Reference to POC for F441 12 VAC 5-371-360 Clinical Records 12 VAC 5-371-310 Diagnostic Services 12 VAC 5-371-360 (E.4) Cross Reference to F514 12 VAC 5-371-310 (A, B) Cross Reference to F502 COV 32.1-126.01 Cross Reference to POC for F502 Based on employee record review, facility 12 VAC 5-371-360 Clinical Records documentation review, and staff interview, the 12 VAC 5-371-360 (E.4) Cross facility staff failed to obtain a sworn statement or Reference to F514 criminal record check for one employee (EMP. 25) in an employee record sample of 25 employees. Cross Reference to POC for F514 For EMP. 25, the facility staff failed to obtain a criminal record check within 30 days of hire and failed to obtain a sworn statement prior to or at the time of hire. The findings included:

021199

If continuation sheet 2 of 5

State of Virginia (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495300 B. WING 12/02/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 10051 FOXES WAY HERITAGE HALL KING GEORGE KING GEORGE, VA 22485 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) F 001 Continued From Page 2 F 001 POC for COV 32.1-126.01 Corrective Action(s): EMP. 25, a CNA (certified nursing assistant) was The facility has obtained a sworn hired 12/8/15. Review of the employee record disclosure statement and criminal background check for EMP #25 identified revealed no criminal records check or sworn in the survey. An incident & accident statement were present within the employee form has been completed for this incident. record. Identification of Deficient Practices & When interviewed, EMP. B, human resources Corrective Action(s): manager, stated 12/1/16 at 3:19 p.m., at the time All other employees may have been of EMP. 25's hire, the facility was using a private potentially affected. The Human Resource company to hire staff. Part of the process of the Director will audit 100% of all active company was to do any background or tasks employee records to identify employees at related to hiring the staff including criminal back risk. Any/all negative findings will be ground checks and obtaining sworn statements. corrected at the time of discovery. A Risk EMP. B said the facility realized the company was Management Incident Accident Report not performing the necessary regulatory tasks and the company was not used any more for hiring.

Review of the facility's policy entitled "Guidelines for the Prevention of Abuse" included:

"5. Sworn Disclosure statements and Criminal background checks for all new employees prior to employment."

The administrator, DON (director of nursing) and ADON (assistant DON) were informed of the failure of the staff to obtain a sworn statement and criminal background check prior to or within 30 days of hire for EMP. 25, 12/1/16 at end of day meeting.

12 VAC 5 371-210 Nurse Staffing 12 VAC 5 371-210 E

Based on employee record review, facility documentation review, and staff interview, the facility staff failed to verify licensure with DHP (Department of Health Professions) for two employees (EMP. 8 and 18) in a survey sample of 19 licensed/certified employees.

will be completed for any/all negative findings.

Systemic Change(s):

The facility policy and procedure has been reviewed and no changes are warranted at this time. Administrative Staff will be inserviced and issued a copy of the policy & procedure by the Administrator and/or designee. Administrative Staff / Department Heads extending employment without meeting the requirement established by the Federal and State governments and company policy & procedure will be disciplined. Perspective employees will not be allowed to work until all required documentation has been obtained.

STATE FORM

021199

PNB411

If continuation sheet 3 of 5



PRINTED: 12/12/2016 FORM APPROVED

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495300		B. WING		120	02/2016	
						12/	0212016	
	PROVIDER OR SUPPLIER		!		STATE, ZIP CODE			
			10051 FO	XES WAY DRGE, VA 2	22485			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
	the day after she was 2. For EMP. 18, the with DHP after renes The findings include 1. For EMP. #8, he the day after she was EMP. #8, an LPN (lishired by the facility 2 employee record reverified with DHP or EMP. B, the human 12/1/16 at 3:19 p.m. EMP. 8's hire) was to the first day of orien since changed her proceed to hire. Review of the facility For the Prevention of the Prevention of the failure staff prior to employ The administrator, Dinformed of the failure 8's license with DHP end of day meeting. 2. For EMP. 18, the with DHP after renewed the facility 6/3/15. He with DHP and expire	er license was verified as hired; and er facility staff failed to wal of her license. ed: I license was verified as hired. I censed practical nure 2/20/16. Review of her LPN licenter 2/21/16. I resources manager in a 2/21/16. I resources manager in the practice (at the to verify licensure with tation. EMP. B state practice to verify licensure with the practice of the staff to verify licenser in cluded: I on performed for all ment." I oon, and ADON were of the staff to verify prior to hire, 12/1/10 facility staff failed to wal of her license. I gistered nurse) was lest received and in the license was initial errors.	d with DHP rse), was her hise was , stated time of th DHP on ed she has hisure prior uidelines licensed re fy EMP. 6 at the hired by ly verified	F 001	Monitoring: The Human Resources Direct responsible for maintaining of The Business Office Manager designee will conduct monthly employee files tool to maintain compliance. The administrator review all audits and report agfindings to the Quality Assura Committee for review, analysi recommendations for changes procedure, and/or facility pract Completion Date: 1/16/17 12 VAC 5-371-210 Nurse Sta 12 VAC 5-371-210 E Corrective Action(s): The facility administrator and I director were notified that the failed to verify EMP #8 & #18 with DHP in a timely manner a of hire and at the time of renew incident & accident form has be completed for this incident. Identification of Deficient Pra Corrective Action(s): All other licensed nurses may he potentially affected. The Busine Manager and/or designee will an of all active licensed nurse's emercords to identify employees at Any/all negative findings will be corrected at the time of discover Management Incident Accident will be completed for any/all negative findings.	mpliance. and/or audits of a will gregate nce s, and in policy, ice. ffing Medical acility s license the time al. An hen ctices & ave been ss Office dit 100% ployee risk. cy. A Risk Report		
TATE FORM	A .		021199		PNR411	If continue	ation sheet 4 of 5	

STATE FORM

PNB411

If continuation sheet 4 of 5



PRINTED: 12/12/2016 FORM APPROVED

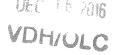
State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING 495300 B. WING 12/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY HERITAGE HALL KING GEORGE KING GEORGE, VA 22485 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION m (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 001 Continued From Page 4 F 001 Systemic Change(s): The facility policy and procedure has review of EMP. 8's employee record revealed no been reviewed and no changes are verification of her license after the license expired. warranted at this time. The human Documentation was evident that EMP. 8 was resources department will be inserviced terminated from employment on 10/31/15. and issued a copy of the policy & procedure for verifying and maintaining a When interviewed 12/1/16 at 3:19 p.m., EMP, B current copy of the nurse's current license stated EMP, 18 quit sometime in September. verification from the Department of Health professions as well as current CPR 2015. EMP. B stated she did not think EMP. 18 certification for licensed nurses by the worked after 8/31/15 but was unable to verify that regional nurse consultant. Perspective as EMP. 18 was salaried and did not have to employees will not be allowed to work punch a time clock. EMP. B stated she did not until all required documentation has been verify EMP. 18's license after it expired, but was obtained. uncertain why the license was not verified after renewal. Monitoring: The Human resource Manager is The DON stated 12/2/16 at 9:12 a.m., EMP, 18 responsible for maintaining compliance. resigned 9/8/15. The DON stated she knew that The Business Office Manager and/or EMP. 18 worked between 8/31 and 9/8/15. designee will conduct monthly audits of employee files using the employee file The administrator, DON, and ADON were audit tool to maintain compliance. The informed of the failure of the staff to verify EMP. administrator will review all audits and 18's RN license with DHP after renewal, 12/2/16 at report aggregate findings to the Quality end of day meeting. Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. Completion Date: 1/16/17

021199

STATE FORM

PNB411

ECEIVED If continuation sheet 5 of 5



PRINTED: 12/12/2016 FORM APPROVED

CENTE	RS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0338-038.
	T OF DEFICIENCIES DEF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
	495300	B. WING _	<u> </u>	12/02/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
			10051 FOXES WAY	
HERITAG	GE HALL KING GEORGE		KING GEORGE, VA 22485	
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLÉTION
F 000	INITIAL COMMENTS	F 00	00	
F 164 SS=D	An unannounced Medicare/Medicaid standard survey was conducted 11/29/16 through 12/2/16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 130 certified bed facility was 94 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents #1 through #16 and #20) and 3 closed record reviews (Residents #17 through #19). 483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at \$483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records,	F 16	F164 Corrective Action: CNA F performing incontine resident #8 was inserviced or policy and procedure for proprivacy during incontinence ADL care. Identification of Deficient I Corrective Action(s): All residents receiving incommay have been potentially at 100% observation audit of a receiving incontinence care conducted to identify any refor the potential unnecessary their bodies during personal services. Any residents iden exposed during the audit will at time of discovery and stat will receive immediate inser An Incident & Accident For completed for any/all incide exposure.	re the facility viding care and Practice(s) & Intinence care ffected. A Ill residents will be sidents at risk y exposure of care and tiffied as being Il be corrected ff involved rvice training. rm will be

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.

Electronically Signed

LABORATORY DIRECTOR'S OR PROVIDER'S PPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE & MEDICAID SERVICES		(DMB NO. 0938-0391
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
Mallard Colored Colore	495300	B. WING		12/02/2016
	PROVIDER OR SUPPLIER BE HALL KING GEORGE	, 10i	REET ADDRESS, CITY, STATE, ZIP CODE	
		, NI	NG GEORGE, VA 22485	
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 164	Continued From page 1 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 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to aver a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, facility documentation and clinical record review, the facility staff failed for one resident, Resident #8, in a survey sample of 20 residents, to ensure the resident was provided privacy during incontinence care. Resident #8 was exposed during incontinence care.	F 164		cedure has ges are staff will be d/or Social nt Rights, al Privacy to are during compliance. esignee will nent care to maintain re findings ly and aken as ngs will be rance vsis, and es in policy, actice.
	The findings included:			
	Resident # 8 was admitted to the facility on			

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

10/11/16. Diagnoses for Resident #8 included but not limited to Hypertension, intracranial

Event ID: PM3B11

Facility ID: VA0103

If continuation sheet Page 2 of 49



PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARI	E & MEDICAID SERVICES				OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		E SURVEY MPLETED
		495300	B. WING _			12/	/02/2016
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		MATERIA MATERI
HERITAG	HERITAGE HALL KING GEORGE		***************************************		FOXES WAY GEORGE, VA 22485		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 164	Continued From pa	age 2	F 16				
, , , ,		h edema (swelling of the lower	1 10	1-4			
	legs) and seizure of	lisorder. Resident #8's					
		(an assessment protocol) with ference Date of 10/18/16					
	coded Resident #8	with a BIMS (brief interview of					
	,	re of "11" out of a possible 15, e impairment. In addition, the					
		coded Resident #8 requiring					
		ce for Activities of Daily Living					
	•	resident required extensive assistance of one staff					
		g. She was coded as being					And the second s
	frequently incontine	ent of bowel and bladder.					***************************************
		0 PM, Resident #8 was					
		hallway in bed. Resident #8's If the privacy curtain was pulled					
		er legs and buttocks in view.					
		n the process of receiving CNA (certified nursing					***
		d writer and continued to					
	provide care, not cl	osing the curtain.					
	Review of Residen	t #8's care plan dated 10/11/16					
		lent #8 had an "inability to					
	retention, and histo	e to cerebral infarct, urinary ry of stroke.					
	Daview of the facili	hda naliay "Ovality of Life					
		ty's policy "Quality of Life- " read as followed: "Staff shall					
		and protect resident privacy,					
	personal care."	acy during assistance with					
		50 PM, an interview with					
		onducted. Resident #8 was rivacy curtain was not pulled					
		during care. She stated,					

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

"That's terrible, I want them to close the curtain."

Event ID: PM3B11

Facility ID: VA0103

If continuation sheet Page 3 of 49



PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

VLIVIL	TO TOTAL COLOT A VE	L & MEDIO/ ND OLI (VIOLO	Т		NID 140. 0330-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER GE HALL KING GEOR		100	REET ADDRESS, CITY, STATE, ZIP CODE 051 FOXES WAY	12/02/20 <u>16</u>
HEKHA	JE MALL KING GLOS	(GE	KII	NG GEORGE, VA 22485	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 164	Continued From pa	age 3	F 164		
SS=D	was conducted. He providing incontine on the door, wait ar that he would introd the water, get soap asked if pulling the CNA (D) stated, "Ye resident was expossaw you, I should hon 12/1/16 at 6:45 DON (director of nufindings. 483.12 FREE FROI SECLUSION 483.12 The resident has the neglect, misappropriand exploitation as includes but is not licorporal punishmentary physical or cheil treat the resident's staff interview, the frone Resident (Resident 20 Residents was Resident #13 was well #14, who stated "I'm	NT is not met as evidenced	F 223	F223 Corrective Action(s): Alternate placement is being invefor Resident #14 at a facility more suitable manage his behaviors. Resident's #13has been reassesse their attending physician, Mental services, and the Interdisciplinary planning team to establish interve be implemented to prevent them further potential verbal or physica from resident #14 or any other resident #14 or any other resident.	ed by Health y Care entions to from any al abuse

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

Event ID: PM3B11

Facility ID: VA0103

If continuation sheet Page 4 of 49



RECEIVED

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION		TE SURVEY MPLETED
		495300	B. WING _				/02/2016
	PROVIDER OR SUPPLIEF GE HALL KING GEOI		· · ·	10051 F	raddress, city, state, zip code foxes way George, va. 22485		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIECT OF THE APPROPRIEC	OULD BE	(X5) COMPLETION DATE
F 223	facility 5/1/13 and hospitalization 4/10 osteoporosis, histocholesterol, deep vaortic valve disord diabetes mellitus, weakness, cardiace Resident #13's moset) with an ARD (10/15/16 was code Resident #13 was and long term mer moderate assistant decisions. Reside extensive to total a activities of daily live Resident #14, a metalogical extensive to total a activities of daily live Resident #14, a metalogical extensive to total a activities of daily live Resident #14, a metalogical extensive to total a activities of daily live Resident #14, a metalogical extensive to total a activities of daily live Resident #14, a metalogical extensive to total a activities of daily live Resident #14 was disease, depressive psychiatric symptochronic obstructive Resident #14 was and long term mer moderate assistant decisions. He was during the look baccoded as requiring of one to two staff	male, was admitted to the readmitted after a 0/16. Her diagnoses included by of breast cancer, elevated wein thrombosis, nonrheumatic er, hypertension, type II contact dermatitis, muscle arrhythmia, and contractures. Dest recent MDS (minimum data assessment reference date) of ed as a quarterly assessment, coded as having some short mory deficits and required ce with making every day life int #13 was coded as requiring assistance with performing her	F 22	23	Identification of Deficient Corrective Action(s): All residents may potentially The last 3 months or resident minutes and the last 60 days resident to resident altercation reviewed by the administration any residents at risk. Any/all identified will immediately investigated to determine if are required to prevent and presidents from future verbal abuse. All incident & accident the past 60 days will be reviewed for proper reporting interventions put in place and findings will be reported to appropriate state agency, attity physician, and the responsibility incident & accident completed for each negative.	y be affected at council sof reported ons will be or to identify I residents be intervention protect or physical ent forms for ewed by the ents of verbaindings willing and propend all negative the tending ble party. A form will be	s s al be err

eating. For eating Resident #14 was coded as

PRINTED: 12/12/2016 FORM APPROVED

CENTE	RS FOR MEDICARE & MEDICAID SERVICES	OMB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495300	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION (X3) DATE SURVEY
	PROVIDER OR SUPPLIER GE HALL KING GEORGE	1	STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485
(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 (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
F 223	Continued From page 5 needing supervision. During the Group interview, 11/30/16 at 1:30 p.m., Resident #14 stated "there was someone that wandered in my bedroom and said terrible things to me. I asked if he was still here and no one will tell me if he is." Review of the Group minutes for August 2, 2016, revealed Resident #13 stated she was afraid of one of the Residents due to his wandering in and out of Resident bedrooms. The Resident that was wandering was identified as Resident #14. During an interview, Resident #13 stated she had	F 223	The facility Policy and Procedure for reporting and preventing resident abuse has been reviewed and no changes are warranted at this time. The administrative staff will be inserviced by the administrator on the Policy and Procedure for reporting and preventing abuse and will be given a copy. All staff members will be inserviced and given a copy of the Abuse reporting and prevention policy and procedure by the Administrator. The inservices provided will include information on the procedure for reporting incidents of abuse, both verbal and physical, interventions and
	told the staff she was afraid of Resident #14 after		monitoring techniques for residents who

he wandered into her bedroom. She was unable to remember exactly when the incident had occurred however it was "couple of months" ago. Resident #13 stated she was in bed and Resident #14 wandered into her room and stated "I am going to (f**k) you". Resident #13 stated it startled her and she told him to leave her bedroom. Resident #14 left her room. Resident #13 stated she did not recall if she told the staff at the time of the incident but the Resident council meeting was shortly after that and she told the activities director during the meeting.

Resident #13 stated Resident #14 would wander in and out of other Resident bedrooms and other Residents had told her they were concerned about Resident #14. Resident #13 stated she had not seen Resident #14 at the facility recently and "they (administration) won't tell me if he is still here." She further stated the staff told her "he (Resident #14) has rights also."

Resident #13 stated other than Resident #14 she was not afraid at the facility and that no one else

are acting out verbally and physically, and notification to responsible party, attending physician as state agencies per policy and procedure.

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

Event ID: PM3B11

Facility ID: VA0103

If continuation sheet Page 6 of 49



RECEIVED



PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	l' '	DATE SURVEY COMPLETED
	495300	B. WING _		12/02/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HERITAGE HALL KING GEO	RGE	1	10051 FOXES WAY	A MAN ASTRONO
			KING GEORGE, VA 22485	
PREFIX (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE

F 223 Continued From page 6 had every tried to hurt her.

Review of Resident #13's clinical record revealed no psychosocial concerns were identified for Resident #13. Resident #13 had been evaluated and was being followed by psychological services prior to the incident and review of the notes since August, 2016 revealed no concerns regarding Resident #13 being afraid.

During abuse interviews with five staff members, all of the staff stated they were to report any incidents of abuse to their supervisor immediately and to keep their Residents "safe."

Review of Resident #14's clinical record revealed, from the time of his admission, he had a history of wandering around the facility, including in Resident's bedrooms. No other incidents of Resident to Resident interactions were noted with the exception of Resident #14 hitting one of the Residents foot with his wheelchair.

When interviewed, Other C, the activities director, 12/2/16 at 8:30 a.m., stated she let the managers know of any concerns that are identified during the Resident council meetings. Other C stated she completed a form regarding the concerns voiced on 8/2/16.

The form, entitled "Resident Grievance/Complaint Form", only included "Resident in others rooms taking their personal items. What is being done to prevent this from happening?" Nothing was included in the communication form indicating Resident #13 was afraid of Resident #14.

Review of the facility's policy entitled "Abuse Prohibition, Identification, Investigation/Protection

F 223

Monitoring:

The administrator and DON are responsible for compliance. All Facility Incident & Accident Forms will be reviewed by the Administrator and DON and initialed as reviewed. All reported incidents of abuse will be investigated and reported to the appropriate state agencies by the Administrator. Confidential files of reported incidents and all follow up documentation will be maintained in the Administrator's office. The Incident and Accident tracking log will be reviewed weekly in the Risk Management meeting to monitor for compliance. All negative findings will be reported to the administrator for investigation and reported to the appropriate state agencies. Aggregate findings will be reported to the Ouality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice.

Completion Date: 1/16/17

RECEIVED

DET 16 2016
Military C. G

PRINTED: 12/12/2016 FORM APPROVED OMB NO 0938-0391

CENTE	19 LOU MITDIOVIVE	A MILDIOMID SLIVICES	· · · · · · · · · · · · · · · · · · ·		OIVID IVO. 0930-039 I
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495300	B. WING_		12/02/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Millionnamilion-spaces
HEDITAG	SE HALL KING GEOR	GE	1	10051 FOXES WAY	
HERHAG	SE HALL KING GLOK	.GL		KING GEORGE, VA 22485	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 223	Continued From pa	age 7	F 22	23	
	And Reporting," inc				
	anyone, including b other residents, cor other agencies serv members, legal gua individuals."	ot be subjected to abuse by out not limited to facility staff, insultants or volunteers, staff of ving the individual, family ardians, friends or other other attend 12/2/16 at 9:20 a.m., the			
	concern identified in #13 regarding Residus the appropriate in the Grievance form after concerns were #14, the facility devincluded referral to Residents "stop signimute checks, and	n Resident council by Resident dent #14 was not identified, information was not written on. The administrator stated identified regarding Resident eloped interventions that psychologist, offering ins for their doors, every 15 care plan meeting with ily to attempt to find a more			
	ADON (assistant dirinformed of the failu Resident #13 was n resulting in her fear day meeting.	DON (director of nursing), and rector of nursing) were are of the staff to ensure not subjected to verbal abuse, 12/2/16 at 12/1/16 at end of 1-(4) INVESTIGATE/REPORT DIVIDUALS	F 22	F-225 Corrective Action(s)	
(a) The facility must- (3) Not employ or otherwise engage individuals who-				A thorough investigation into the allegations of verbal abuse invooresident'#14 against resident #1 conducted and the outcome of the investigations have been reported.	olving 3 has been the internal
	(i) Have been found	guilty of abuse, neglect,		appropriate State agencies.	

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

exploitation, misappropriation of property, or

Event ID: PM3B11

Facility ID: VA0103 CE VED If continuation sheet Page 8 of 49



PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY - COMPLETED
NAME OF PROVIDER OR SUPPLIER	495300	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	12/02/20 <u>16</u>
HERITAGE HALL KING GEOR	GE		10051 FOXES WAY KING GEORGE, VA 22485	in the second
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
			1	

F 225 Continued From page 8 mistreatment by a court of law;

- (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or
- (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.
- (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.
- (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:
- (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

F 225

Identification of Deficient Practices & Corrective Action(s):

All residents to include may have been potentially affected. A 100% review of all resident council minutes for the last 3 months and the Facility Incident & Accident Forms for the previous 60 days have been reviewed to identify residents at risk. Any/all negative findings of reportable occurrences identified will result in an internal investigation with appropriate notification of outcomes to the State agencies, attending physician and responsible parties.

Systemic Change(s):

Policy and Procedure for reporting resident abuse & neglect has been reviewed. No changes are required. All administrative staff will be inserviced on the facility policy and procedures regarding reporting, investigation and proper notification to state agencies of allegations of verbal or physical abuse and injuries of unknown origin by the administrator. All staff will be inserviced on the facility policy and procedures regarding reporting, investigation and proper notification to state agencies of allegations of verbal or physical abuse and injuries of unknown origin by the Administrator. The Administrator, DON and/or designee is responsible for completing internal investigations of neglect, abuse, and/or complaints. The Administrator will review all findings and verify that the appropriate notification to the RP, attending physician and State agencies was completed as indicated.

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
	PROVIDER OR SUPPLIER GE HALL KING GEOR		B, WING	STREET ADDRESS, CITY, STATE, ZIP COL 10051 FOXES WAY KING GEORGE, VA 22485	12/02/20<u>16</u> DE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI	HOULD BE COMPLETION
	(3) Prevent further exploitation, or missinvestigation is in p (4) Report the result administrator or his representative and with State law, included a state of the alleged violatic corrective action must by: Based on Resident documentation revistaff interview, the fallegation of verbal (Resident #13) in a Residents. Resident #13 report #14 to the activities was not reported to	that all alleged violations are ated. potential abuse, neglect, treatment while the rogress. Its of all investigations to the or her designated to other officials in accordance uding to the State Survey orking days of the incident, and on is verified appropriate ust be taken. NT is not met as evidenced to interview, facility ew, clinical record review, and facility staff failed to report an abuse for one Resident survey sample of 20 ted she was afraid of Resident director and the allegation the administrator. ed: nale, was admitted to the	F 22	Monitoring: The Administrator is responsaintaining compliance. False Accidents forms will be by the DON and/or Adminimitialed as reviewed. Conformed incidents and adocumentation will be main Administrator's office. The Management Committee will Reports for identifying and/onegative patterns weekly. A findings will be reported an Aggregate findings will be requality Assurance Committee analysis, and recommendation changes in policy, procedure facility practice. Completion Date: 1/16/17	acility Incident reviewed daily istrator and fidential files I follow-up ntained in the E Risk fill review I&A for correcting Il negative d investigated. Eported to the te for review, to review in sort

hospitalization 4/10/16. Her diagnoses included osteoporosis, history of breast cancer, elevated cholesterol, deep vein thrombosis, nonrheumatic aortic valve disorder, hypertension, type II diabetes mellitus, contact dermatitis, muscle weakness, cardiac arrhythmia, and contractures.

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARI	& MEDICAID SERVICES	to approximate an accompany of the second			OMB NO. 0938-039	1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495300	B. WING _			12/02/2016	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	Bestelmanner	****
HERITAG	SE HALL KING GEOF	RGE			0051 FOXES WAY		
· · · · · · · · · · · · · · · · · · ·	(A) 11 15 1A 1 (A) 1 (A) 1	TO JOHN OF DESIGNATION			KING GEORGE, VA 22485		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION	1
F 225	Continued From pa	age 10	F 22	25			
	set) with an ARD (a 10/15/16 was code Resident #13 was and long term men moderate assistant decisions. Resider extensive to total a	st recent MDS (minimum data assessment reference date) of d as a quarterly assessment. coded as having some short nory deficits and required ce with making every day life at #13 was coded as requiring ssistance with performing her					
	4/1/16. His diagno diabetes mellitus, a disease, depressive psychiatric symptor	ing. ale, was admitted to the facility ses included failure to thrive, interiosclerotic cardiovascular e disorder with severe ms, cerebral infarction, and pulmonary disease.					
	9/28/16 was coded Resident #14 was of and long term mem moderate assistant decisions. He was during the look bac coded as requiring of one to two staff r activities of daily live	st recent MDS with an ARD of as a quarterly assessment. Coded as having some short ory deficits and required be with making daily life coded as having no behaviors of period. Resident #14 was extensive to total assistance members to perform his ng with the exception of Resident #14 was coded as no.					
	Resident #14 stated wandered in my bed to me. I asked if he tell me if he is." Re August 2, 2016, rev she was afraid of or	terview, 11/30/16 at 1:30 p.m., if "there was someone that droom and said terrible things was still here and no one will view of the Group minutes for ealed Resident #13 stated ne of the Residents due his ut of Resident bedrooms. The					***************************************

Resident that was wandering was identified as

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		OATE SUR V EY OMPLETED
		495300	B. WING		unidaskahanda dakadida dakadida dakadida dakadida kahanda saha sama mada dakada lada lada lada sama dakada lada	1	2/02/2016
NAME OF	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		And description of the second contract of the
HERITA	GE HALL KING GEOR	GE			51 FOXES WAY G GEORGE, VA 22485		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 11	F 2	25			
	told the staff she was he wandered into he wandered into he resident #13 stated #14 wandered into going to (f**k) you". startled her and she bedroom. Resident #13 stated she did the time of the incide meeting was shortly activities director du Resident #13 stated in and out of other Residents had told about Resident #14 had not seen Resident #14 had not seen Resident #14 has During abuse intervall of the staff stated incidents of abuse to and to keep their Resident #14 has During abuse intervall of the staff stated incidents of abuse to and to keep their Resident's bedroom Res	d Resident #14 would wander Resident bedrooms and other her they were concerned. Resident #13 stated she ent #14 at the facility recently ration) won't tell me if he is still stated the staff told her "he rights also." iews with five staff members, if they were to report any to their supervisor immediately					

the exception of Resident #14 hitting one of the

Residents foot with his wheelchair.

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB N	O. 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	IPLE CONSTRUCTION NG	1, ,	ATE SURVEY OMPLETED
		495300	B. WING			2/02/2016
NAME OF	PROVIDER OR SUPPLIEF	₹		STREET ADDRESS, CITY, STATE, ZIP COL	DE	
HERITAG	GE HALL KING GEO	RGE	A CONTRACTOR OF THE CONTRACTOR	10051 FOXES WAY KING GEORGE, VA 22485		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRÓVIDER'S PLAN OF CORR	HOULD BE	(X5) COMPLETION DATE
F 225	12/2/16 at 8:30 a.r managers know of identified during the Other C stated she the concerns voice. The form, entitled Form", only included taking their person to prevent this from included in the concerns that Resident #13 was stated she did not that Resident #13. Other C stated she it to the administration Review of the facil Prohibition, Identificant And Reporting," incompared to the code of VA, suspected abuse, origin, or mistreatm supervisor or an administration of the alleging neglect or mistreatment perpetrator may be the facility, another	of the C, the activities director, m., stated she let the fany concerns that are ele Resident council meetings. ele completed a form regarding ed on 8/2/16. "Resident Grievance/Complaint ed "Resident in others rooms hal items. What is being done happening?" Nothing was munication form indicating afraid of Resident #14. Other C know why she did not report was afraid of Resident #14. ecompleted the form and gave tor. Ity's policy entitled "Abuse cation, Investigation/Protection cluded: Inong those who are mandated Section 63.1-55.3 to report neglect, injuries of unknown ment of any resident to their diministrative staff membering any alleged incident. In add without regard to the ed perpetrator of the abuse, ment (i.e. the alleged efacility staff, persons visiting resident, family member, or other contractor of the	F 22	?5		

immediately.

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	NO FOR MILDICAN	A MEDICAID	SERVICES					ען סועוכ	U. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S	UPPLIER/CLIA ON NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTI	RUCTION			ATE SURVEY OMPLETED
									基
		49:	5300	B. WING	:			4	2/02/2046
NAME OF I	PROVIDER OR SUPPLIER				CTDEET AF	DDECC CITY CTAT	E 710 CODE		2/02/2016
MAINE OF I	PROVIDER OR SOFT EIER	45.5			21	DRESS, CITY, STAT	E, ZIP CODE		
HERITAC	SE HALL KING GEOF	RGE		1	10051 FOX				
					KING GE	ORGE, VA 2248	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFIC Y MUST BE PRECEI SC IDENTIFYING IN	DED BY FULL	ID PREFIX TAG		PROVIDER'S PLAN EACH CORRECTIVE DSS-REFERENCED DEFICI	ACTION SHOUL TO THE APPROI	DBE	(X5) COMPLETION DATE
F 225	Continued From pa	age 13		F 22	5				
	2. The Administrat	-	ar of Nuroina	1 44	J				
	are to be notified in		or or ivursing						
	are to be notined in	imediately.							
	3. Closely monitor	and document	thoroughly the						
	behavior and condi								
	evaluate any injury		en involved to						
	evaluate arry injury	•							
	4. Notification MUS	ST be made to t	he following of						
	all residents involve						,		
	a. Attending pl								
	b. Responsible								
		- F · · · · · · ·							
	The administrator s	stated he was ui	naware that						
	Resident #13 was a								
	at 9:20 a.m. He sta								
	failed to appropriate	ely complete the	Grievance						
	form and did not inc	clude that Resid	lent #13 was						
	afraid of Resident #	14. After other	incidents						
	involving Resident								
	facility implemented	d a number of in	terventions to						
	promote safety for t	the Residents a	t the facility.						
	The administrator a								
	were informed of th						•		
	an allegation of abu		#13, 12/2/16						
	at end of day meeti	-							
	483.20(b)(2)(iii) CO		E ASSESS AT	F 27	õ	F275			
SS=D	LEAST EVERY 12 I	MONTHS				Corrective A	ction(s):		
	(1.)(0).14(1					Resident #2 h	nas had a Comp	orehens	ive
	(b)(2) When require					Significant C	hange Assessn	nent	
	prescribed in §413.					completed, R	esident #2's co	omprehe	ensive
	must conduct a con					care plan rev	iewed and revi	sed to re	effect
	resident in accordar					resident spec	ific approaches	s and	_
	specified in paragra						to address her	specific	C
	this section. The tir					needs.			
	§413.343(b) of this	cnapter do not a	apply to CAHs.						

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

(iii) Not less than once every 12 months.

Event ID: PM3B11

Facility ID: VA0103

If continuation sheet Page 14 of 49







PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES			OMB NO. 0938-039 ⁻
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495300	B. WING		12/02/2016
	PROVIDER OR SUPPLIER GE HALL KING GEOF	Secretary and the second	10	TREET ADDRESS, CITY, STATE, ZIP CODE 2051 FOXES WAY ING GEORGE, VA 22485	12/02/20 16
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
	by: Based on staff intereview, the facility so (minimum data set instrument) at least Resident (Resident Residents. For Resident #2, not assessment was confer admission, 10/2 The findings include Resident #2, a femathe facility 10/23/15 chronic congestive cardiovascular dise hypertension, chrorosteoarthritis, and proceeding as a quarterle was coded as a quarterle was coded as having and required minimum daily life decisions. needing extensive to member to perform living with the exceptating. For transfer needing limited assistentials as a code as a seating she was code as a code as a guarterle was coded as having and required minimum daily life decisions. The seating extensive to perform living with the exceptating. For transfer needing limited assistentials as a code as a c	NT is not met as evidenced erview and clinical record staff failed to complete a MDS) RAI (Resident assessment tevery twelve months for one t#2) in a survey sample of 20 annual MDS RAI completed within 12 months of 23/15. ed: ale, was initially admitted to it. Her diagnoses included heart failure, arteriosclerotic ase, type II diabetes mellitus, nic kidney disease,	F 275	Identification of Deficient Procorrective Action(s): All other residents may have pleen affected. A 100% review assessments will be done by the and/or designee to ensure that have had a comprehensive assess the last 366 days. Any/all negating findings will be reported to the care coordinator at time of dissimmediate correction. Comprescare plans will be revised as not reflect resident specific measure objectives and interventions. Systemic Change(s): The facility Policy and Procedule been reviewed and no changes warranted at this time. The Rescoordinator has read Chapter 2 Resident Assessment Instrume. Manual that covers assessment and has demonstrated through and written examples understare MDS scheduling process. All Minclude unscheduled, significare and quarterly MDS's will now reviewed each month according MDS calendar and initialed by to ensure the accuracy and integresident data.	potentially w of resident he RCC all residents essment in attive he resident covery for chensive heeded to rable ure has are sident Care of the nt User's scheduling discussion hding the MDS' to ht change be g to the the DON
		#2's clinical record revealed			

11/5/15) had been completed after Resident #2's

admission to the facility. Since that

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		40.5200	D. MINIO		
***************************************		495300	B. WING		12/02/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
UEDITA	GE HALL KING GEOF		1	10051 FOXES WAY	
HERHAU	JE HALL KING GEOF			KING GEORGE, VA 22485	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 275	Continued From page	age 15	F 27	'5	
	•	sessment, only quarterly		Monitoring:	ancible for
		been completed. No other		The DON and RCC are responsible compliance. An MDS audit v	
		sessments had been		conducted monthly coincidin	
	completed.			MDS calendar to verify that i	
	•			assessment is correct and was	
	Guidance is provid	ed in "Long Term Care Facility		according to RAI guidelines.	
	Resident Assessm	ent Instrument 3.0 User's		negative findings from the au	
	Manual Version 1.1	14 October, 2016, page 2.21		reported to the DON and the	
		•		make corrections at the time	of discovery.
		sment is a comprehensive		Aggregate findings of the audreported to the Quality Assur	
		Resident that must be		Committee for review, analyst	
		nnual basis (at least every 366		recommendations for change	
		SA or a SCPA (significant		policy, procedure, and/or pra	
		completed since the most		Completion Date: 1/16/2017	
	completed."	sive assessment was		-	
	completed.				
	When interviewed	LPN (licensed practical nurse)			
		ator, stated she had missed			
		ual assessment, 11/30/16 at			
	11:08 a.m.				
		and DON (director of nursing)			
		ne failure of the staff to			
		al MDS assessment within 12			
		at end of day meeting.		F278	
	483.20(g)-(j) ASSE		F 278	8 Corrective Action(s):	
SS=D	ACCURACY/COOF	RDINATION/CERTIFIED		Resident #2 has had their most i	
				MDS modified by the MDS coo to accurately code section G for	
		sessments. The assessment		A facility Incident & Accident f	
	must accurately ref	lect the resident's status.		completed for this incident.	
	(h) Coordination			-	
		must conduct or coordinate		Resident #4 has had a modificat	
	each assessment v			competed to the most recent MI	
	participation of hea			accurately code the residents me	dication
	participation of nou	0.000.011010.		usage in section N. A facility In	cident &
	(i) Certification			Accident form was completed for incident.	or uns
	` '			AAA W A 34 W AA 54	

PRINTED: 12/12/2016 FORM APPROVED OMB NO 0938-0391

CENTE	RS FOR MEDICARI	<u>E & MEDICAID SERVICES</u>			OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
ì		495300	B. WING _		12/02/20 <u>1</u> 6
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE
HERITAG	GE HALL KING GEOF	rejok sa tibu kati RGE	1	10051 FOXES WAY KING GEORGE, VA 22485	
44.2 # \$ 18%	T2 V9AMMI2	FATEMENT OF DEFICIENCIES	L	PROVIDER'S PLAN OF COR	DECTION OF
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE COMPLETION
F 278	Continued From pa	age 16	F 27	8 Identification of Defici	
		irse must sign and certify that		All other residents may been affected. A 100% a resident assessments wil	have potentially audit of all current
		I who completes a portion of th sign and certify the accuracy o assessment.		the MDS Coordinator ar ensure that MDS section and Section N – Medica and coded correctly. All	nd/or designee to n G – Transfers tion are assessed negative findings
	(j) Penalty for Falsi (1) Under Medicare who willfully and kr	e and Medicaid, an individual		will be reported to the N for immediate correction will be completed for earlidentified on the most cu	n. A Modification ch discrepancy
	resident assessme	rial and false statement in a ent is subject to a civil money e than \$1,000 for each		Systemic Change(s): The Resident Interdiscip have been inserviced by Nurse consultant on the assessment and coding o	the Regional proper f all areas of the
	and false statemen	r individual to certify a material nt in a resident assessment is oney penalty or not more than sessment.		MDS to include sections MDS. All comprehensive quarterly MDS's will not each week according to t schedule by the RCC and ensure the accuracy and it	e MDS's and w be reviewed he MDS I/or DON to
	(2) Clinical disagree material and false s	ement does not constitute a statement.		resident data.	integrity of
	This REQUIREMENT by:	NT is not met as evidenced erview and clinical record		Monitoring: The DON and RCC are remonitoring compliance.	
	review, the facility s accurate MDS (min assessment instrum	erview and clinical record staff failed to complete an nimum data set) RAI (Residen ment) for two Residents) in a survey sample of 20	nt	assessment audit will be a weekly coinciding with the to monitor for compliance findings from the audits we to the DON and RCC at the second s	completed ne MDS calendar e. All negative vill be reported
	1. For Resident #2 miscoded, while she	P, her ability to transfer was ne was a Hoyer lift transfer, she ding only limited assistance of and		discovery for immediate of Aggregate findings will be Quality Assurance Commender for review, analysis, and recommendations for charpolicy, procedure, and/or Completion Date: 1/16/1	correction. e reported to the nittee monthly nge in facility practice.
	O D - 1 1 - 1 10 41 - 3 1	4DO (

2. Resident #4's MDS (minimum data set) was

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

Comment of the contract of the		Q MEDIO, ND OLIVIOLO			CIVID IVO. UUUU-UUU I
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495300	B. WING		12/02/2016
	PROVIDER OR SUPPLIER SE HALL KING GEOR	GE		STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU	LD BE COMPLETION
	daily hypnotics when hypnotics. The findings included the finding was coded as need one staff member. Resident #2, a femather facility 10/23/15 chronic congestive to cardiovascular disest hypertension, chronic osteoarthritis, and provided as a quarterly was coded as a quarterly was coded as having and required minimal daily life decisions. In needing extensive to member to perform living with the except eating. For transfer needing limited assiting she was coded Guidance is provided Resident Assessment Manual Version 1.14. Transfer: How Resident The finding included the finding inclu	lent was coded as having in the resident was not on ed: the her ability to transfer was a was a Hoyer lift transfer, she ing only limited assistance of ale, was initially admitted to the Her diagnoses included heart failure, arteriosclerotic ase, type II diabetes mellitus, ic kidney disease, ruritis. The recent MDS with an ARD ince date) of 10/25/16 was assessment. Resident #2 g minimal memory deficits all assistance with making Resident #2 was coded as a total assistance of one stafficall of her activities of daily without of transferring and ring she was coded as stance of one staff and for ed as requiring supervision. In "Long Term Care Facility in the Instrument 3.0 User's Cotober, 2016, p. G-3 dent moves to and from	F 2	278	
	surfaces including to wheelchair, standing	or from bed, chair, position (excludes to or from			

toilet).

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES				OMB N	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		DNSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495300	B. WING	**	NOCASSINA ARMININASINASINASINASINASINASINASINASINASIN	1	2/02/2016
NAME OF	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	•	maj Clarif Los C T C C
HERITAC	SE HALL KING GEOF	RGE	1		FOXES WAY GEORGE, VA 22485		
/3/ 43 +F5	TS VGAMMIS	ATEMENT OF DEFICIENCIES		KING		101	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 278	Continued From pa	age 18	F 2	78			
	highly involved in a assistance in guide	ed Assistance: If Resident was activity and received physical and maneuvering of limb or earing assistance on three or east 7 days.					
F !	performance of an by the Resident for	tance: if there was full staff activity with no performance any aspect of the ADL ving) activity and the activity nore times"					
	F, an MDS coordin the assessment 11 said there is no wa	LPN (licensed practical nurse) ator, stated she had miscoded /30/16 at 11:08 a.m. LPN F y Resident #2 could assist with Hoyer lift and that it took two r to be completed.					
	were informed of the accurately code and 11/30/16 at end of 2. Resident #'4's Miscoded; the resident were informed of the accurately code and the accurate and	and DON (director of nursing) the failure of the staff to MDS for Resident #2, day meeting. MDS (minimum data set) was dent was coded as having the the resident was not on					
	12/12/14. Diagnos but not limited to Hy dementia and psyc #4's Minimum Data with an Assessmen coded Resident #4	dmitted to the facility on es for Resident #4 included pertension, depression, niatric symptoms. Resident Set (an assessment protocol) t Reference Date of 9/7/16 with a BIMS (brief interview of e of "0" out of a possible 15,					

or severe cognitive impairment. In addition, the

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	13 FOR MEDICARE & MEDICAID SERVICES			1910 110. 0000 0001
	F OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300 PROVIDER OR SUPPLIER GE HALL KING GEORGE	1	TREET ADDRESS, CITY, STATE, ZIP CODE 0051 FOXES WAY KING GEORGE, VA 22485	12/02/2016
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 278	Continued From page 19 Minimum Data Set coded Resident #4 as not walking in the last seven days, and used a wheelchair with limited assistance with one staff member. The resident was coded as having received hypnotics in the last seven days.	F 278		
	Review of the resident's MDS dated 9/7/17 and 7/17/16 revealed that on section N0410 D, the resident was documented as having received hypnotics daily for the last seven days. Review of the resident's MAR's (medication administration record) for September and July did not have these medications documented as given.	f		
	On 12/2/16 at 10:15 AM, an interview with the MDS coordinator (other D) was conducted. She stated, "It was a data entry error. She was on antipsychotics."			
F 004	On 12/1/16 at 6:45 PM, the DON (director of nursing) and Administrator were notified of above findings. 483.21(b)(3)(i) SERVICES PROVIDED MEET	F 281		
F 281 SS=D	PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans	1 201	F281 Corrective Action(s): Resident #12's attending physic been notified that the facility sta	
	The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-		to accurately administer an inhal have the resident rinse their mou use per physician orders. Reside physician orders have been revie ensure all medication orders accu	ler and tth after nt #12's wed to
	(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed for 1 resident (Resident #12) of 20 residents in the survey sample to follow professional standards of		Facility Incident & Accident For completed for these incidents.	

PRINTED: 12/12/2016 FORM APPROVED

CENTER	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
Ě	PROVIDER OR SUPPLIER BE HALL KING GEOR	sagas at the safe	1_1	TREET ADDRESS, CITY, STATE, ZIP CODE 0051 FOXES WAY ING GEORGE, VA 22485	12/02/20 <u>16</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLETION
F 281	For Resident #12, resident to rinse his after the administrate The findings included Resident #12, a 72 facility on 3/7/16. hypertension, diabout wheezing. Resident #12's meassessment was a assessment refered coded with a Brief score of 12 indicated He required extensions adminitude of the medication adminitude of the medication purse who prepared observation. Upon entering the Resident #12's pill Resident #12 take inhaler. Afterward	tion administration. the nurse did not require the is mouth per physician order ation of Breo, an inhaler.		Identification of Deficient Practices/Corrective Active Active Active All other residents may have potentially affected. The Deand/or designee will conduct review of all resident's meto identify any residents at residents identified at risk of corrected at time of discovered Incident & Accident form of completed for each negative attending physicians will be each incorrect medication of the second	on(s): we been ON, ADON ct a 100% dication orders risk. All will be ery and an will be e finding. The e notified of order. cedure has ions are nursing enced by the tation in the an orders nt for the g of care transcribing ordered per physician e inserviced by urse consultant or medication

left the room. This surveyor stayed in the room with the resident. Resident #12 swished the water around in his mouth and then swallowed the water. LPN A did not re-enter the room.

Resident #12's physician orders, signed 11/10/16,

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES			OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
minusky na odvaný výdela 1990a	PROVIDER OR SUPPLIER	495300	A. BUILDING B. WING STF	REET ADDRESS, CITY, STATE, ZIP CODE	12/02/2016
	The state of the s	entre de la Santa de la Companión	100	051 FOXES WAY NG GEORGE, VA 22485	No. American
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
	were reviewed. Inc Ellipta 100-25 micr every day for whee use". On 11/30/16 at 11: and pass observati When asked what the administration of stated the resident what was supposed LPN A stated that the the water. It was re she gave Resident room and did not re resident swallowed Fundamentals of N Potter-Perry, p. 841 guidance for standa administration "To administration the r nursing standard ca medication adminis can be linked, in so adhering to the six r administration. The administration inclu 1. The right medica 2. The right dose 3. The right client 4. The right time 6. The right docum The issue with the E	cluded was an order for Breo rogram inhale 1 inhalation exing "rinse mouth after each 15 a.m., the medication pour ion was reviewed with LPN A. was supposed to happen after of the Breo inhaler, LPN A needed to rinse. When asked d to happen after the rinse, he resident needed to spit out eviewed with LPN A that after #12 water to rinse, she left the eturn. It was reviewed that the I the water after he rinsed. Jursing, 6th Edition, 1, provides the following ards of medications of ensure safe medication enurse should be aware of a alled the six rights of stration. All medication errors ome way, to an inconsistency in rights of medication es ix rights of medication de the following: ation	F 281	Monitoring: The DON is responsible for no compliance. The DON, ADO Unit Manager will review me orders weekly in order to mai compliance. Any/all negative will be corrected at time of didisciplinary action will be takeneded. Aggregate findings audits will be reported to the Assurance Committee quarter review, analysis, and recomm for change in facility policy, and/or practice. Completion Date: 1/16/17	N and/or edication intain findings ascovery and ten as of these Quality for mendations

Administrator at the end of day meeting on 11/30/16. The Director of Nursing stated that the

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

	- OF DECIDENCE		T		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495300	B. WING		12/02/20 <u>16</u>
	PROVIDER OR SUPPLIER JE HALL KING GEOF		100	REET ADDRESS, CITY, STATE, ZIP CODI 051 FOXES WAY NG GEORGE, VA 22485	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	IOULD BE COMPLETION
F 281	Continued From pa	age 22 cott as their nursing standard	F 281		
F 309 SS=D	reference. 483.24, 483.25(k)(IFOR HIGHEST WI 483.24 Quality of life Quality of life is a frapplies to all care a residents. Each refacility must provide services to attain opracticable physical well-being, consisted comprehensive assembles of the facility must erprovided to resident consistent with profithe comprehensive and the residents' (I) Dialysis. The facility must erprovided to resident with profithe comprehensive and the residents' (I) Dialysis. The facility must erprovided to resident with profithe comprehensive and the residents' (I) Dialysis. The facility must erprovide to residents who requiservices, consistent of practice, the comprehensive and the residents who requiservices, consistent of practice, the comprehenses. This REQUIREMENT by: Based on observative record review the facility of life is a fragrence of the comprehenses.	I) PROVIDE CARE/SERVICES ELL BEING ife fundamental principle that and services provided to facility esident must receive and the lethe necessary care and or maintain the highest al, mental, and psychosocial ent with the resident's sessment and plan of care.	,	Corrective Action(s): Resident #1's attending planotified that the facility stadminister Norvase accomphysician parameters as ophysician. A facility Incide Accident form was complincident. Identification of Deficieneractive Action All other residents may potentially affected. The and Unit Managers will caudit of all resident's phymark's to identify resident Residents identified at riscorrected at time of discontending physicians will each negative finding and Incident & Accident Forn completed for each negative	nt taff failed to bridge to bridge to bridge to bridge to bridge to bridge the dent and letted for this nt tation(s): have been DON, ADON, conduct a 100% by sician orders and that at risk. sk will be bridge to be notified of da facility m will be
		, the facility failed to c (for blood pressure)			

according to physician ordered parameters.

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES					10. 0938-039°
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) [DATE SURVEY COMPLETED
		495300	B. WING_	3.6.6.	Action of the second of the se		12/02/2016
NAME OF	PROVIDER OR SUPPLIER		**************************************		EET ADDRESS, CITY, STATE, ZIP CODE		-
HERITA	GE HALL KING GEOF	₹GE			1 FOXES WAY G GEORGE, VA 22485		Maria, estable
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	Continued From pa	age 23	F 30	09	Systemic Change(s):		
	The findings includ			The facility policy and procedule been reviewed and no revision:	s are	<u> </u>	
	For Resident #1 administer Norvaso according to physic			warranted at this time. The nursing assessment process as evidenced by 24 Hour Report and documentation medical record /physician orders ren		he ns	
	Resident #1, a 90 y facility on 6/12/15. hypertension, cong chronic obstructive and depression.			the source document for the de and monitoring of the provision which includes, obtaining, tran and completing physician order medication orders, treatment or DON and/or Regional nurse co will inservice all licensed nursi	ovision of care, g, transcribing n orders, nent orders. The rse consultant I nursing staff of	e on	
	Her most recent Mi was a quarterly ass reference date of 9. Interview of Mental severe cognitive im			the procedure for obtaining, tra and completing physician medi treatment orders. As well as fol physician ordered parameters for administration.	ication ar llowing		
	Resident #1's physic were reviewed. Incomorvasc 5 milligram daily if systolic blood or diastolic blood process. The November 201 Record (MAR) was were documented in box. The following the parameters for a documented on the	r activities of daily living. ician orders signed on 11/8/16 cluded was an order for In tablet, one tablet by mouth of pressure is greater than 160 ressure is greater than 90. 6 Medication Administration reviewed. Blood pressures In the Norvasc administration blood pressures, which met administration, were MAR. Norvasc should have on these days but was not			Monitoring: The DON will be responsible for maintaining compliance. The D and/or ADON will perform were audits coinciding with the care calendar to monitor for compliant Any/all negative findings and owill be corrected at time of disc disciplinary action will be taken needed. Aggregate findings of audits will be reported to the Quantity and will be reported to the Quantity analysis, and recomment for change in facility policy, pro and/or practice. Completion Date: 1/16/17	oON, ekly char plan ance. or errors overy an as these uality for adations	

11/8/16: 169/73 11/13/16: 162/71 11/16/16: 161/74

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

F 309 Continued From page 24 11/24/16: 172/71 On 12/1/16 at 2:00 p.m., Licensed Practical Nurse A (LPN A) was working the medication cart on Resident #1's hail. LPN A was asked what the parameters on the Norvasc order meant. LPN A stated that the order said OR, so only one of the parameters on the Norvasc needed to be met rather than both. LPN A stated that parameters were set up in the computer so that the computer would alert when the Norvasc needed to be met rather than both. LPN A stated that parameters were set up in the computer so that the computer would alert when the Norvasc parameters was not given on five occasions when it should have been. On 12/1/16 at 2:40 p.m., the issue with the Norvasc parameters was reviewed with the Director of Nursing (DON). The DON stated that if either one of the parameters were met, then the Norvasc should be given. After reviewing the MAR, she agreed that the Norvasc should have been given on the five occasions in November listed above. Fundamentals of Nursing, 6th Edition, Potter-Perry, page 419, provides the following guidance regarding physicians' orders, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients. Therefore all orders must be assessed, and if one is found to be erroneous or harmful, further clarification from the physician is necessary." The issue was reviewed with the Administrator and DON at the end of day meeting on 12/1/16. No further information was provided.	procedure of the state of the s		STITE OF THE SELECTION				JIVID IYO	, UJJU-UJJ I
NAME OF PROVIDER OR SUPPLER HERITAGE HALL KING GEORGE (24.1) (SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCY MIST BE PRECEDED BY 101. PRETIX (EACH DEFICIENCY) F 309 Continued From page 24 11/24/16: 172/71 On 12/1/16 at 2:00 p.m., Licensed Practical Nurse A (LPN A) was working the medication cart on Resident #1's hall. LPN A was asked what the parameters on the Norwas corder meant. LPN A stated that the order said OR, so only one of the parameters medical to be given. It was reviewed that the medication was not given on five occasions when it should have been. On 12/1/16 at 2:40 p.m., the issue with the Norwasc needed to be given. After reviewing the MAR, she agreed that the Norwasc should have been given on the five occasions in November listed above. Fundamentals of Nursing, 6th Edition, Potter Perry, page 419, provides the following guidance regarding physicians' orders, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients. Therefore all orders must be assessed, and if one is found to be erroneous or harmful, further clarification from the physician is necessary." The issue was reviewed with the Administrator and DON at the end of day meeting on 12/1/16, No further information was provided.	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1					
FREFIX ILEACH DEFICIENCY MIST BE PRECEDED BY PUIL. TAG CROSS-REPERENCED TO THE APPROPRIATE COMMETING MEGRATION OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 24 11/24/16: 172/71 On 12/11/16 at 2:00 p.m., Licensed Practical Nurse A (LPN A) was working the medication cart on Resident #1's hall. LPN A was asked what the parameters on the Norvasc order meant. LPN A stated that the order said OR, so only one of the parameters needed to be met rather than both. LPN A stated that parameters were set up in the computer would alert when the Norvasc parameters was not given on five occasions when it should have been. On 12/11/16 at 2:40 p.m., the issue with the Norvasc parameters was reviewed with the Director of Nursing (DON). The DON stated that if either one of the parameters were met then the Norvasc should be given. After reviewing the MAR, she agreed that the Norvasc should have been given on the five occasions in November listed above. Fundamentals of Nursing, 6th Edition, Potter-Perry, page 419, provides the following guidance regarding physicians' orders, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients. Therefore all orders must be assessed, and if one is found to be erroneous or harmful, further clarification from the physician is necessary." The issue was reviewed with the Administrator and DON at the end of day meeting on 12/11/16. No further information was provided.				B. WING	STRE 1005	51 FOXES WAY	12.	/02/20 <u>16</u>
11/24/16: 172/71 On 12/1/16 at 2:00 p.m., Licensed Practical Nurse A (LPN A) was working the medication cart on Resident #1's hall. LPN A was asked what the parameters on the Norvasc order meant. LPN A stated that the order said OR, so only one of the parameters needed to be met rather than both. LPN A stated that parameters were set up in the computer so that the computer would alert when the Norvasc needed to be given. It was reviewed that the medication was not given on five occasions when it should have been. On 12/1/16 at 2:40 p.m., the issue with the Norvasc parameters was reviewed with the Director of Nursing (DON). The DON stated that if either one of the parameters were met, then the Norvasc should be given. After reviewing the MAR, she agreed that the Norvasc should have been given on the five occasions in November listed above. Fundamentals of Nursing, 6th Edition, Potter-Perry, page 419, provides the following guidance regarding physicians' orders, "The physicians' orders unless they believe the orders are in error or would harm the clients. Therefore all orders must be assessed, and if one is found to be erroneous or harmful, further clarification from the physician is necessary." The issue was reviewed with the Administrator and DON at the end of day meeting on 12/1/16. No further information was provided.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETION
F 323 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT F 323		On 12/1/16 at 2:00 Nurse A (LPN A) was on Resident #1's had parameters on the I stated that the order parameters needed LPN A stated that the computer so that the Norvasc needed that the medication occasions when it successions when it succession	p.m., Licensed Practical is working the medication cart ill. LPN A was asked what the Norvasc order meant. LPN A resaid OR, so only one of the to be met rather than both. It is computer would alert when it to be given. It was reviewed was not given on five should have been. In the issue with the sewas reviewed with the (DON). The DON stated that arameters were met, then the given. After reviewing the at the Norvasc should have we occasions in November we occasions in November insing, 6th Edition, 19, provides the following physicians' orders, "The lible for directing medical are obligated to follow inless they believe the orders harm the clients. Therefore is sessed, and if one is found armful, further clarification in necessary."					

PRINTED: 12/12/2016 FORM APPROVED

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES				OMB NO	. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		STRUCTION	(X3) DAT	E SURVEY MPLETED
		495300	B. WING			12 ,	/02/2016
NAME OF	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		*
HERITAG	GE HALL KING GEOF	RGE	***************************************		OXES WAY GEORGE, VA 22485		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323		_	F 32	23			
	(d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.				Corrective Action(s): Resident #4's attending p been notified that facility: apply and maintain a phys wheelchair alarm and self-belt alarm per physician or incident and accident form completed for this incident. Resident #15's attending p been notified that facility s apply and maintain a physi bed and wheelchair alarm porder. A facility incident at form has been completed for the practices/Corrective Action All other residents with phybed and wheelchair alarms preventive devices to preventive devices to preventive devices to preventive of all residents with ordered alarms and fall preventives to identify the preventive devices to preventive of all residents with ordered alarms and fall preventives to identify the preventive devices to preventive devices device	staff failed to sician ordered releasing sea rder. A facility has been to shysician has staff failed to sician ordered per physician accident or this incider or this incider or other not falls may ted. The DON a 100% physician rention	t y nt.
	appropriate for the rather This REQUIREMENth by: Based on observatorecord review, the faresidents, (Resident survey sample of 20 living environment.	bed's dimensions are resident's size and weight. NT is not met as evidenced ion, staff interview and clinical acility staff failed for two t #4 and Resident #15) in a D residents, to provide a safe fety alarm was non functional			devices to identify residents inconsistent application and the equipment. All resident risk will be corrected at time and an Incident & Accident completed for each negative attending physician will be reach incident.	monitoring of sidentified at e of discovery form will be finding. The	t ′
	i. Resident #4's sa	iety alarm was non functional					

during several falls and on observation.

2. Resident #15's safety alarm was non

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICAR	RE & MEDICAID SERVICES	en e		OMB NO. 0938-0391
STATEMENT	T OF DEFICIENCIES , OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495300	B. WING		12/02/2016
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
TACSIVIL. OT .	THO THE TANK			10051 FOXES WAY	
HERITAG	GE HALL KING GEO	RGE	ł	KING GEORGE, VA 22485	
	CALIBANA COV. CO.	TATELIENE OF DECICIENCIES			FIOLE
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE COMPLETION
F 323	Continued From p	page 26	F 323	Systemic Change(s):	
	functional during o	-		The facility policy and proce prevention and management	t has been
	The findings include			reviewed and no revisions at this time. The DON and/o	or regional
		safety alarm was non functional s and on observation.		nurse consultant will inservi staff regarding proper use of prevention equipments to in-	f fall clude
	12/12/14. Diagnos	admitted to the facility on ses for Resident #4 included		wheelchair and bed alarms to falls.	o prevent
	dementia and psyd #4's Minimum Data with an Assessme coded Resident #4 mental status) sco or severe cognitive Minimum Data Set walking in the last wheelchair with limmember. The resid one fall since the last observed up in the (Resident #4 lives a self releasing sea attached alarm. Time with a member with the control of	Hypertension, depression, chiatric symptoms Resident ta Set (an assessment protocol) and Reference Date of 9/7/16 4 with a BIMS (brief interview of ore of "0" out of a possible 15, to e impairment. In addition, the at coded Resident #4 as not seven days, and used a mited assistance with one staff dent was coded as sustaining ast review, with no injury. 25 AM, Resident #4 was to wheelchair on the "A" side unit on "B" side). The resident had the alarm was checked and it, it did not alarm when		Monitoring: The DON is responsible for compliance. The DON, ADO designee will perform daily all residents with physician of prevention devices to monito compliance. Any/all negative will be corrected at time of disciplinary action will be taneeded. Aggregate findings reviews will be reported to the Assurance Committee quarter review, analysis, and recommite for change in facility policy, and/or practice. Completion Date: 1/16/17	ON and/or inspections of order fall or for e findings discovery and aken as of these he Quality erly for mendations
	(certified nursing a releasing seat belt when resident was	30 AM, the restorative CNA assistant) D released the self to the did not alarm, did not alarm a standing. CNA (D) checked plugged in." The alarm was			

and was in working order.

On 12/1/16 at 11:00 AM, the alarm was checked

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495300		1 ' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		B. WING _		12/02/2016	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE				STREET ADDRESS, CITY, STATE, ZIP CO 10051 FOXES WAY KING GEORGE, VA 22485	**************************************
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 323	Continued From p	age 27	F 32	3	
	revealed a physici. "pressure alarm to releasing seat belt Further review of t resident sustained alarm was not fund They are as follow 4/18/16: fall, bed at the alarm. 5/13/16: fall, press 6/25/16: fall, alarm (wheelchair). 9/1/16: fall, alarm to bed. 9/17/16: fall, alarm alarm. 11/11/16: fall, alarm new seat belt alarm. 11/11/16: fall (wheelchair). 9/1/16: fall (wheel	larm did not sound, replaced ure alarm did not sound. on, not sounding on, not sounding, new pressure on, not sounding, replaced n on, not sounding (bed alarm),			

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OWR NO	<i>).</i> 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		CONSTRUCTION		TE SURVEY
******************************		495300	B. WING			12	2/02/2016
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E HALL KING GEOR	GE			51 FOXES WAY G GEORGE, VA 22485		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
F 323	Continued From pa	age 28	F 3	23			
	inventory was provi ordered new alarm February, five in Ju September, 10 pad magnet alarms in C belts in November.	ided where the facility had s: Five pad alarms in ne, 10 in July, three in alarms and five pull string october, and four self releasing PM, the Administrator and					
	2. Resident #15's sfunctional during ob	safety alarm was non oservation.					
	2/13/04. Diagnoses but not limited to Hy intracranial hemorrh Minimum Data Set an Assessment Ref Resident #15 with a mental status) scor or moderate cogniti the Minimum Data walking in the last swheelchair with stamember. The resident was supported to the minimum bata walking in the last support	admitted to the facility on s for Resident #15 included ypertension, dementia and hage. Resident #15's (an assessment protocol) with ference Date of 9/28/16 coded a BIMS (brief interview of e of "8" out of a possible 15, we impairment. In addition, Set coded Resident #15 as not seven days, and used a andby assistance with one staff ent was coded as sustaining st review, with no injury.					
	observed in the hall	00 AM, Resident #15 was way in his wheelchair. A fall to the wheelchair; the alarm activated.					
	observed in the hall (certified nursing as	5 AM, Resident #15 was way. Restorative CNA ssistant) E stood resident up larm on his chair; it did not					

sound. CNA (E) stated, "It should sound right

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

OF 141F	101 ON MEDIONAL	A MEDIO/ND OLIVIOLO	~		OND NO. 0938-039 I
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	495300		STREET ADDRESS, CITY, STATE, ZIP CODE	12/02/2016
HERITA	GE HALL KING GEOR	GE	E E	10051 FOXES WAY KING GEORGE, VA 22485	Si wiwaki I
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 323	Continued From pa	ge 29	F 323		
		al record revealed a ated 11/21/16 for a "pressure heelchair.			
	the resident was at	plan dated 9/28/16 revealed risk for falls due to right foot ntion for a "pressure alarm to ."			
	On 12/1/16 at 6:45 I DON were notified of 483.45(f)(2) RESIDE SIGNIFICANT MED	ENTS FREE OF	F 333	F333 Corrective Action(s):	
	medication errors. This REQUIREMEN by: Based on observati record review the far	free of any significant IT is not met as evidenced on, staff interview, and clinical cility staff failed for 1 resident asure the resident was free		Resident #18's attending physical been notified that the facility fradminister Vancomycin per phorder. The nurse involved in the medication error is no longer ethe facility. A facility Incident Accident form was completed incident.	ailed to nysician ne mployed at &
	Resident #18 rec Vancomycin (antibio	eived 72 additional doses of tic) after the the resident was a diff (Clostridium difficile- a		Identification of Deficient Prand Corrective Action(s): All other residents receiving Plordered antibiotics may have peen affected. A 100% review residents with antibiotic orders	hysician otentially of all
	Vancomycin (antibiodalready treated for C	d: ed 72 additional doses of tic) after the the resident was diff (Clostridium difficile- a dition frequently caused by		conducted to identify residents residents identified at risk will corrected at time of discovery appropriate disciplinary action Incident and Accident form will completed for each negative firm	at risk. All be and taken. An ll be

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

495300

B. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

12/02/2016

HERITAGE HALL KING GEORGE

10051 FOXES WAY

KING GEORGE, VA 22485

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 333 Continued From page 30

Resident # 18 was admitted to the facility on 10/28/16. Diagnoses for Resident #18 included but not limited to Hypertension, End Stage Renal Disease, lupus and bipolar disorder. Resident #18's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 11/1416 coded Resident #18 with a BIMS (brief interview of mental status) score of "11" out of a possible 15, or minimal cognitive impairment.

There were no observations of this resident as this was a closed record review.

Review of the clinical record revealed the resident was was placed on contact isolation for C. Diff on admission of 10/28/16. Further review of the clinical record revealed the resident had no episodes of diarrhea during her stay. A nurse's note dated 11/17/16 contained the note: "Contact isolation maintained." A nurse's note dated 11/8/16 read: "Pt (patient) roaming halls in wheelchair and advised on importance in staying in compliance with contact isolation precautions. Resident refused."

Review of the hospital discharge record dated 10/28/16 revealed the following: "C. diff colitis: resolved. Continue Vancomycin 125 mg (milligrams) every 6 hours for one more day." Review of the discharge medications included the following: "Vancomycin 125 mg 1 cap (capsule) every six hours 1 day, no refills." Information for the Referring Provider read as followed: "Admitted on 10/13/16 for diarrhea with positive C diff colitis. She was treated with Vancomycin with significant improvement. She will be sent to SNF (skilled nursing facility) with one more day of Vancomycin 125 mg every six hours. Stop date 10/29/16.

F 333

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 policy and procedure by the DON regarding the administration of medications per physician orders to include the proper administration of antibiotics as ordered by the physician.

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: 1/16/2017

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

Event ID: PM3B11

Facility ID; VA0103

If continuation sheet Page 31 of 49



VDHIOLC

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE & MEDICAID SERVICES			DMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	B. WING		12/02/2016
NAME OF F	PROVIDER OR SUPPLIER	STF	REET ADDRESS, CITY, STATE, ZIP CODE	with development to construct the construction of the construction
HERITAG	GE HALL KING GEORGE	1	51 FOXES WAY	
		KIN	NG GEORGE, VA 22485	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 333	Continued From page 31 Resident #18 received Vancomycin 125 mg every six hours while in the hospital. The discharge summary included information that the course of treatment would be completed on 10/29/16 (at the SNF facility) with one more day of the antibiotic. The discharge summary included that the "C. diff was resolved." Resident #19 's transcribed orders dated 10/28/16, which were signed by the physician on this date, included the order for Vancomycin 125 mg every six hours by mouth. There was no notation in the order to stop the Vancomycin on 10/29/16. The resident continued to receive the Vancomycin until her discharge date of 11/17/16. There was no stop date for the antibiotic even though the resident had no episodes of diarrhea during the facility stay. Review of the MAR (medication administration record) revealed the resident received 72 additional doses of Vancomycin during the skilled stay. On 12/1/16 at 2:50 PM, the DON (director of nursing) was questioned about the facility's C. diff policy. The DON stated, "The resident is placed on contact isolation for C. diff. Once antibiotic therapy is completed, and if still symptomatic, we do a stool culture." She went on to state that while on antibiotics, keep on with the isolation precautions. In addition she said that the physician would usually want a stool culture once the treatment with antibiotics was completed. She stated, "The CDC (centers for disease control) lean away from treating with antibiotics and if non symptomatic, take off isolation."			
	In Clinical Practice Guidelines for Clostridium			

Difficile Infection in Adults listed treating C. diff with "Vancomycin (Vancomycin is the drug of

Land Street Street					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495300	B. WING		12/02/20 <u>16</u>
á.	PROVIDER OR SUPPLIER BE HALL KING GEOR		1005	EET ADDRESS, CITY, STATE, ZIP 51 FOXES WAY G GEORGE, VA 22485	CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE COMPLETION DATE
F 333	choice) 125 mg fou	ur times daily for 10-14 days."	F 333		
	10 (E) read as follo	ty policy on Clostridium Difficile wed: "residents who are rhea free) for 48 hours can be cautions."			
F 441 SS=D	DON were notified	e)(f) INFECTION CONTROL,	F 441	F441 Corrective Action	
	The facility must es and control prograr a minimum, the foll (1) A system for preinvestigating, and communicable disevolunteers, visitors, providing services trangement based conducted accordinaccepted national signals.	eventing, identifying, reporting, controlling infections and eases for all residents, staff, and other individuals under a contractual dupon the facility assessmenting to §483.70(e) and following standards (facility assessment		was notified that the ensure contact precimplemented when #16. LPN-A and Contact isolation proceed by the Docontact isolation procedure and isolation precaution Accident form was incident. The attending physical was notified that the resident on contact	cautions were a caring for resident CNA-C have been OON on the proper rocedure to be utilized d assisting residents on
	for the program, wh limited to: (i) A system of surv possible communic	chase 2); ds, policies, and procedures hich must include, but are not eillance designed to identify able diseases or infections read to other persons in the		was completed for e	

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICAR	<u>RE & MEDICAID</u>	SERVICES					OMB N	<u>10. 0938-039</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICAT	SUPPLIER/CLIA TON NUMBER:	(X2) MULT A. BUILDIN	IPLE CONS	TRUCTION	and the same of th		DATE SURVEY COMPLETED
		49	5300	B. WING_				ja Jan	12/02/2016
NAME OF	PROVIDER OR SUPPLIE	R		40	STREETA	DDRESS, CITY, S	TATE, ZIP CODE		Manufacturing and Control of Cont
		<u> </u>		ı	10051 FO	XES WAY			
HERITAG	GE HALL KING GEO	ORGE			KING G	EORGE, VA 22	485		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFIC CY MUST BE PRECE R LSC IDENTIFYING II	DED BY FULL	ID PREFIX TAG		(EACH CORRECTI ROSS-REFERENCE		ILD BE	(X5) COMPLETION DATE
F 441	Continued From (ii) When and to v communicable direported; (iii) Standard and to be followed to possible followed the followed to possible followed to possible followed the facility's actions taken by to possible followed the facility's actions. Person	whom possible in sease or infection transmission-based or infection transmission-based with infection should be infection and infection and infection and infection in	ns should be used precautions of infections; Id be used for a to: solation, ent or organism on should be the sident under the oth the facility ommunicable om direct d, if direct and to be followed contact. ts identified orrective		11	Identification Corrective Ac All residents o potential to be of PPE, hand v infection contr DON,ADON a conduct audits observe proper proper PPE us tesident care. A be addressed in disciplinary ac facility Incider be completed f Systemic Chai The facility po been reviewed warranted at th will be inservic and procedure include the pro residents on isc ADON and/or Monitoring: The DON is re- compliance. The Unit Manager weekly audits o precautions to i compliance. Ar	of Deficient Pretion(s): on isolation may affected by imp washing and improl techniques. The and/or Unit Man is on residents on infection control and the analysis of the anal	have the roper us roper the ager wil isolation of practifing duridings we ded. A form will finding are sing staff y policy trol to for ON, consultation and/or dom staff for ings will	e I noto ces, and sill I continue ces, and sill I continue ces, and sill I continue ces, and
	process, and trans spread of infection	sport linens so a ı.	s to prevent the			disciplinary act Findings of the the QA Commi	ne of discovery a tion taken as wan audits will be re ittee for review,	ranted. eported t analysis	
	(f) Annual review. annual review of it						dations for chang procedure, and/o		ce.

by:

program, as necessary.

This REQUIREMENT is not met as evidenced

Completion Date: 1/16/17

PRINTED: 12/12/2016 FORM APPROVED OMB NO 0938-0391

CENTE	RS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-039	1
	OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
	495300	B. WING		12/02/2016	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE	Management of the Control of the Con	
UEDITA	GE HALL KING GEORGE	1	10051 FOXES WAY		
HERMA	SE HALL KING GLONGE		KING GEORGE, VA 22485	5	
(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 (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION THE APPROPRIATE DATE	1
F 441	F-3-	F 44	41		
	Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure an effective infection control program for 2 residents (Resident #16 and #18) of 20 residents in the survey sample.				
	1. For Resident #16 the facility staff failed to ensure contact isolation precautions were followed for a resident with MRSA.				
	2. Resident #18 was placed on contact isolation for a resolved C difficile (Clostridium difficile) infection.				
	The findings included:				
	Resident #16, a 58 year old, was admitted to the facility on 11/29/16. His diagnoses included gangrene, Methicillin Resistant Staphylococcus aureus (MRSA) infection, peripheral vascular disease and end stage renal disease.				
	Resident #16 was new to the facility and did not have a Minimum Data Set assessment.				***************************************
	Resident #16's physician orders were reviewed. Included was an order dated 11/30/16 that read "contact isolation for MRSA: wounds." The 'Nursing Admitting Assessment" date 11/29/16 documented that Resident #16 had wounds to the fingers, toes and the right shin.				
	On 11/30/16 at 3:30 p.m., Resident #16's room was observed to have a red sign on the door that read "Isolation". A plastic drawer was observed				

outside of the room containing personal

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

		WINEDIO NO OLIVIOLO		-		OND NO	. 0930-0391
1	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		E SURVEY MPLETED
NAME OF	PROVIDER OR SUPPLIER	495300	B. WING		TREET ADDRESS OFFI STATE 7/D CODE	12/	/02/20 <u>16</u>
	BE HALL KING GEOR	GE		10	REET ADDRESS, CITY, STATE, ZIP CODE 1051 FOXES WAY ING GEORGE, VA 22485		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	***************************************	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	opened. Licensed Practical Nobserved approximately LPN A was wearing	ge 35 Int (PPE). The drawer was not shown was not shown was ately two feet into the room. In a mask and gloves, no gown, ale visitor in the room without	F 4	41			
	procedures were disasked what was supenter a contact precedure that a gown and gloomask was optional. follow this procedure needed to follow. We the room without a gwas unsure what specific followed so she had was standing or her. She stated that she only needed to was going to touch respectively.	o.m., contact precaution scussed with LPN A. When oposed to happen in order to aution room, LPN A stated wes needed to be worn and a When asked who needed to e. LPN A stated everyone then asked why she was in jown, LPN A stated that she ecific precautions needed to had one of the therapy staff utside of the room check for the therapy staff told her that wear a gown if she (LPN A) esident.					
	the drawer when she room. LPN A stated On 12/1/16 at 8:50 a was asked about the precautions. She stated were required and sl crossing the thresho a mask was optional	was preparing to enter the					

On 12/1/16 at 8:52 a.m., Certified Nursing

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		ATE SURVEY OMPLETED
ngan kalanda k		495300	B. WING _			1	2/02/2016
	PROVIDER OR SUPPLIER GE HALL KING GEOF	RGE	Appendix Control of the Control of t	100	REET ADDRESS, CITY, STATE, ZIP CODE 151 FOXES WAY NG GEORGE, VA 22485		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ganagamatan manakan atah	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	Assistant C (CNA C room. CNA C work not wear gloves. S and touched the reback to the door armask, disposing thup the resident's brexited the room to re-entered the room washed her hands. At 8:58 a.m., CNA isolation procedure needed to be worn. She did not mention stated that she tools she could exit the room then returned to the wash her hands. On 12/1/16 at 2:50 precautions were redirector of Nursing Nursing (DON). The mask, gloves and of the room. They stated the room is the room of the room.	C) entered Resident #16's a gown and a mask. She did the walked through the room sident's closet. She walked and removed the gown and em appropriately. She picked reakfast tray in the room and place the tray on the cart. She in without gown and gloves and	F 44	41			
	The facility policy ti Transmission- Base Under the section t read "4. Gloves and wearing gloves as of Precautions, wear g when entering the r	tled "Isolation- Categories of ed Precautions" was reviewed. itled "Contact Precautions" d Handwashing, In addition to outlined under Standard gloves (clean, non-sterile) oom." In addition, the policy es before leaving the room and					

perform hand hygiene."

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
	PROVIDER OR SUPPLIER SE HALL KING GEOR	495300 GE	B. WING	STREET ADDRESS, CITY, STATE, ZIP C 10051 FOXES WAY KING GEORGE, VA 22485	12/02/2016 CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE COMPLÉTION
F 441	Precautions room of The Administrator a	d "5. Gown, Wear a bon entering the Contact or cubicle." and DON were notified of the dissue at the end of day	F	441	

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495300	B. WING		12/02/2016
	PROVIDER OR SUPPLIER SE HALL KING GEOF		-	STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY	
				KING GEORGE, VA 22485	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 441	Continued From pa	age 38	F 44	41	
		as placed on contact isolation ficile (Clostridium difficile)			
	10/28/16. Diagnos but not limited to H Disease, lupus and #18's Minimum Da protocol) with an A 11/14/16 coded Reinterview of mental possible 15, or min	admitted to the facility on less for Resident #18 included ypertension, End Stage Renal I bipolar disorder. Resident ta Set (an assessment sessment Reference Date of sident #18 with a BIMS (brief status) score of "11" out of a imal cognitive impairment.			
	was was placed on on admission of 10 clinical record reve episodes of diarrhe note dated 11/17/1 isolation maintaine 11/18/16 read: "Pt (wheelchair and adv	cal record revealed the resident contact isolation for C Difficle /28/16. Further review of the aled the resident had no a during her stay. A nurse's contained the note: "Contact d." A nurse's note dated (patient) roaming halls in rised on importance in staying contact isolation precautions.			
	10/28/16 revealed to resolved. Continue (milligrams) every 6	ital discharge record dated the following: "C. diff colitis: Vancomycin 125 mg bhours for one more day." harge medications included the			

PRINTED: 12/12/2016 FORM APPROVED OMB NO 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495300 B. WING 12/02/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (X5) COMPLETED (X6) (X6) (X6) COMPLETED (X6) (X6) (X7) COMPLETED (X7) (X7) (X8) (X7) (X7) (X7) (X8) (X7)	CENTER	RS FOR MEDICAR	RE & MEDICAID SERVICES			OMB NO. 0938-0391	:
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE DOST FOXES WAY KING GEORGE 10051 FOXES WAY KING GEORGE, WA 22485	STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED	
HERITAGE HALL KING GEORGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECUEDED BY FULL TAG DEFICIENCY) FA41 Continued From page 39 (CARRELL CONTROLL) (Admitted on 10/13/16 for disarrhea with positive C diff colitis. She was treated with Vancomycin of Vancomycin during the skilled nursing facility) with one more day of Vancomycin during the skilled stay. On 12/116 at 2:50 PM, the DON (director of nursing) was questioned about the facility's C diff policy. The DON stated, "Contact isolation for C. diff. Once antibiotic herapy is completed. She went on to state that while on antibiotics, keep on with the isolation precaultions. In addition she said that the physician would usually want a stool culture once the treatment with antibiotics were completed. She stated, "The CDC (centers for disease control) lean away from treating with antibiotics and if non symptomatic, take off isolation." In Clinical Practice Guidelines for Clostridium Difficile Infection in Adults listed treating C, diff with "Vancomycin (Vancomycin is the drug of choice) 125 mg four times daily for 10-14 days."			495300	B. WING	And the second s	12/02/2016	
HERTAGE HALL KING GEORGE (p.4) 10	NAME OF F	PROVIDER OR SUPPLIEF	₹			***************************************	-
SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ON THE APPROPRIATE OF T	HERITAG	SE HALL KING GEO	RGE	I) and an analysis of the state			
following: "Vancomycin 125 mg 1 cap (capsule) every six hours 1 day, no refilis." Information for the Referring Provided read as followed: "Admitted on 10/13/16 for diarrhea with positive C diff colitis. She was treated with Vancomycin with significant improvement. She will be sent to SNF (skilled nursing facility) with one more day of Vancomycin 125 mg every six hours. Stop date 10/29/16." Review of the MAR (medication administration record) revealed the resident received 72 doses of Vancomycin during the skilled stay. On 12/1/16 at 2:50 PM, the DON (director of nursing) was questioned about the facility's C. diff policy. The DON stated, "Contact isolation for C. diff. Once antibiotic therapy is completed, and if still symptomatic, do a stool culture." She went on to state that while on antibiotics, keep on with the isolation precautions. In addition she said that the physician would usually want a stool culture once the treatment with antibiotics were completed. She stated, "The CDC (centers for disease control) lean away from treating with antibiotics and if non symptomatic, take off isolation." In Clinical Practice Guidelines for Clostridium Difficile Infection in Adults listed treating C. diff with "Vancomycin (Vancomycin is the drug of choice) 125 mg four times daily for 10-14 days."	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR	ULD BE COMPLÉTION	_
10 (E) read as followed: "residents who are symptomatic (diarrhea free) for 48 hours can be removed from precautions."	F 441	following: "Vanconevery six hours 1 the Referring Prove "Admitted on 10/1 diff colitis. She was significant improve (skilled nursing far Vancomycin 125 r 10/29/16." Review of the MA record) revealed to Vancomycin du On 12/1/16 at 2:50 nursing) was questo policy. The DON diff. Once antibiotistill symptomatic, to state that while isolation precaution the physician wou once the treatmer completed. She stated that while isolation." In Clinical Practical Difficile Infection in with "Vancomycin choice) 125 mg for Review of the fact 10 (E) read as foll symptomatic (diar	mycin 125 mg 1 cap (capsule) day, no refills." Information for vided read as followed: 3/16 for diarrhea with positive C as treated with Vancomycin with ement. She will be sent to SNF cility) with one more day of mg every six hours. Stop date R (medication administration the resident received 72 doses uring the skilled stay. O PM, the DON (director of stioned about the facility's C. diff stated, "Contact isolation for C. ic therapy is completed, and if do a stool culture." She went on on antibiotics, keep on with the ons. In addition she said that alld usually want a stool culture that with antibiotics were stated, "The CDC (centers for ean away from treating with non symptomatic, take off e Guidelines for Clostridium on Adults listed treating C. diff (Vancomycin is the drug of our times daily for 10-14 days." illity policy on Clostridium Difficile llowed: "residents who are rehea free) for 48 hours can be		1		

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

On 12/1/16 at 6:45 PM, the Administrator and

Event ID: PM3B11

Facility ID: VA0103

If continuation sheet Page 40 of 49



PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	49 LOV MEDICALL & MEDICAID SELVICES			OND NO. 0330-0331
STATEMENT AND PLAN C	of deficiencies (X1) Provider/supplier/clia identification number:	A. BUILDING_	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	B. WING		12/02/2016
NAME OF I	PROVIDER OR SUPPLIER	. i	REET ADDRESS, CITY, STATE, ZIP COD	Œ
HERITAG	SE HALL KING GEORGE	1	051 FOXES WAY	and the second s
HERITAG	TALL MING OLOMOL	KI	NG GEORGE, VA 22485	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 441	Continued From page 40	F 441		
	DON were notified of above findings.			
F 502	483.50(a)(1) ADMINISTRATION	F 502		
SS=D			F502 Corrective Action(s):	
	(a) Laboratory Services		Resident #11's attendir been notified that the fa	
	(1) The facility must provide or obtain laboratory		obtain a BMP lab test a	
	services to meet the needs of its residents. The		physician. A Facility Ir	ncident &
	facility is responsible for the quality and timeliness of the services.		Accident form has been	n completed for
	This REQUIREMENT is not met as evidenced		the missing labs.	
	by:		Identification of Defic	eient Practice(s)
	Based on staff interview and clinical record		& Corrective Action(s	
	review, the facility staff failed to obtain physician		All other residents who	had physician
	ordered lab work for one Resident (Resident #11)		ordered lab tests may h	
	in a survey sample of 20 Residents.		been affected. A 100% resident's lab orders wi	
	For Resident #11, the facility staff failed to obtain		identify residents at ris	
	a BMP (basic metabolic panel) per physician's		findings will be correct	ed at the time of
	order.		discovery. The attending	
			be notified of the missi	
	The findings included:		obtained timely and lab without a physician ord	
			Incident & Accident Fo	
	Resident #11, a female, was admitted to the	•	completed.	
	facility 1/2/15. Her diagnoses included			
	hypertension, unspecified dementia with behavior disturbances, osteoporosis, depression,		Systemic Changes:	
	peripheral vascular disease, gastroesophageal		The facility policy and	·
	reflux disease, and hypothyroidism.		been reviewed and no owarranted at this time.	
	31 - 32 - 33 - 33 - 33 - 33 - 33 - 33 - 3		tracking system has bee	en reviewed and
	Resident #11's most recent MDS (minimum data		implemented to track a	nd validate that
	set) with an ARD (assessment reference date) of		required lab work has b	peen completed
	9/29/16 was coded as a quarterly 90 day		per physician order and procedure. The DON a	poncy and
	assessment. She was coded as having short and		Consultant will inservi	
	long term memory deficits and required total assistance with making daily life decisions. She		staff on physician order	
	was also coded as requiring total to extensive		testing, protocols, & tra	
	assistance of one staff member to perform her		used.	

activities of daily living.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF	PROVIDER OR SUPPLIER	495300	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	12/02/20 <u>16</u>
HERITA	GE HALL KING GEOR	GE	1	10051 FOXES WAY KING GEORGE, VA 22485	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 502	she was hospitalized 6/28/16. Included was for the following "TSH (thyroid stimul (basic metabolic par Included within her or results that included were evident for a B When interviewed, A director of nursing), staff obtained a CMF panel) instead of the The administrator, D	#11's clinical record revealed and returned to the facility with her re-admission orders g lab work to be obtained, lating hormone) and BMP nel) on 6/29/16." clinical record were lab work to a TSH however no results	F 502	Monitoring: The DON is responsible for compliance. The DON and/o will complete the Facility La weekly to monitor for compliance findings will be repattending physician and discaction will be taken as warra results of these audits will be the Quality Assurance Compreview, analysis, & recomme change in facility policy, pro and/or practice. Completion Date: 1/16/17	or designee the audit tool iance. Any orted to the iplinary inted. The expressed to inittee for endations for
SS=D	obtain a BMP per ph #11, 12/1/16 at end of 483.50(a)(2)(i) LAB SORDERED BY PHYSO (a) Laboratory Service (2) The facility must-(i) Provide or obtain I ordered by a physicial practitioner or clinical accordance with State practice laws. This REQUIREMENT by: Based on staff intervireview, the facility fail	nysician's order for Resident of day meeting. SVCS ONLY WHEN 'SICIAN' ces laboratory services only when an; physician assistant; nurse	F 504	F504 Corrective Action(s): Resident #11's attending pl been notified that the facili CBC and a CMP laborator a physician order. A facilit Accident form has been co this incident	ty obtained a y test without y Incident &

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

, n. boilon	NG	COMPLETED
B. WING		12/02/2016
	STREET ADDRESS, CITY, STATE, ZIP CODE	namenti ili di californi con
	10051 FOXES WAY KING GEORGE, VA 22485	
FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
	B. WING S ID FULL PREFIX	STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485 S ID PROVIDER'S PLAN OF CORRECTION FULL PREFIX (EACH CORRECTIVE ACTION SHOULD ATION) TAG CROSS-REFERENCED TO THE APPROPRI

F 504 Continued From page 42

Resident (Resident #11) in a survey sample of 20 Residents.

For Resident #11 a CMP (comprehensive metabolic panel) and CBC (complete blood count) were obtained without a physician's order.

The findings included:

Resident #11, a female, was admitted to the facility 1/2/15. Her diagnoses included hypertension, unspecified dementia with behavior disturbances, osteoporosis, depression, peripheral vascular disease, gastroesophageal reflux disease, and hypothyroidism.

Resident #11's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/29/16 was coded as a quarterly 90 day assessment. She was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was also coded as requiring total to extensive assistance of one staff member to perform her activities of daily living.

Review of Resident #11's clinical record revealed a CBC and CMP were obtained 6/30/16. A thorough review of the clinical record revealed no physician's order for the blood work to be obtained.

When interviewed ADM C stated 12/1/16 at 3:10 p.m., the blood work was obtained as part of routine labs after hospitalization. She stated the CBC and CMP were obtained as part of her other blood work and after reviewing the clinical record, there was no physician's order.

F 504

Identification of Deficient Practice(s) & Corrective Action(s):

All other residents may have potentially been affected. A 100% audit of resident clinical records will be completed to identify residents who may have had laboratory tests completed without a physician order. All negative findings will be corrected at the time of discovery and the attending physician will be notified. A Facility Incident & Accident form will be completed for each incident.

Systemic Changes:

The facility policy and procedure has been reviewed and no changes are warranted at this time. Licensed staff will be inserviced by the DON and/or nurse consultant on the policy and procedure for obtaining resident laboratory tests, which includes obtaining a physician order prior to obtaining the lab test.

Monitoring:

The DON is responsible for maintaining compliance. The DON ,ADON and/or Unit manager will review all lab tests results weekly to ensure that all resident lab tests obtained had an appropriate physician order for the lab tests prior to obtaining. Any negative findings will be reported to the attending physician and the appropriate disciplinary action taken for staff involved. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice.

Completion Date: 1/16/17

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

Event ID: PM3B11

Facility ID: VA0103

If continuation sheet Page 43 of 49



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495300	B. WING		12/02/2016
,	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485	12/02/20 16
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
	ADM C were informobtain a physician's CBC (complete blo Resident #11, 12/1 483.70(i)(1)(5) RES RECORDS-COMPLE (i) Medical records. (1) In accordance with standards and pracmaintain medical reare— (i) Complete; (ii) Accurately documii) Readily accessification (iii) Readily accessification (iii) Systematically (iiii) Systematically (iiiiii) A record of the record of the record (iiiiii) The comprehent provided;	DON (director of nursing) and ned of the failure of the staff to sorder prior to obtaining a od count) and CMP for /16 at end of day meeting. Selected professional stices, the facility must excords on each resident that organized ord must containation to identify the resident; esident's assessments; sive plan of care and services by preadmission screening evaluations and	F 504		ty staff failed dered TSH he clinical and accident or this incident. It is incident as y staff failed ess note was in y incident and apleted for this as y staff failed est fai
	(v) Physician's, nurs professional's progr	e's, and other licensed ess notes; and			

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION		DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIES HERITAGE HALL KING GEO	Angelon Angelon Angelon (1997)	1 1	STREET ADDRESS, CITY, S 0051 FOXES WAY KING GEORGE, VA 22	STATE, ZIP CODE	12/02/20 <u>16</u>
PREFIX (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE

F 514 Continued From page 44

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for three Residents (Residents' #2, #3 and #13) in a survey sample of 20 Residents.

- 1. For Resident #2, the facility staff failed to ensure TSH (thyroid stimulating hormone) blood results were in the clinical record;
- 2. For Resident #3, the facility staff failed to ensure a physician's progress note was in the clinical record; and
- 3. For Resident #13, the facility staff failed to ensure physician orders were legible.

The findings included:

1. For Resident #2, the facility staff failed to ensure TSH (thyroid stimulating hormone) blood results were in the clinical record.

Resident #2, a female, was initially admitted to the facility 10/23/15. Her diagnoses included chronic congestive heart failure, arteriosclerotic cardiovascular disease, type II diabetes mellitus, hypertension, chronic kidney disease, osteoarthritis, and pruritis.

Resident #2's most recent MDS with an ARD (assessment reference date) of 10/25/16 was coded as a quarterly assessment. Resident #2 was coded as having minimal memory deficits

F 514

Identification of Deficient Practices & Corrective Action(s):

All other residents may have potentially been affected. A 100% audit of all resident medical records will be conducted by the DON, ADON and/or Medical Records clerk to identify residents at risk for an inaccurate medical record and illegible documentation. All negative findings will be clarified and/or corrected at time of discovery and the attending physician notified of the incident. 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 and Medical Records clerk will be inserviced by the DON or regional nurse consultant on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include accurate documentation of medical information in the appropriate medical record and maintaining legible physician orders according to the acceptable professional standards and practices.

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		OMB NO. 0938-0	391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	DITIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED	Υ.
		495300	B. WING_		6
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HERITA	GE HALL KING GEOR	RGE		10051 FOXES WAY KING GEORGE, VA 22485	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION
F 514	Continued From pa	age 45	F 51	514	
	daily life decisions. needing extensive member to perform living with the exce eating. For transfe needing limited asseating she was cook Review of Resident signed physician's a "Lab: TSH on 11/7." A thorough review of the side of th	7/16." of Resident #2's clinical record rk results for a TSH that was		Monitoring: The DON is responsible for maintaining compliance. The DON, and/or ADON will audit medical records, MAR's, TAR's, ADL records and care plans weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 1/16/17	
	clerk, stated he wor 10:58 a.m. A copy presented 11/30/16 ADM C stated the clocated and the lab facility. ADM C state the results and shor results were documentation was evider	EMP. A, the medical records uld find the results, 11/30/16 at of the blood work was at 1:30 p.m. At 5:10 p.m. original copy was unable to be faxed another copy to the ted the facility had received wed the lab log where the nented as having returned. A at on the log that indicated the notified of the results and no			

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

new orders were necessary.

12/2/16 at end of day meeting.

The administrator, DON (director of nursing) and ADON (assistant director of nursing) were informed of the failure of the staff to ensure TSH results present in Resident #2's clinical record

2. For Resident #3, the facility staff failed to

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			01	MB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495300	B. WING		anne cannot con excellenter	12/02/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY	, STATE, ZIP CODE	minima anticide de monte de la compressión de la
HERITAG	E HALL KING GEOF	RGE		10051 FOXES WAY KING GEORGE, VA		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 514	10/19/16. His diag obstructive pulmon	e, was admitted to the facility noses included chronic lary disease, hypertension, attack, and hyperlipidemia.	F 514	1		
	Resident #3's most 10/21/16 was coded He was coded as herm memory defice with making daily licoded as requiring	t recent MDS with an ARD of d as an annual assessment. having some short and long its and required assistance fe decisions. He was also supervision of one staff all of his activities of daily				
	no physician's prog time frame betwee asked, EMP. A stat to check on the pro p.m. At 4:50 p.m. a faxed copy of a p 5/24/16. When inte note had been faxe EMP. A stated the leave the note at the	t #3's clinical record revealed gress note was evident for the n 4/21/16 and 7/5/16. When ted he would review the record gress note, 11/30/16 at 1:36 on 11/30/16, EMP. A presented hysician's progress note dated erviewed, EMP A stated the ed from the physician's office. physician sometimes forgets to be facility after he assesses the oletes the progress note.				
	informed of the failt progress note com Resident #3's clinic day meeting.	DON, and ADON were ure of the staff to ensure a pleted 5/24/16 was filed within all record, 12/1/16 at end of			RECEIVED DEC 10 4016 VDH/C/LC	
	3. For Resident #1	3, the facility staff failed to			vur/ol.C	

ensure physician orders were legible.

Resident #13, a female, was admitted to the

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		1	OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495300	B. WING		12/02/2016
NAME OF	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
HERITA	GE HALL KING GEOR	GE	ł	051 FOXES WAY ING GEORGE, VA 22485	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 514	osteoporosis, histo cholesterol, deep vaortic valve disordediabetes mellitus, oweakness, cardiace. Resident #13's mosset) with an ARD (a 10/15/16 was code Resident #13 was cand long term memmoderate assistant decisions. Resider extensive to total as activities of daily live. Review of Resident three physician's te unable to be read. paper and the origin paper) were so light difficult to decipher all. EMP. A, the medica 11/30/16 at 2:35 p.r. the NCR paper and EMP. A said the origin batches and the back on the record. had the signed order orders in question. from October, 2016	eadmitted after a 1/16. Her diagnoses included ry of breast cancer, elevated ein thrombosis, nonrheumatic er, hypertension, type II contact dermatitis, muscle arrhythmia, and contractures. est recent MDS (minimum data assessment reference date) of d as a quarterly assessment. coded as having some short arry deficits and required the with making every day life at #13 was coded as requiring assistance with performing her	F 514		

The administrator, DON, and ADON were

orders.

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	12/02/20 <u>16</u>
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	Alaman and an
HERITAGE HALL KING GEORGE 10051 FOXES WAY KING GEORGE, VA 22485	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514 Continued From page 48 F 514 informed of the failure of the staff to ensure physician orders were legible for Resident #13, 12/1/16 at end of day meeting.	