State of Virginia

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		VA0103	B, WING		04/(5/2019
Alberte	ROVIDER OR SUPPLIER E HALL KING GEOR	10051 FO	DRESS, CITY, XES WAY DRGE, VA 2	STATE, ZIP CODE 12485		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
F 000	Inspection was con The facility was not Virginia Rules and	iennial State Licensure ducted 4/2/19.through 4/5/19. In compliance with the Regulations for the Licensure s. One complaint was	F 000			
F 001	The census in this	130 licensed bed facility was he survey. The survey sample	F 001	F 001 12 VAC 5-371-370 (A) Cros F-584 Cross Reference POC for F-		
-	The facility was out following state licer This RULE: is not	of compliance with the nsure requirements:		12 VAC 5-371-140 (A) - Cro F-607 Cross Reference POC for F- 12 VAC 5-371-250 (A) - Cro	607	
	to F-584. 12 VAC 5-371-140 to F-607.	(A). Please Cross Reference (A). Please Cross Reference		F-636 Cross Reference POC for F- 12 VAC 5-371-250 (A) - Cr F-641 Cross Reference POC for F-	oss Reference to	
	to F-636.	(A.) Please Cross Reference(A). Please Cross Reference		12 VAC 5-371-250 (G) - Cr F-656 Cross Reference POC for F- 12 VAC 371-250 (F) - Cros	656	
	12 VAC 5-371-250 to F-656.	(G). Please cross reference		F-657 Cross Reference POC for F-	657	
	to F-657.	(F). Please Cross Reference		12 VAC 371-200 (B) (1) (ii) Reference to F-658 Cross Reference POC for F-		
	reference to F-658.	(B) (1) (ii). Please cross (E)(11). Please cross		12 VAC 371-360 (E) (11) - to F-661 Cross Reference POC for F-		

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

6899

Holministrator

4/24/19

State of Virginia

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		VA0103	B. WING		04/0	5/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, I	STATE, ZIP CODE		
HERITAG	SE HALL KING GEOR	GE in a committee in the interest of the contract of	XES WAY DRGE, VA 2	2485		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT 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 APPROVIDER OF THE	D BE	(X5) COMPLETE DATE
F 001	Continued From pa	ge 1	F 001	10 YA C 271 200 (A) C D C		
	reference to F-661.			12 VAC 371-220 (A) - Cross Referent F-685 Cross Reference POC for F-685	ce to	
	12 VAC 5-371-220 F-685.	(A). Please cross reference to		12 VAC 371-220 (A) - Cross Reference	on to	
				F-689	CC 10	
	12 VAC 5-371-220 F-689.	(A). Please cross reference to		Cross Reference POC for F-689		
	19 VAC 5-371-000	(C) (3). Please cross		12 VAC 371-220 (C) (3) - Cross Refe to F-690	гепсе	
	reference to F-690.			Cross Reference POC for F-690	:	
	12 VAC 5-371-260 F-730.	(F). Please cross reference to		12 VAC 371-260 (F) - Cross Reference F-730	e to	
od drogonost Grandos				Cross Reference POC for F-730		
	12 VAC 5-371-270 F-740.	(A). Please cross reference to		12 VAC 371-270 (A) - Cross Reference		
		(A). Please cross reference to		F-740 Cross Reference POC for F-740	2610	
	F-755.			:	Telegraphic Control of the Control o	
	12 VAC 5-371-220 F-757.	(A). Please cross reference to		12 VAC 371-300 (A) - Cross Reference F-755	ce to	
				Cross Reference POC for F-755		
	12 VAC 5-371-220 F-758,	(A). Please cross reference to		12 VAC 371-220 (A) - Cross Reference F-757	e to	
		(A). Please cross reference to		Cross Reference POC for F-757		
	F-812			12 VAC 371-220 (A) - Cross Referen F-758	ce to	
	12 VAC 5-371-360 F-842.	(E). Please cross reference to		Cross Reference POC for F-758		
				12 VAC 371-340 (A) - Cross Referen F-812	ce to	
				Cross Reference POC for F-812		
				12 VAC 371-360 (E) - Cross Referen F-842	ce to	
			ya e e e	Cross Reference POC for F-842		
				Completion Date: May 20, 2019		in pada Liakaba

PRINTED: 04/16/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495300	B. WING		C	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE		era vilasi da 🕽 🖠 da 🖠	STREET ADDRESS, CITY, STATE, ZIP 10051 FOXES WAY KING GEORGE, VA 22485	04/05/2019 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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETE BE APPROPRIATE DATE	
E 000	Initial Comments		E 000)		
F 000	survey was conducted facility was in substant 483.73, Required Facilities. No emer	Emergency Preparedness cted 4/2/19 through 4/5/19. The tantial compliance with 42 CFR rement for Long-Term Care gency preparedness vestigated during the survey.	F 000			
	survey was conducted Corrections are recorded CFR Part 483 Federequirements. The	Medicare/Medicaid standard ited 4/2/19 through 4/5/19. quired for compliance with 42 eral Long Term Care Life Safety Code survey/report nplaint was investigated during				
	The census in this 102 at the time of t consisted of 30 res	130 certified bed facility was he survey, The survey sample ident.				
F 558 SS=D	Reasonable Accon CFR(s): 483.10(e)(nmodations Needs/Preferences (3)	F 558	F558 Corrective Action(s): Resident #49 & Resident #6	58 have had	
	services in the faci accommodation of	right to reside and receive lity with reasonable resident needs and t when to do so would		the clocks in their rooms se time. A facility Incident & was completed for this incident	t to the correct Accident form	
	other residents. This REQUIREME	h or safety of the resident or NT is not met as evidenced		Identification of Deficient Corrective Action(s): All other residents may hav	e potentially	
	interviews and clini	tions, staff interviews, resident cal record review, the facility re reasonable accommodation		been affected. The Mainter and/or Maintenance Assista perform 100% review of all clocks to identify residents	int will resident room	
	of resident needs a	and preferences for two ant # 49 and # 68) in a survey		resident room clocks will be corrected at the time of disc	e will	

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495300	B. WING		C 04/05/2019
NAME OF	PROVIDER OR SUPPLIER		Sı	REET ADDRESS, CITY, STATE, ZIP CODE	
turbita.	SE MALL MINO OFOI		10	0051 FOXES WAY	
TENIIA	SE HALL KING GEOF		K	ING GEORGE, VA 22485	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION
F 558	1. For Resident # make sure the close 2. For Resident # make sure the close Findings included: 1. For Resident # make sure the close Resident # 49, a 9 to the facility on 12 but were not limite Hypertension, Mal Gastroesophagea Osteoarthritis, and Resident # 49's m (MDS) was a quar Assessment Refer The MDS coded Finterview for Mentindicating severe of # 49 was coded as assistance of one Daily Living excepperson for bathing occasionally incon During the initial to 12:17 PM, the whi closet in Resident	49, the facility staff failed to ck in his room was correct. 68, the facility staff failed to ck in her room was correct. 49, the facility staff failed to ck in his room was correct. 1 year old male, was admitted 2/1/2017. Diagnoses included d to: Alzheimer's Disease, ignant Neoplasm of Prostate, I Reflux Disease, Dementia,		Systemic Change(s): The facility policy and procedure here been reviewed and no changes are warranted at this time. All staff will inserviced by the Administrator and DON on ensuring that resident rook clocks are set to the correct time are (if applicable) for all residents. Monitoring: The Unit Managers are responsible maintaining compliance. DON and Unit Managers will complete rand daily rounds throughout the day to monitor resident room clocks for contime. Any negative findings will be corrective at time of discovery and disciplinary action will be taken as required. Aggregate findings will be reported to the QA Committee for analysis, and recommendations of in facility policy, procedure, or pracompletion Date: May 20, 2019	ll be d/or m nd date e for l/or om orrect e review, change
	On 4/2/2019 at 4:	13 PM, the clock still had the sident # 49 was observed lying			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER;		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	CON	E SURVEY APLETED C	
		495300	B. WING			/05/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE			STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 558	Continued From p	ag e 2	F 558			
	On 4/3/2019 at 8:3 the clock was 11:1	30 AM, the observed time on 5.				
	On 4/3/2019 at 2:4 the clock was 11:1	15 PM, the observed time on 5.				
		15 PM, the observed time on 5. Resident # 49 was oed.				
	conducted during care plan, revised Resident # 49 had Disease and deme	ent # 49's clinical record was the survey. Resident #49's on 02/27/2019, read that a diagnosis of Alzheimer's entia resulting in confusion at interventions listed was ed."				
	Director of Nursing of Nursing stated I and that clocks we to time. The Direct surveyor to Reside clock. The Directors	g the end of day debriefing, the g was interviewed. The Directo Resident # 49 was confused are used to help with orientation for of Nursing went with the ent # 49's room to look at the or of Nursing stated the clock in om should have been accurate				
	2. For Resident # make sure the close	68, the facility staff failed to ck in her room was correct.				
	to the facility on 12 but were not limite Hypertension, Maj	1 year old female was admitted b/1/2017. Diagnoses included d to: Alzheimer's Disease, or Depressive Disorder, Reflux Disease, Dementia,				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495300	B. WING		na.	C /05/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE			100	REET ADDRESS, CITY, STATE, ZIP CODE 051 FOXES WAY NG GEORGE, VA 22485		100/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES DY 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)	OULD BE	(X5) COMPLETION DATE
F 558	Cardiomegaly, and Resident # 68's m (MDS) was a quar Assessment Refer The MDS coded Relaterview for Mentaindicating severe of 68 was coded as of one to two staff Living except total for Bathing. Resident # On 4/2/2019 at 4:11:15. Resident # On 4/3/2019 at 8:3 the clock was 11:1 On 4/3/2019 at 1:3 observed lying in barveyor she was	ost recent Minimum Data Set terly assessment with an rence Date (ARD) of 2/21/2019. Resident # 68 with a BIMS (Brief al Status) score of "3" out of 15, cognitive impairment. Resident is requiring extensive assistance persons for Activities of Daily assistance of one staff person dent # 68 was coded as lent of bowel and bladder.	f	DEFICIENCY		
	pain medicine. Re:	sident # 68 looked at the clock know but I need some				
	On 4/3/2019 at 2:4 the clock was 11:1	5 PM, the observed time on 5.				
		5 PM, the observed time on 5. Resident # 68 was in her room.				
		cal record was conducted on of care plan revealed:				
	Page 1 of 8 Resid	ent #68's care plan, revised on				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495300	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/05/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 578 SS=D	O2/27/2019, read to cognitive/commun Alzheimer's Disea Alzheimer's Disea confusion at times listed was "Reorie On 4/5/2019 durin facility Administratinformed of the fin stated new batteriand that the clock No further informa Request/Refuse/DCFR(s): 483.10(c) \$483.10(c) The discontinue treatm to participate in exformulate an adva \$483.10(c)(8) Not construed as the rithe provision of miservices deemed inappropriate. §483.10(g)(12) The requirements specially services deemed in in the provision of miservices deemed in appropriate.	that Resident #68 had a ication deficit related to se. On page diagnosis of se and dementia resulting in . One of the interventions at as needed." g the end of day debriefing, the or and Director of Nursing were dings. The Director of Nursing were dings. The Director of Nursing es had been placed in the clock should be accurate. Ition was provided. Iscontnue Trmnt; Formite Adv. Dir. (6)(8)(g)(12)(i)-(v) right to request, refuse, and/or ment, to participate in or refuse perimental research, and to note directive. Ining in this paragraph should be right of the resident to receive edical treatment or medical medically unnecessary or efficied in 42 CFR part 489,	F 578	F578 Corrective Action(s): Residents #63 has had their code status and DDNR form reviewed by the DON and the attending physician and the comprehensive care plan and the reside closet care plan have been updated to correctly reflect their DNR code status An Incident and Accident form was completed for this incident. Identification of Deficient Practice(s Corrective Action(s): All other residents may have been potentially affected. The Social Service Director and/or Activities Director will review all resident's medical records to ensure the Code status and the DDNR accurate and that the DDNR form is accurately filled out. Any negative findings with result in the Social Service Director and/or Admission Director to contact all responsible parties to verify each resident's code status and advance directives to insure that the proper code status has been explained and that writt notification has been placed in the medical record, comprehensive care plant and the code status care plant and the code status care plant and the medical record, comprehensive care plant and the code status and the medical record, comprehensive care plant and the code status and the medical record, comprehensive care plant and the code status and the medical record, comprehensive care plant and the code status and the code status and the medical record, comprehensive care plant and the code status and advanced in the code status and advanced in the code status and code stat	ents () & es () es

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		The state of the s	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495300	B. WING		C 04/05/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE			10	TREET ADDRESS, CITY, STATE, ZIP CODE 2051 FOXES WAY ING 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 578	and applicable Sta (iii) Facilities are p entities to furnish t legally responsible requirements of th (iv) If an adult indivitime of admission information or artic has executed an a may give advance individual's resider with State Law. (v) The facility is n provide this inform or she is able to re Follow-up procedu the information to appropriate time. This REQUIREME by: Based on observe record review, and facility staff failed t Directives preferen resident's care for a sample size of 3 The findings include Resident #63, a 66 to the facility on 04 but not limited to N myocardial infarcti infarction, hyperter hemiplegia. Resident #63's mo had an Assessmen	ermitted to contract with other his information but are still for ensuring that the is section are met. Vidual is incapacitated at the and is unable to receive culate whether or not he or she dvance directive, the facility directive information to the nt representative in accordance of relieved of its obligation to action to the individual once he ceive such information. In the individual directly at the individual directly at the individual directly at the individual directly at the accurately convey Advanced of accurately convey Advanced onces to the staff responsible for one resident (Resident #63) in 0 residents.	F 578	Systemic Change(s); The Facility policy and procedure reviewed and no changes are warr this time. The Admissions Director Social Services director have been inserviced on the proper completic DDNR and Advance Directives w required. The Admission Director discuss with each future Admission advance directors and resuscitation upon admission to the facility. An concerns expressed will be reported Administrator. The Administrator Director of Nursing will speak to a concerned or with questions about area & follow through on all concensure proper resuscitation status reflected in the medical record. Monitoring: The Admission Director and Social Services Director are responsible a maintaining compliance. The Social Services Director and/or Admission Director will audit all Residents more records monthly to monitor complifor having a current resuscitation of and/or advance directive Any/all infindings will be reported to the Administrator for immediate correlaction to include an investigation. Completion Date: May 20, 2019	ranted at or and on on of a when will on their on status ty/all ed to the & those t each erms to is all for ial ons nedical liance order negative

FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
	495300	B. WING		and a street of the street	7 / 15 4	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE			051 FOXES WAY		/05/2019 	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION:	SHOULD BE	(X5) COMPLETION DATE	
assessment. Reside Interview of Menta of possible 15 indiction in pairment. Function transfers, dressing coded as requiring staff. Functional staff. Functio	dent #63 was coded with a Brief I Status (BIMS) score of 3 out cative of severe cognitive ional status for bed mobility, and personal hygiene were all extensive assistance from atus for eating was coded as on from staff. 4:15 PM, the current in the electronic health record physician's order dated ented, "Resident Hospice care spice company name]." A ated 11/26/2018 documented, scitate)." e electronic health record was m onset dated 04/02/2015 sident #63] has an inability to ivities of Daily Living) ondary to muscle spasms, HTN A (cerebral vascular accident), A (right above-the-knee ssion. Resident refuses meals ime." (sic) One "approach"	F 578	DEFICIENCY)			
C was conducted. It would find out infor Resident #63, she plan" that is posted #63's closet door. Centered Resident #60 opened Resident #60 was conducted. It would be seen to	When asked where a CNA mation about how to care for stated she looks at "the care on the inside of Resident CNA C and this surveyor then 63's room and CNA C then 63's closet door to show a					
	SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pr assessment. Resid Interview of Menta of possible 15 indic impairment. Functi transfers, dressing coded as requiring staff. Functional st requiring supervisi On 04/02/2019 at 4 physician's orders were reviewed. A 11/25/2018 docum as of 11/16/18 [hos physician's order d "DNR (do not resus) The care plan in th reviewed. A problet documented, "[Resiperform ADLs (Act independently secon (hypertension), CV hemiparesis, RAKA amputation), depret & supplements at t documented for thi code." On 04/02/2019 at 4 C was conducted. Would find out infor Resident #63, she plan" that is posted #63's closet door. Centered Resident #6 opened Resident #6 opened Resident #6	PROVIDER OR SUPPLIER SE HALL KING GEORGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 assessment. Resident #63 was coded with a Brief Interview of Mental Status (BIMS) score of 3 out of possible 15 indicative of severe cognitive impairment. Functional status for bed mobility, transfers, dressing, and personal hygiene were all coded as requiring extensive assistance from staff. Functional status for eating was coded as requiring supervision from staff. On 04/02/2019 at 4:15 PM, the current physician's orders in the electronic health record were reviewed. A physician's order dated 11/25/2018 documented, "Resident Hospice care as of 11/16/18 [hospice company name]." A physician's order dated 11/26/2018 documented, "DNR (do not resuscitate)." The care plan in the electronic health record was reviewed. A problem onset dated 04/02/2015 documented, "[Resident #63] has an inability to perform ADLs (Activities of Daily Living) independently secondary to muscle spasms, HTN (hypertension), CVA (cerebral vascular accident), hemiparesis, RAKA (right above-the-knee amputation), depression. Resident refuses meals & supplements at time." (sic) One "approach" documented, "Full	PROVIDER OR SUPPLIER SE HALL KING GEORGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 assessment. Resident #63 was coded with a Brief Interview of Mental Status (BIMS) score of 3 out of possible 15 indicative of severe cognitive impairment. Functional status for bed mobility, transfers, dressing, and personal hygiene were all coded as requiring extensive assistance from staff. Functional status for eating was coded as requiring supervision from staff. On 04/02/2019 at 4:15 PM, the current physician's orders in the electronic health record were reviewed. A physician's order dated 11/25/2018 documented, "Resident Hospice care as of 11/16/18 [hospice company name]." A physician's order dated 11/26/2018 documented, "DNR (do not resuscitate)." The care plan in the electronic health record was reviewed. 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CNA C and this surveyor then entered Resident #63's closet door to show a limitation of the popend Resident #63's closet door to show a limitation of the popend Resident #63's closet door to show a limitation of the popend Resident #63's closet door to show a limitation of the popend Resident #63's closet door to show a limitation of the popend Resident #63's closet door to show a limitation of the popend Resident #63's closet door to show a limitation of the popend Resident #	PROVIDER OR SUPPLIER 3E HALL KING GEORGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) Continued From page 6 assessment. Resident #63 was coded with a Brief Interview of Mental Status (BIMS) score of 3 out of possible 15 indicative of severe cognitive impairment. Functional status for bed mobility, transfers, dressing, and personal hygiene were all coded as requiring extensive assistance from staff. Functional status for eating was coded as requiring supervision from staff. On 04/02/2019 at 4:15 PM, the current physician's order dated 11/25/2018 documented, "Resident Hospice care as of 11/16/18 [hospice company name]." A physician's order dated 11/26/2018 documented, "Resident Hospice care as of 11/16/18 [hospice company name]." The care plan in the electronic health record was reviewed. A problem onset dated 04/02/2015 documented, "[Resident #63] has an inability to perform ADLs (Activities of Daily Living) independently secondary to muscle spasms, HTN (hypertension), CVA (cerebral vascular accident), hemiparresis, RAKA (right above-the-knee amputation), depression. Resident refuses meals & supplements at time." (sic) One "approach" documented for this problem documented, "Full code." On 04/02/2019 at 4:40 PM, an interview with CNA C was conducted. When asked where a CNA would find out information about how to care for Resident #63, she stated she looks at "the care plan" that is posted on the inside of Resident #63's closet door. CNA C and this surveyor then entered Resident #63's closet door to show a	A BUILDING 495300 B. WIND THEOROGE SUPPLIER A STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CONTINUED FROM THE PROPERTIES OF THE APPROPRIATE CONTINUED FROM THE APPROPRIATE CONTINUED FROM THE APPROPRIATE CONTINUED FROM THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 578 TAG CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 578 THE TAG TO THE APPROPRIATE TO 04/02/2019 at 4:15 PM, the current physician's order sin the electronic health record were reviewed. A physician's order dated 11/125/2018 documented, "Resident Hospice care as of 11/16/18 [hospice company name]." A physician's order ated 11/26/2018 documented, "DNR (do not resuscitate)." The care plan in the electronic health record was reviewed. A problem onset dated 04/02/2015 documented, "Resident He33] has an Inability to perform ADLs (Archivities of Daily Living) independently secondary to muscle spasms, HTN (hypertension), CVA (cerebral vascular accident), hemiparesis, RAKA (right above-the-knee amputation), depression. Resident refuses meals 8 supplements at time." (sic) One "approach" documented for this problem documented, "Full odde." On 04/02/2019 at 4:40 PM, an interview with CNA C was conducted. When asked where a CNA would film du information about how to care for Resident #63, she stated she looks at "the care plan" that is posted on the inside of Resident #63's closed door. CNA C and this surveyor then entered Resident#63's room and CNA C then oppened Resident#63's room and cNA C then	

AND PLAN OF CORRECTION IDENTIFICATION MI MARER	MULTIPLE CONSTRUCTION UILDING	(X3) DATE SURVEY COMPLETED
8. W	NG	C 04/05/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/03/2019
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR	ID PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD AG CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	BE COMPLETION
(handwritten). It also included Resident #63's needs pertaining to ADLs. On the left hand side of the paper, it was documented, "Information is current as of this date: 10-31-18." On the top left side of the CNA Care Plan, it was documented "Full code." CNA C then closed the closet door. This surveyor then asked CNA C what Resident #63's code status was and she stated, "She's a full code." A copy of the CNA Care Plan was requested and CNA C stated she would have to ask the nurse. On 04/02/2019 at approximately 4:45 PM, this surveyor and CNA C walked to the nurse's station. After speaking with a nurse, CNA C went to Resident #63's room to retrieve the CNA Care Plan on the closet door. The staff nurse got Resident #63's hard chart and displayed the Durable Do Not Resuscitate Order and stated to this surveyor, "Do you realize this resident is on hospice and she's a DNR?" CNA C returned with the CNA Care Plan and handed it to LPN B. LPN B looked at the document and stated, "It (closet care plan) wasn't updated." A copy of the Durable Do Not Resuscitate order and the electronic care plan were requested. On 04/02/2019 at 4:55 PM, a Durable Do Not Resuscitate document was provided. It was dated 11/20/18 and signed by physician, responsible party, and a witness. A paper copy of the electronic care plan was provided. Under the problem entitled, "[Resident #63] has an inability to perform ADLs (Activities of Daily Living) independently secondary to muscle spasms, HTN (hypertension), CVA (cerebral vascular accident), hemiparesis, RAKA (right above-the-knee amputation), depression. Resident refuses meals	F 578	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION (DENTIFICATION NUM		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		E SURVEY IPLETED
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	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE			STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485		
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F 578	dated or initialed). I updated version of on the unit. Employ	ge 8 added (handwritten and not added (handwritten and not Employee L stated the most the care plan is on paper kept ee L stated electronic care on the computer) are updated	F 57	8		
	Employee H, the M was conducted. Who determine when an was implemented, I date interventions." intervention either cresolved. When asl intervention, Emploit." Employee H state are kept in a book opaper, and eventual When asked about	10 AM, an interview with DS, Care Plan Coordinator in asked about how to intervention on a care plan Employee H stated, "We don't She went on to say the continues or it would be sed about a resolved yee H stated, "I would delete ed the paper copy care plans on the unit, updated on the lly entered into the computer. the CNA (closet) care plans, closet care plans are also				
	was reviewed. Sect "Information about whas executed an addisplayed prominen Section 10 docume each resident will be documented treatm advanced directive." In summary, there was regarding Resident	whether or not the resident vanced directive shall be tly in the medical record." Inted, "The plan of care for e consistent with his or her ent preferences and/or				
	copy care plan, and	the CNA closet care plan. pproximately 2:30 PM, the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/03/2019	
MEDITAC	E HALL KING GEOR		TO THE PARTY OF THE PARTY OF	0051 FOXES WAY		
HLIMIAC	L HALL KING GEOR		K	ING 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 578	and they offered no documentation.	ator were notified of findings further information or	F 578			
F 582 SS=D	CFR(s): 483.10(g)(17) The (i) Inform each Med writing, at the time facility and when the Medicaid of-(A) The items and a nursing facility service for which the reside (B) Those other ite facility offers and for charged, and the a services; and (ii) Inform each Mechanges are made specified in §483.10(g)(18) The resident before, or periodically during available in the facility's per diem re (i) Where changes and services cover Medicaid State plan notice to residents reasonably possible (ii) Where changes items and services items and services	ifacility must- licaid-eligible resident, in of admission to the nursing e resident becomes eligible for services that are included in ices under the State plan and ent may not be charged; ms and services that the or which the resident may be mount of charges for those dicaid-eligible resident when to the items and services O(g)(17)(i)(A) and (B) of this of facility must inform each at the time of admission, and the resident's stay, of services lity and of charges for those any charges for services not licare/ Medicaid or by the ate, in coverage are made to items ed by Medicare and/or by the of the change as soon as is	F 582	Corrective Action(s): The Business Office Manager and the Social Services Director have been inserviced on the procedure for notify Medicare recipients on the termination skilled services and that a beneficiary signature is required to be obtained. A Facility Incident and Accident form we completed for the incident. Identification of Deficient Practice(Corrective Action(s): All other residents receiving Medicare Skilled Services may have been potentially affected. The Business Off Manager will review all current reside that have Medicare Skilled Benefits to insure that the termination of benefits process has been explained and that written notification has been or will be sent to the resident and/or Responsible Party and that a signature from the beneficiary has been obtained to acknowledge that they have received notice of their Medicare benefits will terminating.	ing n of was signification of the control of the co	

		IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495300	B. WING		C 04/05/2019
	A95300 IAME OF PROVIDER OR SUPPLIER IERITAGE HALL KING GEORGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 582 Continued From page 10 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, th facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to notify resident/responsible party of termination of Medicare Part A benefits for one resident (Resident #77) in a sample of 3 residents. The findings included: Resident #77, a 99-year old female, was admitt to the facility on 02/15/2019. Diagnoses include but not limited to diabetes, hypertension, and hyperlipidemia.	100	REET ADDRESS, CITY, STATE, ZIP CODE 251 FOXES WAY NG GEORGE, VA 22485	\ \frac{\fracc}{\frac}{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac}{\frac}}}}{\frac{\frac{\frac{\frac{\frac{\frac{\fracc}}}}}{\firan{\frac{\frac{\frac{\frac{\frac{\frac{\fracc}}}}}{\frac{\frac{\	
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 582	60 days prior to im (iii) If a resident did transferred and do facility must refund representative, or deposit or charges per diem rate, for tresided or reserve facility, regardless discharge notice may be a facility must resident represent the resident within date of discharge (v) The terms of all behalf of an individuality must not continue these regulations. This REQUIREME by: Based on staff int documentation revenotify resident/residen	plementation of the change. Es or is hospitalized or is seen not return to the facility, the it to the resident, resident estate, as applicable, any already paid, less the facility's the days the resident actually dor retained a bed in the of any minimum stay or equirements. It refunds to the resident or ative any and all refunds due 30 days from the resident's from the facility. In admission contract by or on dual seeking admission to the onflict with the requirements of enview and facility riew, the facility staff failed to consible party of termination of enefits for one resident.	F 582	Systemic Change(s); Facility policy and procedure was reviewed and no changes are warranthis time. The Business Office Mana and/or Social Services Director will discuss with each future Medicare recipient the termination of benefits notification process upon notification Medicare skilled services are stoppin resident. Any/all concerns expressed be reported to the Administrator. The Administrator & Business Office Manager will investigate & follow through on all concerns. Monitoring: The Business Office Manager is responsible for maintaining compliant The Business Office Manager will au all Medicare recipients monthly to monitor compliance with the notificat of termination of Medicare Benefits. Any/all negative findings will be repot to the Administrator for immediate corrective action to include an investigation. Completion Date: May 20, 2019	ger a that g for will ce. dit
	Resident #77, a 99 to the facility on 02 but not limited to d	9-year old female, was admitted 2/15/2019. Diagnoses included			
	Set) assessment v reference date) of annual assessmen	ost recent MDS (Minimum Data with an ARD (assessment 02/22/2019 was coded as an nt. The Brief Interview for MS) was coded as 9 out of			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C C 04/05/2019	
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	PROVIDER OR SUPPLIER SE HALL KING GEOF	ige.		STREET ADDRESS, CITY, STATE, ZIP COD 10051 FOXES WAY KING GEORGE, VA 22485			
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F 582	impairment.	age 11 lve of moderate cognitive lice of Medicare Non-Coverage	F 58	2			
	(NOMNC) and Skil Beneficiary Notice were reviewed. Ne	led Nursing Facility Advance of Non-Coverage (SNFABN) ither form was signed.					
	Employee N was countere were no signary N provided a copy 03/07/2019. Employ documents were mon 03/07/2019. Where the countered to state of the state of the countered to the co	3:00 PM, an interview with conducted. When asked why atures on the forms, Employee of a page from a ledger dated byee N stated it shows that the ailed to the responsible party sen asked how it is verified the he information, Employee N hey were received because es. Employee N verified they forms as evidence the vas notified.	1				
	confirmed that Res skilled care on 02/1	i:10 AM, Employee L ident #77 was admitted to 5/2019, received physical ischarged to long-term care 15/2019,					
	Notices was provided documented, "A no form CMS 10123, so resident/represents services are ending leaving the facility of informs the resident or expedited determing the facility of informs the resident or expedited determing the facility of informs the resident or expedited determing the facility of	ntitled Advance Beneficiary ed by facility staff. Section 5 tice of Medicare non-coverage thall be issued to the dive when medicare-covered in no matter if resident is remaining in the facility. This t on how to request an appeal mination from their quality dization." Section 6 matter that the resident, or enough time to make a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIEF			TREET ADDRESS, CITY, STATE, ZIP CODE 0051 FOXES WAY CING GEORGE, VA 22485	1 04/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 584	question and assunotice shall be pro- last anticipated co "Delivery Requirer "The notice shall be (sic) to obtain ben- shall retain the ori- resident represent On 04/05/2019 at Administrator and and offered no fund documentation. Safe/Clean/Comfo CFR(s): 483.10(i)(§483.10(i) Safe Er The resident has a comfortable and h- but not limited to re- supports for daily I The facility must p §483.10(i)(1) A saft homelike environn- use his or her pers- possible. (i) This includes er receive care and significant and (ii) The facility shall the protection of the or theft.	or not to receive the services in me financial responsibility, the vided within two days of the vered day." Section 12 entitled nents" part (b) documented, he hand-delivered as possible eficiary signature. The facility ginal and give a copy to the ative." approximately 2:30 PM, the DON were notified of findings her information or rtable/Homelike Environment 1)-(7) wironment. right to a safe, clean, comelike environment, including eceiving treatment and iving safely. rovide- e, clean, comfortable, and hent, allowing the resident to conal belongings to the extent resuring that the resident can ervices safely and that the he facility maximizes resident does not pose a safety risk. I exercise reasonable care for e resident's property from loss rekeeping and maintenance	F 582	F584 Corrective Action(s): Resident #71's Foot Board on her bed was replaced and the entire bed was inspected to ensure it was in proper working order. Identification of Deficient Practice(s and Corrective Action(s): All other resident beds may have potentially been affected. A complete documented Bed review of all facility beds will be conducted by the Maintenance Director and/or Maintenances Assistant to identify resident beds at right All resident beds identified at risk will repaired or replaced by the Maintenan Department.	ance isk.
	services necessar	to maintain a sanitary, orderly,			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	CONSTRUCTION	(X3) DATE COMP	LETED
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	provider or supplier Ge Hall King Geo		10	REET ADDRESS, CITY, STATE, ZIP CODE 051 FOXES WAY NG GEORGE, VA 22485		
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F 584	and comfortable in §483.10(i)(3) Clear in good condition; §483.10(i)(4) Priving resident room, as §483.10(i)(5) Aderevels in all areas; §483.10(i)(6) Comfevels. Facilities in 1990 must mainta 81°F; and §483.10(i)(7) For sound levels. This REQUIREMI by: Based on observing record review the hospital bed was in (Resident #71) in residents. The facility staff fain good repair for The findings incluing Resident #71, a 7 facility on 5/18/16 included but were dementia with bely hypothyroidism, edepressive disord	nterior; in bed and bath linens that are ate closet space in each specified in §483.90 (e)(2)(iv); quate and comfortable lighting after the interior of the maintenance of comfortable enterior in a temperature range of 71 to the maintenance of comfortable enterior in a temperature range of 71 to the maintenance of comfortable enterior in staff interview, and facility facility staff failed to ensure one in good repair for one resident a survey sample of 30 sided to maintain a hospital bed Resident #71.	F 584	Systemic Change(s): The facility's policy & procedure providing a safe, sanitary, and comfortable environment has beer reviewed. No changes are warranthis time. The Maintenance Direct provide inservices to all staff on fapolicy and procedure on the maintentification system to use when facquipment and repairs are noted a needed throughout the facility. Monitoring: The Maintenance Director and the administrator are responsible for maintaining compliance. Docume facility rounds will be completed to monitor compliance. The admin will review the findings of the audweekly to ensure negative finding being corrected. Cumulative finding be reported to the Quality Assurar Committee for review, analysis, a recommendations for change in fapolicy, procedure, and/or practice Completion Date: May 20, 2019	nted at tor will acility tenance acility and tenance acility and tenance acility and tenance acility and tenance are are are and acility acility	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 9		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485				
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F 584	set) (an assessmet (assessment refer coded as an Annua was coded of havin Mental Status) scoresident's cognitive impaired. Resider extensive assistant dressing and eatin assistance of two stoilet use and pers. During initial obser at approximately 2 bed was noted to be 4/5/19 at 9:25am thremain broken. On was conducted with didn't know about the bed while the rishe is up I can put. On 4/5/19 at 12:34 conducted with Emhave access to ent broke that bed and out a work order." The Administrator a informed of the fail furniture in good re on 4/5/19.	st recent MDS (minimum data nt tool) with an ARD ence date) of 2/25/19, was all assessment. The residenting a BIMS (Brief Interview for re of 5, which indicated the efunctioning was severely it #71 was coded as requiring ce of one staff member for g; required extensive staff members for transfers, onal hygiene. vation of the facility on 4/2/19 at 9:35am an interview in Employee I; he stated, "I his footboard. I can't work on esident is in it, but as soon as a replacement on." pm an interview was ployee M who stated, "all staff er work orders. Whoever noticed it should have filled and Director of Nursing were ure of staff to maintain pair during end of day meeting	F 584				
	No further informat Develop/Implemen	ion was provided. t Abuse/Neglect Policies	F 607				

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	COM	E SURVEY IPLETED
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F 607 \$\$=E	CFR(s): 483.12(b) S483.12(b) The faimplement written \$483.12(b)(1) Proneglect, and explains appropriation \$483.12(b)(2) Est to investigate any \$483.12(b)(3) Including paragraph \$483.9 This REQUIREMI by: Based on staff in review and in the investigation, the investigation, the their abuse and nemployees. (Employees prior to reference checks licenses/certification.) The findings including the facility of the facility staff facility staff facility staff facility staff facility employees prior to reference checks licenses/certification. The findings including the facility of the facil	cility must develop and policies and procedures that: shibit and prevent abuse, bitation of residents and of resident property, ablish policies and procedures such allegations, and lude training as required at 5, ENT is not met as evidenced terview, facility documentation course of a complaint facility staff failed to implement eglect policy for 5 of 25 ployee D, Employee E, LPN C, E) alled to implement their abuse of by failing to pre-screen on hire by failing to obtain and verifying on.	F 607	F607 Corrective Action(s): Employee LPN C has had her licer verification completed and the find her license have been reviewed by DON. C.N.A. E has had her Certification and printed off by the DO facility Incident and Accident for the been completed for this incident. Employee D, employee E and C.N have all had their reference check the reviewed by the HR director and an and omissions have been corrected Facility Incident & Accident form been completed for this incident. Identification of Deficient Practice Corrective Action(s): All other employees may have been potentially affected. The Human Resources department will audit 10 all active employee records to identemployees at risk. Any/all negative findings will be corrected at the time discovery. A Facility Incident and Accident Report will be completed any/all negative findings.	dings on the ication N. A has li errors A has ces & n	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	 A Martin for the month of the con- 	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495300	B. WING		C
NAME OF	PROVIDER OR SUPPLIER		l s	STREET ADDRESS, CITY, STATE, ZIP CODE	04/05/2019
			Programme 📗 2.44	0051 FOXES WAY	
HERITAC	SE HALL KING GEO	RGE	Anna Astalia 📗 Sta	(ING GEORGE, VA 22485	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	l iD	PROVIDER'S PLAN OF CORRECTION	N (ve)
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F 607	Continued From p	ano 16	F 007	Systemic Change(s):	
		THE BUTCH AS A STREET BOTH THE STATE OF STREET	F 607	The facility policy and procedure has	
		laint of misconduct, which the		been reviewed and no changes are	
	facility was not aw	are of prior to her hire. During		warranted at this time. Administrative	
		Employee F), Human		Staff, Department Managers and the H	R
		nator, on 4/4/19 at 9:37am,		department will be inserviced on the	
	when asked if this	is something the facility would	the Amily	policy & procedure regarding abuse	lit, a sijar
	want to know prior	to hire, she replied, "I would		prevention and pre-employment	
	assume so, when	I saw that I spoke with the		procedures by the Administrator.	
	DON." Review of	CNA E's file revealed no		Administrative Staff and Department	
	certification verific	ation prior to hire could be		Heads extending employment without	
	found. On 4/4/19,	an interview with Employee F	强力 点口	meeting the requirements of the facility	y in the minimum of
	was conducted an	d she stated, "it's not in here, it		policy & procedure will receive	
	should have been		14 E E E 1975	disciplinary action. Perspective	
				employees will not be allowed to work	
	The facility failed t	o check references prior to hire		until all required documentation has be	
	for 3 of 25 employ	ees. References were not		obtained and reviewed by the appropri	ate
	checked prior to h	ire for employees (Employee D, CNA F). Employee D's		department manager.	
		were not dated as to when they		Monitoring:	
		nployee E's reference checks		The Human Resources Manager is	
		he form had multiple		responsible for maintaining compliance	e.
		had a reference check that		The Human Resources Director and/or	
		icate when it was obtained.		designee will conduct monthly audits of	of l
tania sa A			in such till	all new hire employee files for each	
	On 4/4/19 at 9:37s	ım, an interview was conducted	1.	month to maintain compliance. The	
		when asked about the process		administrator will review all audits and	1 國際發展
	for reference chec	ks she stated, "I call the people	[数][40][40]	report aggregate findings to the Quality	
	on the application	l ask the questions on the		Assurance Committee for review,	
		ave them before the person		analysis, and recommendations for	
	can enter orientati			changes in policy, procedure, and/or	
	Call Giller Offerhall			facility practice.	
	Dougou of the facil			Completion Date: May 20, 2019	
	heview of the facil	ity policy titled "Guldelines for			
		abuse" with a revision date of			
		standard as, "The resident has			
		from verbal, sexual, physical,			
		, corporal punishment, and			
	involuntary seclusi	ion." The policy reads, "4.			
	Careful screening	of all employees, physicians,			
	and contracted pro	ofessionals. All information			
	provided by the ap	plicant is verified and at least	lea estado	[한 14호 환경 보고 민준화로 모든 10 전략을	#15 fa. #36 254

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495300	(X2) MULTIPLE A. BUILDING B. WING	ECONSTRUCTION	COM	re survey MPLETED C	
NAME OF I	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	04/	05/2019	
HERITAG	E HALL KING GEO	î î	and a second of the contract of	051 FOXES WAY			
			K	NG GEORGE, VA 22485			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 607	Continued From p	ag e 17	F 607				
	maintained in the	contacted with documentation personnel file. 6. License ned for all licensed staff prior to					
	made aware of the	and Director of Nursing were findings on 4/4/19 at 5:30pm.					
	No further informa Notice Requireme CFR(s): 483.15(c)	nts Before Transfer/Discharge	F 623	F623 Corrective Action(s):			
	§483.15(c)(3) Noti Before a facility tra resident, the facilit	nsfers or discharges a		The state ombudsman office has been notified that the facility failed to provid discharge/transfer notice for resident #41's discharges to the hospital on	dea :		
	(i) Notify the reside representative(s) of the reasons for the	ent and the resident's of the transfer or discharge and o move in writing and in a		02/19/19 and 02/25/19. A facility Incide and Accident form has been completed for this incident.			
	facility must send a representative of t	ner they understand. The a copy of the notice to a ne Office of the State		Identification of Deficient Practices/Corrective Action(s): All other residents discharged and/or			
	discharge in the re	onbudsman. sons for the transfer or sident's medical record in aragraph (c)(2) of this section;		transferred from the facility may have been affected. The Social Services Director will conduct a 100% audit of	all		
	and	otice the items described in		residents who have been discharged and/or transferred in the past 90 days to identify residents at risk. Residents	-		
	§483.15(c)(4) Timi	ng of the notice.		identified at risk will be corrected at ti of discovery and the required notificat to the state ombudsman will be made.	ions		
	(c)(8) of this section discharge required made by the facility resident is transfer (ii) Notice must be before transfer or	made as soon as practicable		facility Incident & Accident Form will completed for each negative finding.	be		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	COM	E SURVEY PLETED
		495300	B. WING			C 05/2019
NAME OF I	PROVIDER OR SUPPLIE	R . 1833 (1.1. 1833 (STREET ADDRESS, CITY, STATE, ZIP COD		03/2013
4 + 2 - 1 T				10051 FOXES WAY		
HERITAG	SE HALL KING GEO			KING GEORGE, VA 22485		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ILSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(XS) COMPLETION DATE
F 623	Continued From	page 18	F 62	23 Systemic Change(s):	<u> </u>	
	be endangered u	nder paragraph (c)(1)(i)(C) of		Facility policy and procedures h	ave been	111
	this section;			reviewed. No revisions are war		
国际 电位	(B) The health of	individuals in the facility would	1.5	this time. The Administrator and	l/or	
		under paragraph (c)(1)(i)(D) of		Regional Nurse Consultant will		HY 144
	this section;	일본 시간 시간 하는 바람이 되었다.		the facility's social worker on the		
		s health improves sufficiently to		requirement that the state ombu-		
		nediate transfer or discharge,		notified of resident discharges/to	ansfers.	: ::
		(c)(1)(i)(B) of this section;				
		transfer or discharge is		Monitoring:	11 1	
		esident's urgent medical needs,		The Social Services Director wi		
		(c)(1)(i)(A) of this section; or		responsible for maintaining con The Social Services Director wi		
		s not resided in the facility for 30		all residents who have been disc		
	days.			and/or transferred from the facil		
				weekly to monitor for complian		
		ntents of the notice. The written		Any/all negative findings and o		maa ta k
		n paragraph (c)(3) of this section		will be corrected at time of disc		
	must include the			disciplinary action will be taker		
		or transfer or discharge;		needed. Aggregate findings of t		
		date of transfer or discharge;		audits will be reported to the Qu		
		to which the resident is		Assurance Committee quarterly	for	
	transferred or dis			review, analysis, and recommer		
		of the resident's appeal rights,		for change in facility policy, pre-	ocedure,	
		ne, address (mailing and email),		and/or practice.		
		imber of the entity which		Completion Date: May 20, 20	19	
		quests, and information on how eal form and assistance in		i divitik ile e eseking surpresid	BALER - UNIXE	
		orm and submitting the appeal			grett Freit	
	hearing request;	mii and submitting the appear				
		Idress (mailing and email) and				[[日本培典]]
		er of the Office of the State				Tiroja, -u
	Long-Term Care					
		acility residents with intellectual		선물 경기 사람들은 이 경기를 받는데 없었다.		
		tal disabilities or related		용기가 보고 하는 사이 있는 사람들은		
		nailing and email address and				P arities Y
Mar 25		er of the agency responsible for				
		d advocacy of individuals with				
		isabilities established under Part				
		mental Disabilities Assistance		되고 있을 때문 하는 사람들이 하셨다.		
	<u> </u>				<u>ang sa sa sa kabupatén kabup</u>	

NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM-		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485 (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 623 Continued From page 19 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and			495300 B. WI				C	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 623 Continued From page 19 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and				1	0051 FOXES WAY		/05/2019	
and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE	
disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally III Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure in the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ornbudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(i). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to notify the Ombudsman of a transfer to the hospital on 2 separate occasions for 1 resident (Resident #41, the facility staff failed to notify the Ombudsman upon transfer to the hospital on 12 separate occasions for 1 resident (Resident #41, the facility staff failed to notify the Ombudsman upon transfer to the hospital on 02/19/2019 and 02/25/2019.	F 623	and Bill of Rights A codified at 42 U.S. (vii) For nursing far disorder or related email address and agency responsible advocacy of individestablished under for Mentally III Individestable on the information in effecting the transfinust update the reas practicable once becomes available §483.15(c)(8) Notice In the case of facility the administrator of written notification to the State Survey State Long-Term Of the facility, and the well as the plan for relocation of the re 483.70(I). This REQUIREME by: Based on staff intereview, and clinical failed to notify the Office Interesidents. For Resident #41, 1 the Ombudsman up	Act of 2000 (Pub. L. 106-402, C. 15001 et seq.); and cility residents with a mental disabilities, the mailing and telephone number of the e for the protection and duals with a mental disorder the Protection and Advocacy viduals Act. Inges to the notice. In the notice changes prior to er or discharge, the facility ecipients of the notice as soon the updated information. In the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of Agency, the Office of the care Ornbudsman, residents of resident representatives, as the transfer and adequate sidents, as required at § In the facility documentation record review, the facility staff or opparate occasions for 1 #41) in a sample size of 30 the facility staff failed to notify on transfer to the hospital on					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495300	B. WING			C	
	PROVIDER OR SUPPLIER GE 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 623	Continued From pa	age 20	F 623				
	The Findings inclu	ded:					
	admitted to the fac diagnoses to include	year old male who was ility on 06/19/2018 with de but not limited to diabetes, y failure requiring dialysis, and					
	(MDS) with an Ass (ARD) of 03/13/20 an acute hospital. I Brief Interview of M	est recent Minimum Data Set essment Reference Date 19 was coded as re-entry from Resident #41 was coded with a Mental Status (BIMS) score of a 15 indicating moderately					
	Resident #41 was quietly in bed. Resi	approximately 9:15 AM, observed awake and resting ident #41 stated that he had pitalizations in February 2019 r interview.					
	2019 were reviewe	e nurse's notes for February d and confirmed 2 hospital 19/2019 and 02/25/2019.					
	Notification for both was requested. The stated "I send the n Ombudsman at the cannot explain why from my list and I chave been overloopolicy regarding resumd provided by the	copy of the Ombudsman In February hospital admissions In Secretary hospital admissions In Secretary hospital admissions In Secretary (Employee G) In otifications to the In end of each month, however In It (Resident #41) is missing It (Resident #41) is missing It (Resident #41) is missing It (It is missing it missing it is missing it missi					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495300	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE			STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 623	Continued From proceedings of the Care Ombudsman On 04/04/2019 at Administrator (Em Nursing (DON, Er findings: No furthe Notice of Bed Hol CFR(s): 483.15(d) Notice §483.15(d) Notice §483.15(d) (1) Not nursing facility trathe resident goes nursing facility must be resident or respecifies— (i) The duration of any, during which return and resumm facility; (ii) The reserve be plan, under § 447 (iii) The nursing facility for the nursing facility.	page 21 states that "a copy of the notice Office of the State Long-Term n". approximately 5:30 PM, the aployee A) and Director of aployee B) were notified of the er information was received. d Policy Before/Upon Trasfr	F 625	F625 Corrective Action(s): Resident #41's and their RP has been notified that the facility failed to provie them with the facility Bed-Hold policy when resident #41 was transferred to the hospital. Resident #41 and their RP has had the facility bed-hold policy review with them by the Social Services Direct An Incident and Accident form has been completed for each resident identified in the review. Identification of Deficient Practice(s) and Corrective Action(s): All other residents could potentially be affected. The Bed-Hold policy and formare now kept at the nursing station for after hour's transfers to the hospital to	de ne s ed tor.		
	resident to return; (iv) The information of this section. §483.15(d)(2) Beauthe time of transfer hospitalization or facility must provide resident representation.	n specified in paragraph (e)(1) I-hold notice upon transfer. At		completed by the charge nurse. The Social Services director/Admissions director will be responsible for normal business hour transfer notification of al bed-holds to residents and/or Responsi parties.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	스 발표 경기 등 기업으로 1985년 - 1985년 -	495300	B. WING.		C 04/05/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE			10	REET ADDRESS, CITY, STATE, ZIP CODE 051 FOXES WAY NG GEORGE, VA 22485	0.002013
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 625	described in paracy This REQUIREME by: Based on staff intreview, and clinica failed to provide n Policy on 2 separa (Resident #41) in For Resident #41, provide notice of the host of transfer to the host of transfer tran	graph (d)(1) of this section. ENT is not met as evidenced serview, facility documentation at record review, the facility staff otice of the facility Bed Hold ate occasions for 1 resident a sample size of 30 residents. The facility staff failed to he facility Bed Hold Policy upon spital on 02/19/2019 and and are serviced by the facility of the facility of the facility of the facility Bed Hold Policy upon spital on 02/19/2019 and are serviced by the facility of the facility	F 625	Systemic Change(s): The facility Policy and Procedure habeen reviewed and no changes are warranted at this time. The Social Services Director, Admissions Director and licensed nursing staff have been inserviced by the administrator on the bed-hold requirement and the proper and notification of Bed-Hold policy. Monitoring: The Admissions Director and Social Service Director are responsible for compliance. All transfers/discharges the facility will be audited the by the Social service director and/or Admis Director to ensure proper bed-hold notification was completed at the tim transfer or therapeutic leave. Any/all negative findings will be corrected a of discovery. The results of these audition will be forwarded to the Quality Assurance Committee quarterly for review, analysis, and recommendation for change in facility policy, proceduand/or practice. Completion Date: May 20, 2019	from sions ne of t time dits

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA UND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE A, BUILDING	(X3) DATE SURVEY COMPLETED		
	Madalip kiratatut 1996. Kliva istoliai istoliai erika	495300	B. WING		C 04/05/2019
	PROVIDER OR SUPPLIER NE HALL KING GEO		100	REET ADDRESS, CITY, STATE, ZIP CODE 51 FOXES WAY NG GEORGE, VA 22485	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 625	On 04/04/2019, a Notification for bot was requested. Th stated "I cannot fir have been done". regarding bed hole by the Director of The facility's policy Returns" (revised "prior to transfers residents or reside	age 23 copy of the Bed Hold th February hospital admissions ne Social Worker (Employee G) nd any forms, they must not A copy of the facility policy ds was requested and provided Nursing (DON, Employee B). y entitled "Bed-Holds and 3/17, updated 1/19) states that and therapeutic leaves, ent representatives will be y of the bed-hold and return	F 625		
F 636 SS=D	Administrator (Em B) were notified of information was re Comprehensive A CFR(s): 483.20(b) §483.20 Resident The facility must of a comprehensive, reproducible assefunctional capacity §483.20(b) Comp §483.20(b) (1) Re A facility must material assessment of a regoals, life history resident assessment by CMS. The asset the following:	ssessments & Timing (1)(2)(i)(iii) Assessment conduct initially and periodically accurate, standardized ssment of each resident's rehensive Assessments sident Asses'sment Instrument, ke a comprehensive esident's needs, strengths, and preferences, using the ent instrument (RAI) specified essment must include at least and demographic information	F 636	F636 Corrective Action(s): Resident #35 has had a modification of to her most recent MDS to accurately code section B 1000 – Vision to reflect her current vision status. Identification of Deficient Practices Corrective Action(s): All other residents may have potential been affected. A 100% review of sect B 1000 – Vision of all residents most current MDS will be completed by the RCC to identify residents at risk. All residents identified will have their cur MDS assessments modified at the time discover and their comprehensive care plans updated to accurately reflect the vision status.	& & lly ion crent e of

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	(X3) DATE SURVEY COMPLETED	
		495300	B. WING		C 04/05/2019
	PROVIDER OR SUPPLIEF SE HALL KING GEO	경 보신을 하는 분들하게 하는 것이 별 위험이 보냈다. 이 동생물 보고 본 사람들의 생활 사람들은 기계를 보고	10	TREET ADDRESS, CITY, STATE, ZIP CODE 2051 FOXES WAY ING 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 636	(iii) Cognitive patter (iv) Communication (v) Vision. (vi) Mood and behous (vii) Psychological (viii) Physical function (ix) Continence. (x) Disease diagnot (xi) Dental and nutric (xi) Skin Condition (xii) Activity pursur (xiv) Medications. (xv) Special treatm (xvi) Discharge plat (xvii) Documentation (xvii) Documentation (xviii) Documentation (xviiii) Documentation (xviiii) Documentation (xviiii) Documentation (xviiii) Documentation (xviiiii) Documentation (xviiiiii) Documentation (xviiiiiiii) Documentation (xviiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	avior patterns. avior patterns. well-being. tioning and structural problems. psis and health conditions. tritional status. is. it. nents and procedures. unning. on of summary information tional assessment performed triggered by the completion of Set (MDS). ion of participation in assessment process must ervation and communication as well as communication with censed direct care staff	F 636	Systemic Change(s): The facility policy and procedure was reviewed and no changes are warranted this time. The regional nurse consultan will inservice the Resident Care Coordinator's and the interdisciplinary Care Plan Team on accurately coding a sections of the MDS. This will include accurate coding of section B Vision. Monitoring: The RCC is responsible for maintaining compliance. The RCC will complete MDS audit tool weekly coinciding with the MDS calendar to monitor for compliance. Any/all negative findings will be reported to the RCC and the DC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy procedure, and/or facility practice. Completion Date: May 20, 2019	t all g

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	(X3) DATE SURVEY COMPLETED	
		495300	B. WING_		04/05/2010
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	04/05/2019 CODE	
HERITAC	RITAGE HALL KING GEORGE 10051 FOXES WAY KING 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION DATE
F 636	Continued From pa	age 25	F 63	16	
	following a tempora or therapeutic leav	rary absence for hospitalization /e.)			
	This REQUIREME by:	nce every 12 months. NT is not met as evidenced			
	record review, and the facility staff faile	ation, staff interview, clinical facility documentation review, led to conduct accurate			
	one resident (Residents, For F	ident's functional capacity for dent #35) in a sample size of Resident #35, the facility staff assess her visual functional			
	capacity				
	The findings includ	led:			
	the facility on 10/22	year female, was admitted to 2/2011. Diagnoses include but failure, hypertension, morbid le weakness.			
	had an Assessmen 01/02/2019 and wa change in status as	est recent Minimum Data Set nt Reference Date (ARD) of as coded as a significant assessment. Resident #35 was			
	(BIMS) score of 15 intact cognition. Fu mobility, dressing, a	Interview of Mental Status out of possible 15 indicative of unctional status for bed and personal hygiene were all			
	coded as requiring	extensive assistance from oded as adequate - sees fine gular print in			
	Resident #35 was of had any concerns, an eye exam last ye	12:51 PM, an interview with conducted. When asked if she Resident #35 stated she had rear but never received #35 stated she spoke with LPN			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING	COM	E SURVEY IPLETED	
		495300	B. WING		internal et al. 📗 in a son so	05/2019	
	PROVIDER OR SUPPLIEF			UILDING COM /ING 04/ STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485 ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 636	B about it. Reside read but is unable glasses. Resident at the time of the i	nt #35 also stated she loves to to do so without her reading #35 was not wearing glasses nterview.	1	36			
	observed in her be	9:10 AM, Resident #35 was ad sleeping with the head of the eximately 30 degrees.					
	observed in bed, a elevated approxim on. Resident #35 v Resident #35 state	9:00 AM, Resident #35 was wake, with the head of her bed ately 45 degrees. The TV was was not wearing glasses. ed, "my left eye is my good to say that if she closes her left blurry.					
	she was aware Re LPN B stated, "Yes process of getting	4:05 PM, LPN B was asked if sident #35 needed glasses and s." When asked about the glasses for Resident #35, LPN ial worker takes care of that."					
	Employee G, a soo the process for vis stated she visits w they want to see the name is put on a li	approximately 4:40 PM, cial worker, was asked about ion services and Employee G ith residents and asks them if he eye doctor and if so, their st. Employee G then provided Resident #35 was scheduled on 04/17/2019.					
	observed in her roasked if a social w	9:25 AM, Resident #35 was om, in bed, awake. When orker had talked with her about d she stated, "No." She went eing able to read."					
	On 04/05/2019 at a	approximately 10:05 AM,					

	ora a fala a a a fi 🜓 oraș fila un filologică de la filo
495300 B. WING	C 04/05/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE STREET ADDRESS, CITY, STATE, 10051 FOXES WAY KING GEORGE, VA 22485	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION DATE
Continued From page 27 Employee G was interviewed. When asked about the process if a resident has concerns pertaining to their glasses, she stated if the glasses are broken, she will ry to fix them herself and used the example of applying superglue to the hinge. She also stated that if a resident needs reading glasses, she has a whole box of them in her office and will give them to the residents that need them. When asked if she knew why Resident #35 wanted to see the eye doctor, she stated she didn't know. On 04/05/2019 at approximately 10:15 AM, the MDS coordinator, Employee H, confirmed that Social Services completes Part B of the MDS assessment and then it is signed off by the nurse. Vision was coded as "Adequate - sees fine detail, such as regular print in newspapers/books." The social service notes ranging from 05/15/2018 through 03/18/2019. Of the 15 social services entries by Employee G, there were no entries addressing vision services. The facility provided "Summary Ocular Progress Notes" dated 07/13/2018 for Resident #35. An optometrist documented the chief complaint, "Blurred vision, hard to see at distance and near." Under "Diagnosis and Treatments", it was documented, "Age-related nuclear cataract, bilateral - cataracts - OU-Mild/stable - not visually significant - monitor 6 mos (months)." The progress notes also included a glasses prescription that expires 7/13/19. The prescription documented, "OD (right eye) -2.75 sph xadd +2.50." In summary, Resident #35 was examined by an optometrist in July 2018 which included a	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
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	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		04/05/2019		
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F 641 D	prescription for glaread but is unable have glasses and following the exammonths ago. The ridocumented Resident Book and Administrand they offered no documentation. Accuracy of Asses CFR(s): 483.20(g) §483.20(g) Accurating the assessment in resident's status. This REQUIREME by: Based on resident facility documentative documentative assessment of the the resident's statu. For Resident #55, accurately code the assessment tool). The findings included. Resident #55, a 55 facility on 2/1/19. included, but were	sses. Resident #35 loves to to do so because she did not did not receive glasses by the optometrist nearly 9 nost recent MDS assessment lent #35's vision was adequate approximately 2:30 PM, the rator were notified of findings of further information or sments cy of Assessments. nust accurately reflect the NT is not met as evidenced interview, staff interview, ion review and clinical record staff failed to ensure the resident accurately reflected is for one resident (Resident imple of 30 residents. the facility staff failed to e MDS (Minimum Data Set) (ar	F 6	36	e section bley hensive revised eter and pleted Accident dent. tice(s) Catheter ed. A nt MDS y the hat e coded vill be for cation epancy

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
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F 641	Resident #55's mi (assessment referas an admission a coded as having a Memory Status) s resident was cogressive assistant was code extensive assistant Review of the Nurdated 2/1/19 revended in the Nurdated 2/1/19 revended in the Resident had an indischarge from the physical complete that the resident had Resident #55 receivery shift from 2/2 Review of Reside an ARD of 4/3/19 Indwelling cathete present. An interview was 4/4/19 and when the stated, "I've hat hospital." The MDS, with an indicating the resident 2/1/19 is cocontinent of bowe Risk Assessment.	ost recent MDS with an ARD rence date) of 2/8/19 was coded assessment. The resident was a BIMS (Brief Interview for core of 15, indicating the nitively intact. Functional status sing, toilet use and personal ed as Resident #55 required noe. The sing Admission Assessment, aled the resident had an or on admission. The hospital my dated 1/31/19 indicated the idwelling catheter at the time of the hospital. A history and and a foley catheter. Review of ministration Record indicated elived foley cath (catheter) care	F 641	Systemic Change(s): The Resident Interdisciplinary Care has been inserviced by the Regional Nurse consultant on the proper assessment and coding of all sections the MDS. All comprehensive MDS's quarterly MDS's will now be review each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of resident data. Monitoring: The DON and RCC are responsible monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS cal to monitor for compliance. All negatings from the audits will be report to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported Quality Assurance Committee mont for review, analysis, andrecommend for change in facility policy, proceduland/or practice. Completion Date: May 20, 2019	for lendar tive orted to the hly ations

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	R: A BUILDING COMP		E SURVEY PLETED		
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F 641	Continued From pa was, "ambulatory a	*素は5 57 にはないはになった。 2 5 7 0 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	F 641				
	9:34am the reside to go but it makes this diaper and let	n Resident #55 on 4/5/19 at nt stated, "I know when I need it easier for everyone if I use them know when it needs at in my chair and go to the					
	on 4/3/19 at appro interview, CNA M s is continent, he ha	ted an interview with CNA M kimately 2pm. During the stated, "[Resident #55's name] s a foley, he will let me know anged, he just uses his brief."					
	notified of the findi	and Director of Nursing were ngs of facility staff failing to assessment, on 4/4/19 at					
F 645 SS≔E		g for MD & ID	F 645				
	individuals with a I with intellectual dis §483.20(k)(1) A nu	ursing facility must not admit, on		F645 Corrective Action(s) Resident #7's attending physician ar responsible party have been notified the facility failed to obtain a PASAI the resident prior to their admission.	that RR for		
	(i) Mental disorder (i) of this section,	1989, any new residents with: as defined in paragraph (k)(3) unless the State mental health		facility Incident & Accident form hat been completed for this incident.	as		
	independent phys performed by a pe	rmined, based on an cal and mental evaluation are entity other than the hauthority, prior to admission,		Resident #28's attending physician a responsible party have been notified the facility failed to obtain a PASAF the resident prior to their admission.	that RR for		
	(A) That, because	of the physical and mental dividual, the individual requires		facility Incident & Accident form hat been completed for this incident.	as		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 645	the level of service and (B) If the individual services, whether specialized service (ii) Intellectual disabil authority has determined to the level of service and (B) If the individual services, whether specialized services, whether specialized services, whether specialized services paragraph(k)(1) for determination to a nursing facility being admitted to transferred for ca (ii) The State may preadmission scriparagraph (k)(1) to a nursing facility (A) Who is admit hospital after rechospital, (B) Who requires condition for which hospital, and (C) Whose attentioned in the services of the services	es provided by a nursing facility, al requires such level of the individual requires es; or ability, as defined in paragraph citon, unless the State ity or developmental disability rmined prior to admission of the physical and mental dividual, the individual requires es provided by a nursing facility, al requires such level of the individual requires es for intellectual disability. Deptions. For purposes of this con screening program under of this section need not provide in the case of the readmission by of an individual who, after the nursing facility, was		Resident #97's attending physician responsible party have been notified the facility failed to obtain a PASA the resident prior to their admission facility Incident & Accident form have been completed for this incident. Resident #49's attending physician responsible party have been notified the facility failed to obtain a PASA the resident prior to their admission facility Incident & Accident form have been completed for this incident. Resident #68's attending physician responsible party have been notified the facility failed to obtain a PASA the resident prior to their admission facility Incident & Accident form have been completed for this incident. Identification of Deficient Practic & Corrective Action(s): All other residents who were required have a PASARR prior to admissions have been affected. The social served director and/or Admissions director complete a 100% review of all resident identify residents who needed a PASARR completed prior to admission but did not have one. All negative findings will be corrected at the time discovery by notifying the attending physician and responsible party. A facility Incident & Accident form have been completed for each incident.	d that RR for L. A as and d that RR for L. A as and d that RR for L. A as es ed to may ices will lents sion e of	

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5 6	facility services. §483.20(k)(3) Def section- (i) An individual is disorder if the indi disorder defined in (ii) An individual is intellectual disabil intellectual disabil or is a person with described in 435. This REQUIREMI by: Based on staff in and clinical record Residents had (Pi Resident Review) admission for five #97, #49, and #66 residents. 1. For Resident # obtain a PASARF facility. 2. For Resident # obtain a PASARF facility. 3. For Resident # obtain a PASARF facility. 4. For Resident # obtain a PASARF facility.	inition. For purposes of this considered to have a mental vidual has a serious mental		Systémic Change(s): The facility policy and procedu been reviewed and no changes a warranted at this time. The adm director, social worker, DON, a administrator have been inserving regional nurse consultant on the requirement that residents with disorder have a PASARR be comprised to admission Monitoring: The social worker and admissing will be responsible for maintain compliance. Potential new resident a PASARR has been completed if indicated. Negating will be corrected at the time of Aggregate findings will be reputed Aggregate findings will be reputed and recommendation for changes in policy, procedure and/or practing Completion Date: May 20, 20.	are hission and iced by the e a mental completed cons director ming idents will ission to en ve findings f discovery, corted to the alysis and in facility ice.	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION		TE SURVEY MPLETED
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F 645		age 33 screening prior to admission to	F 645			
	The findings includ	e:				
		the facility staff failed to prior to admission to the				
	the facility on 5/2/1: limited to Bipolar D Repeated Falls, Pa	8 year old woman admitted to 3 with diagnoses of but not isorder, Acute Kidney Failure, acemaker implant, Major er, and Seizure Disorder.				
	no PASARR Level chart or electronic r made for PASARR	I record review was done and 1 was found in hard copy of medical record. A request then Level I and or II depending on s diagnoses required.				
	conducted with the the usual process f the Resident come	AM, an interview was Social Worker who stated that or obtaining a PASARR is that s in and is admitted and the of the admissions process.				
	Administrator was r	conference on 4/3/19 the made aware of the issue of IR prior to admission no further ovided.				
		28 the facility staff failed to prior to admission to the				
	Resident # 28 a 65	year old man, admitted to the				

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F. 645	facility on 1/23/18 v limited to Unspecifi Status, Cerebral In and Hemiparesis for Major Depressive I On 4/2/19 a clinical no PASARR Level chart or electronic is made for PASARR what the Resident's On 4/3/19 facility st I screening signed dated 5/11/18. The admission. On 4/3/19 at 11:30 conducted with the the usual process for the Resident comes PASARR is a part of the Resident was probability and process for the Resident comes PASARR is a part of the Resident # 9 obtaining a PASAR information was processed in the facility. Resident #97 is an to the facility on 6/2 limited to Anemia, F	with diagnoses of but not ed Psychosis, Altered Mental farction (stroke), Hemiplegia ollowing cerebral infarction, Disorder and Diabetes Type II. I record review was done and 1 was found in hard copy of medical record. A request ther Level I and or II depending on a diagnoses required. aff submitted PASARR LEVEL by facility Social Worker and PASARR was completed after the AM, an interview was Social Worker who stated that or obtaining a PASARR is that is in and is admitted and the of the admissions process. conference on 4/3/19 the made aware of the issue of R prior to admission no furthe				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 645	On 4/2/19 a clinical no PASARR Level chart or electronic made for PASARF what the Resident On 4/3/19 facility is 1 screening signed dated 6/8/18. The admission. On 4/3/19 at 11:30 conducted with the usual process the Resident come PASARR is a part During end of day Administrator was obtaining a PASAF information was processed at the PASARR Resident # 49, a 9 to the facility on 12 but were not limited Hypertension, Mali Gastroesophageal	al record review was done and 1 was found in hard copy of medical record. A request them a Level I and or II depending on a diagnoses required. Itaff submitted PASARR LEVEL by facility Social Worker and PASARR was completed after AM an interview was a Social Worker who stated that for obtaining a PASARR is that as in and is admitted and the of the admissions process. Conference on 4/3/19 the made aware of the issue of IR prior to admission no further ovided. 49, the facility staff failed to (Preadmission Screening and prior to admission to the facility 1 year old male, was admitted 1/2017. Diagnoses included to: Alzheimer's Disease, gnant Neoplasm of Prostate, Reflux Disease, Dementia,		DEFICIENCY)			
	(MDS) was a quart Assessment Refer The MDS coded R Interview for Menta	ost recent Minimum Data Set erly assessment with an ence Date (ARD) of 2/1/2019, esident # 49 with a BIMS (Briel al Status) score of "3" out of 15 ognitive impairment. Resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	and the control of th	(X3) DATE SURVEY COMPLETED	
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F 645	Continued From page	age 36	F 645			
		requiring limited to extensive				
	assistance of one	staff person for Activities of				
		total assistance of one staff				
		. Resident # 49 was coded as				
	occasionally incon	tinent of bowel and bladder.				
	0-04/04/0040-4					
	record was conduc	2:30 PM, review of the clinical				
	record was conduc	лец.				
	Review of the clinic	cal record revealed there was				
		1 Screening in the electronic				
	or paper clinical re		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
			assign to			
		I:08 AM, an interview was				
		Social Worker who stated the				
		s for the PASARR to be				
		Social Worker on the day of ocial Worker stated she did not				
		reening in the clinical Record				
	for Resident # 49.	The Social Worker stated she				
		PASARR should be done prior				
		tated "I am not a part of the				
		don't see them (residents) until				
	they get here." Th	e Social Worker stated the				
		littee at the facility was				
	responsible for see	eing residents prior to				
		Social Worker was PASARR on the day of				
	admission.	radanin on the day of				
	On 4/4/2019 at 11:	55 AM, the Social Worker				
	stated that she rev	iewed the record and talked				
		s staff. The Social Worker				
		a PASARR screening was not				
	and the first transfer of the first	# 49 because he had been				
		ility as a private pay resident				
		reening was not required for forker was advised that				
		re a Level 1 PASARR				
		V W LOTOF 1 I NOMERIC	1	1.5 startitudes are placed in signal and elementary		

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74511 JI	PROVIDER OR SUPPLIER GE HALL KING GEOF	GE	10	REET ADDRESS, CITY, STATE, ZIP COE 1051 FOXES WAY ING GEORGE, VA 22485			
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F 645	Screening done price of the Administrator a were informed of the Resident # 49. The Director of Nursing admitted to nursing screening prior to a stated the facility stadmissions had a few No further informated by the facility of the facility on 12 but were not limited Hypertension, Major Gastroesophageal Cardiomegaly, and Resident # 68's more (MDS) was a quarted Assessment Referrance MDS coded Reference of the facility on 12 but were not limited for MDS coded Reference for Mental indicating severe of \$68 was coded as of one to two staff purior pathing. Resident R	or to admission. Ing the end of day debriefing, and the Director of Nursing are findings of no PASARR for a Administrator and the were advised that residents a facilities must have a Level 1 admission. The Administrator aff would ensure all future PASARR prior to admission. In was provided. In the facility staff failed to Preadmission Screening and prior to admission to the facility year old female was admitted to: Alzheimer's Disease, or Depressive Disorder, Reflux Disease, Dementia,					
	Review of the clinic	al record was conducted on					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	COI	(X3) DATE SURVEY COMPLETED	
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F 645	A/4/2019. Review of the Screen Mental Retardation Related Conditions Screening and Resignature and a dafor "Screening Corand Street Address On 04/4/2019 at 11 conducted with the facility process was completed by the Sadmission. The Scial Worker State Was hers and she 5/11/2018 because the record. The Social Worker PASARR should be stated "I am not a pand ton't see them (restricted The Social Worker Committee at the free Social Worker Committee at the free Social Worker was responday of admission. On 04/04/2019, duthe Administrator and informed of the find Resident # 49. The	eening for Mental Illness, n/Intellectual Disability, or s, PASARR (Preadmission sident Review) form revealed a ate of 5/11/2018. The spaces mmittee, Telephone number,					
	nursing facilities m	oust have a Level 1 screening The Administrator stated the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495300		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
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	facility staff would had a PASARR price No further informa Baseline Care Plat CFR(s): 483.21(a) §483.21 Comprehe Planning §483.21(a) Baseline §483.21(a) Baseline §483.21(a)(1) The implement a basel that includes the ineffective and perso that meet profession. (ii) Be developed wadmission. (ii) Include the min necessary to propeincluding, but not lit (A) Initial goals basel (C) Dietary orders. (D) Therapy service (E) Social services (F) PASARR reconservices (F) PASARR reconservices (I) Is developed with admission. (ii) Meets the requirements of this section (In this section).	ensure all future admissions for to admission. tion was provided. (1)-(3) ensive Person-Centered Care ne Care Plans facility must develop and for each resident estructions needed to provide on-centered care of the resident onal standards of quality care. plan mustithin 48 hours of a resident's imum healthcare information erly care for a resident mited to-sed on admission orders.	F 645	F655 Corrective Action(s): Resident #6's Attending physician ar have been notified that the facility diaddress the residents Behavioral Heal Needs on the Base line care plan. Resident #6's medical record and Comprehensive care plan has been reviewed and revised to reflect her behavioral health needs and her currediagnosis of Depression and Anxiety Identification of Deficient Practices & Corrective Action(s): All residents may have potentially be affected. A 100% review of all new admissions in the last 30 days will be conducted by the DON, RCC and/or designee to identify residents who die have an accurate baseline care plan completed to address any behavior he needs identified. All residents identified will have their comprehensive care previewed and updated to reflect their current Behavior health needs and the Resident and RP's will be notified of any/all changes to the current comprehensive care plan. A Facility Incident & Accident Form will be completed for each incident identified.	d not lth		

MAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE SUMMAY STATEMENT OF DESCRIPCION RESULATORY OR LSC IDENTIFYING INFORMATION) FOR THE PROVIDER AND THE PROPERTY OF THE			(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
HERITAGE HALL KING GEORGE MERITAGE HALL KING GEORGE PAGENT (REGULATORY OR LSC IDENTIFYING INFORMATION) F 655 Continued From page 40 resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the residents medications and dietary instructions. (iii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This RECUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review: the facility staff failed to complete a baseline care plan to provide behavioral health services for 1 resident (Resident #6) of the 30 residents in the survey sample. For Resident 6, the facility staff failed to complete a baseline care plan to provide behavioral health services for 1 resident (Resident #6) of the 30 residents in the survey sample. The findings included: Resident #6, was admitted to the facility on 12-18-19. Diagnoses included; depression, anxiety, heart disease, diabetes, high blood pressure, and chronic obstructive pulmonary disease (COPD). The most recent Minimum Data Set assessment reference date (ARD) of 3-26-19. Resident #6 was coded with a Brief Interview of Mental Status (BIMS) score of 13 indicating little to no copilitive			495300	B. WING			
MAINTAGE HALL KING GEORGE, VA 22485 SUMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MUST BE PRICEDED BY PULL RESOLATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG. PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICENCY OF THE APPROPRIATE OF CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE OF CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPR	NAME OF F	PROVIDER OR SUPPLIE		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES PRIFIX REGULATORY OR I.S.C IDENTIFYING INFORMATION) TAG REGULATORY OR I.S.C IDENTIFYING INFORMATION TAG REGULATORY OR I.S.C INTENTITY OR IT INFORMATION TAG REGULATORY OR IN		TIME WAS AFA		100	051 FOXES WAY		
FRESIX TAG RESULTORY OR ISC DENTEYNOR INFORMATION) RESULTANT OR ISC DENTEYNOR INFORMATION, RESULTANT OR ISC DENTEYNOR INFORMATION) FRESIX TAG FRESIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FRESIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Systemic Changes: The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the facility and personnel acting on behalf of the facility and personnel acting on the facility and a written summary will be given to the Resident and RP. The RCC, IDT and the DON will be inserviced to the facility and a written summary to the resident and RP. The RCC, IDT and the DON will be inserviced to the facility and a written summary to the resident and RP. The RCC, IDT and the DON will be inserviced to the facility and a written summary to the resident and RP. The RCC and DON are responsible for maintaining compliance. The DON and/or RP. Anylall negative and interview, a	HEHIIAU	ie Hall Ning Ged		KII	NG GEORGE, VA 22485		
resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to complete a baseline care plan to provide behavioral health services for 1 resident (Resident #6) of the 30 residents in the survey sample. For Resident 6, the facility staff failed to develop a base line care plan for behavioral health services. The findings included: Resident #6, was admitted to the facility on 12-18-18. Diagnoses included; depression, anxiety, heart disease, diabetes, high blood pressure, and chronic obstructive pulmonary disease (COPD). The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date (ARD) of 3-26-19. Resident #6 was ooded with a Brief Interview of Mental Status (BIMS) score of 13 indicating little to no cognitive	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE COMPLETION	
activities of daily living. The full admission MDS	F 655	resident and their of the baseline calimited to: (i) The initial goal (ii) A summary of dietary instruction (iii) Any services administered by the on behalf of the folion of the compreher This REQUIREM by: Based on observinterview, clinical document review complete a basel behavioral health (Resident #6) of the sample. For Resident 6, the base line care plant of the care plant of the findings included the findin	representative with a summary tre plan that includes but is not also of the resident. It he resident's medications and is, and treatments to be the facility and personnel acting acility. Information based on the details issive care plan, as necessary. ENT is not met as evidenced retion; resident interview, staff record review, and facility, the facility staff failed to ine care plan to provide services for 1 resident the 30 residents in the survey and facility staff failed to develop a an for behavioral health services. Ided: admitted to the facility on oses included; depression, ease, diabetes, high blood ronic obstructive pulmonary. Minimum Data Set assessment seessment with an assessment with an assessment and Brief Interview of Mental Status I andicating little to no cognitive equiring assistance with physical		The facility Policy and Procedure I been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by 24 Hours Report and documentation the medical record and physician of will be used to develop and revise line care plans within 48 hours of admission to the facility and a writt summary will be given to the Resident and RP. The RCC, IDT and the DC be inserviced by the regional nurse consultant on the development, implementation of the baseline as wensuring that the baseline care plan accurate prior to providing the base care plan summary to the residents RP's. Monitoring: The RCC and DON are responsible maintaining compliance. The DON RCC will perform care plan audits new admissions 48 hours after admit to ensure a base line care plan has been completed accurately and timely and a written summary has been completed and reviewed with the resident and Any/all negative findings will be reto the RCC for immediate correction Detailed findings of the Care Plan a will be reported to the Quality Asse Committee for review, analysis, and recommendations for change in face policy, procedure, and/or practice.	y the on in reders base ten lent DN will well as is line and sission open defend that eted /or RP. sported on. audit arance d	

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F 655	of 12-25-18 which and both documer anxiety as diagnos planned for this Ro An interview was o	also reviewed with an ARD date revealed a BIMS score of 13, hts did not code depression nor ses to be treated or care esident. conducted with Resident #6 on					
	During the intervie The Resident state her family often, at from another state than family. The F family members in facility, and were be working. The Res ever talked with the feelings, and she seed in the the first week I can move out of my ro- was so disruptive. When asked if she the social worker,	n., and on 4-3-19 at 12:00 p.m. ws, Resident #6 was tearful. ed that she did not get to see and had just moved to Virginia a, and had no friends here other desident went on to say the red quite a distance from the pusy raising children, and ident was asked if she had e social worker about her stated "no, I only saw her twice me here, and the day I had to om because my room mate "I haven't seen her since." was interested in talking with Resident #6 stated "no, I would r." When asked if she meant a					
	Psychologist, or a Resident #6's clinic social services not services director (12-19-18, and ten routine admission, SSD did not docur until 3-18-19 to presubmission.	psychiatrist, she stated "yes". cal record was reviewed. The tes indicated that the social SSD) did visit the Resident on days later on 12-29-18 for and "14 day" follow up. The ment seeing the Resident again epare for the quarterly MDS nted the following entry on					
	"There has been n	o change to the resident during					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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F.655	appears anxious, r very pleasant and often, but tends to things of unimports overall care and trestay in room and is On 3-19-19, the Reroom. A review of clinical record did r of the reason for the responded to the nest of the reason for the responded to the nest of the reason for the responded to the nest of the documents, which no aberrant behavior documents rev "medical history", v 12-20-18. This first Resident as negatificand went on to document included in the On 2-7-19, 2-21-19, the Resident and do "recert" visits for sk 3-26-19 was a sick been diagnosed with visits have any documents, as no asses	aviors or mood. The resident nervous in conversation but is nice. Residents son visits complain about "little things" or ance in regards to residents eatment. The resident tends to a socially withdrawn by nature." esident was moved to another all discipline notes in the not reveal any documentation are move, or how the Resident nove. The ents were reviewed, to include physician notes, and MDS revealed that the Resident had					
		s such. No psychiatric					

		ER/SUPPLIER/CLIA ICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	СОМ	E SURVEY PLETED	
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F 655	Continued From page 43 physician evaluation was ever Review of all nursing notes sin		F 655				
	to the time of survey revealed interventions for depression or	no assessment or					
	Physician's orders, and Medica Records (MAR's) were reviews following (4) psychoactive med ordered and administered during stay;	ed and revealed the dications were	3				
	Zoloft 125 milligrams (mg) e a.m. for depression. Ordered continued through survey.						
	2. Buspar 15 mg three times pa.m., 2:00 p.m., and 9:00 p.m. Ordered 12-19-18, and continu	for anxiety.					
	3. Xanax 0.5 mg every 6 hours anxiety. Ordered 12-19-18, dis 12-23-18, reordered 12-25-18	scontinued					
	4. Xanax 0.5 mg every day at 9 anxiety. ordered 2-16-19, and 0 survey.						
	The Residents care plan in the paper copy with revisions from on the nursing unit were review plans revealed, no baseline init comprehensive care plan was the Resident's depression, and behavioral health care needs.	the care plan book wed. The 2 care tial care plan, nor ever devised for					
	On 04/05/19 at 10:10 AM, an in Employee H, the MDS/ Care P was conducted. When asked a	lan Coordinator					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		(02) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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fri in an	PROVIDER OR SUPPLIER SE HALL KING GEO			1005	EET ADDRESS, CITY, STATE, ZIP CODE 51 FOXES WAY	1 0-37	00/2015	
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F 655		n intervention on the care was	F6	55				
	interventions." She intervention either	ployee H stated, "We don't date went on to say the continues or it would be sked about a resolved						
	intervention, Empl it." Employee H st	oyee H stated, "I would delete ated the paper copy care plans on the unit, updated on the						
	paper, and eventu	ally entered into the computer. neeting on 4-3-19, the Director						
	that it did not appe providing for Resid	and Administrator were notified ar that the facility staff were lent #6's behavioral health						
	Resident #6's dep care planned, nor	ewed that it did not appear that ression and anxiety were ever was there any formal ment, nor social work						
	interventions. The asked to provide o	administrative staff were larification in this matter, and ould get back to the surveyors						
	with any information The Administrator	on found. and DON were notified of the						
	Resident #6, and the everything we have able to be provide	er of the first of the figure of the entire						
F 656 SS=D	Develop/Impleme CFR(s): 483.21(b)	nt Comprehensive Care Plan (1)	F6	56	F656 Corrective Action(s):			
	§483.21(b)(1) The implement a comp care plan for each resident rights set	ehensive Care Plans facility must develop and rehensive person-centered resident, consistent with the forth at §483.10(c)(2) and			Resident #63's comprehensive care has been reviewed and revised to ret appropriate goals with measurable ti frames and interventions and approa with dates they were initiated and/or discontinued or changed. A Facility Incident & Assiduat Form was compared.	lect me ches		
	9483.10(c)(3), tha objectives and tim	t includes measurable eframes to meet a resident's			Incident & Accident Form was comfor this incident.	pietea		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 656	medical, nursing, a needs that are ide assessment. The describe the follow (i) The services the or maintain the resphysical, mental, a required under §4 (ii) Any services the under §483.24, §4 provided due to the under §483.10, increatment under §6 (iii) Any specialize rehabilitative service provide as a resul recommendations findings of the PA rationale in the resident's represe (A) The resident's desired outcomes (B) The resident's future discharge, whether the resident's future discharge, whether the resident's requirements set section. This REQUIREMI by: Based on staff in	and mental and psychosocial ntified in the comprehensive comprehensive comprehensive comprehensive comprehensive comprehensive care plan must ving - at are to be furnished to attain sident's highest practicable and psychosocial well-being as 83.24, §483.25 or §483.40; and nat would otherwise be required 83.25 or §483.40 but are not e resident's exercise of rights cluding the right to refuse 483.10(c)(6). d services or specialized ces the nursing facility will to FASARR. It must indicate its sident's medical record. with the resident and the intative(s)-goals for admission and preference and potential for Facilities must document ent's desire to return to the ssessed and any referrals to ncies and/or other appropriate	F 656	Resident #35's comprehensive of has been reviewed and revised appropriate measurable goals are interventions and approaches to the resident's specific medical attreatment needs to include her with deficits and the need for glasses. Facility Incident & Accident Forcompleted for this incident. Resident #6's comprehensive can have been reviewed and revised appropriate goals, interventions approaches to address the reside specific medical and treatment in manage the Resident #6's behat health needs and her current dia Depression and Anxiety. Identification of Deficient Prax & Corrective Action(s): All residents may have potential affected. A 100% review of all comprehensive care plans will conducted by the DON, ADON and/or designee to identify residence or incomplete complex care plans. Resident identified inaccurate or incomplete care phave their care plan reviewed a to reflect their current intervent appropriate approaches to addressed and treatment needs. A Incident & Accident Form will completed for each incident identified.	to reflect and address and vision s. A sorm was sare plan to reflect and ent's needs to needed to vioral agnosis of sectices ally been be I, RCC dents with rehensive with allans will and updated tions and ess their a Facility be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	The findings included. 1. For Resident # date interventions order to establish objectives. 2. For Resident # include vision served. 3. For Resident # develop a comprese behavioral health and anxiety. The findings included to resident # date interventions order to establish objectives. Resident #63, a 6 to the facility on 0 but not limited to 1 myocardial infarct infarction, hyperte hemiplegia. Resident #63's methad an Assessment Resident #63's methad an Assessment Resident Resid	s. led: 63, the facility staff failed to and goals on the care plan in time frames and measurable 35, the facility staff failed to ices/needs on the care plan. 6, the facility staff failed to hensive care plan for the services needs of depression		Systemic Changes: The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation the medical record and physician ordwill be used to develop and revise comprehensive plans of care. The RC IDT and the DON will be inserviced the regional nurse consultant on the development, revision and implementation process of individual care plans. Monitoring: The RCC and DON are responsible formaintaining compliance. The DON at RCC will perform care plan audits we coinciding with the care plan calendal monitor for compliance. Any/all negating findings will be reported to the DON RCC for immediate correction. Detaifindings of the interdisciplinary team audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: May 20, 2019	he in ers CC, by ized or ad/or eekly r to affive / led

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F 656	coded as requiring	g, and personal hygiene were all g extensive assistance from atus for eating was coded as	F 656				
	reviewed. There we interventions asso not include dates of "Goal and Target I."through next re	ne electronic health record was bere 12 problem areas. The ciated with each problem did of initiation and revision. Under Date", each goal would end with eview." There were no ames, initiation, or target dates					
	paper copy of the the most updated paper copy kept of electronic care pla computer) are updefectionic and paper not have dates assisted exception of of (handwritten), "How intervention that we have the exception of the exceptio	4:55 PM, the facility provided a care plan. Employee L stated version of the care plan is on in the unit. Employee L stated ins (what is seen on the lated quarterly. Both the er versions of the care plan did sociated with interventions with the which documented spice as of 11/16/18" and an as crossed out and (discontinued) 1/15/19."					
	Employee H, the M was conducted. W determine when as was implemented, date interventions. intervention either resolved. When as intervention, Employee H stare kept in a book	to AM, an interview with MDS/Care Plan Coordinator then asked about how to an intervention on a care plan Employee H stated, "We don't " She went on to say the continues or it would be sked about a resolved byee H stated, "I would delete ated the paper copy care plans on the unit, updated on the ally entered into the computer.					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION G		E SURVEY (PLETED
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F 656	Continued From p	page 48	F 656	6		
		out the CNA (closet) care plans, ed closet care plans are also ed.				
	DON and Adminis	t approximately 2:30 PM, the strator were notified of findings no further information or				
	2. For Resident include vision ser	#35, the facility staff failed to rvices/needs on the care plan.				
	the facility on 10/2	l-year female, was admitted to 22/2011. Diagnoses include but art failure, hypertension, morbid cle weakness.				
	had an Assessme 01/02/2019 and w change in status a coded with a Briel (BIMS) score of 1 intact cognition. F mobility, dressing, coded as requiring		of			
	Resident #35 was had any concerns an eye exam last glasses. Resident B about it. Reside read but is unable	t 12:51 PM, an interview with s conducted. When asked if she is, Resident #35 stated she had year but never received at #35 stated she spoke with LPN lent #35 also stated she loves to be to do so without her reading at #35 was not wearing glasses				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(00)	(X3) DATE SURVEY COMPLETED C	
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F 656	at the time of the i	nterview. 9:10 AM, Resident #35 was	F 656				
	observed in her be bed elevated appro On 04/04/2019 at observed in bed, a elevated approxim	ed sleeping with the head of the oximately 30 degrees. 9:00 AM, Resident #35 was awake, with the head of her bed nately 45 degrees. The TV was					
	Resident #35 state eye." She went on eye, everything is						
	she was aware Re LPN B stated, "Yes process of getting	4:05 PM, LPN B was asked if esident #35 needed glasses and s." When asked about the glasses for Resident #35, LPN tall worker takes care of that."					
	Employee G, a soo the process for vis stated she visits w they want to see the name is put on a li	approximately 4:40 PM, cial worker, was asked about sion services and Employee Grith residents and asks them if ne eye doctor and if so, their ist. Employee G then provided Resident #35 was scheduled on 04/17/2019.					
	observed in her ro asked if a social w	9:25 AM, Resident #35 was om, in bed, awake. When orker had talked with her about d she stated, "No." She went eing able to read."					
	Notes" dated 07/1: optometrist docum	ed "Summary Ocular Progress 3/2018 for Resident #35, An nented the chief complaint, rd to see at distance and near."					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495300		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
	PROVIDER OR SUPPLIEF SE HALL KING GEO		S1	FREET ADDRESS, CITY, STATE, ZIP CO 1051 FOXES WAY ING GEORGE, VA 22485		05/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES OF 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	(X5) COMPLETION DATE
F 656	Under "Diagnosis documented, "Age bilateral - cataract significant - monitor progress notes also prescription that e documented, "OD +2.50 OS (left eye) The care plan was onset dated 04/11, #35] prefers to strain bed per her chollistening to gospel and participating vom. Enjoys read know new people. (diagnosis) of DM: morbid obesity." A focus included but provide writing mapromote continued for resident to use vision deficit and haddressed on the lin summary, Resident to use vision deficit and haddressed on the lin summary, Resident is unable have glasses and following the exammenths ago. Vision care plan. On 04/05/2019 at DON and Administration.	and Treatments", it was a-related nuclear cataract, s - OU-Mild/stable - not visually or 6 mos (months)." The so included a glasses xpires 7/13/19. The prescriptior (right eye) -2.75 sph xadd) -1.25 sph xAdd +2.50." Is reviewed. A problem/need /2016 documented, "[Resident ucture her own day, and stays ice, enjoys reading Bible, music, keeping up with news, with religious programs in her ling and writing and getting to In past, loved to sing. Has dx 2 (type 2 diabetes) and severe pproaches associated with this not limited to "offer and terials and other materials to d independence; provide Bible as requested." Resident #35's per need for glasses was not				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED C	
		495300	B. WING			C /05/2019	
	PROVIDER OR SUPPLIE SE HALL KING GEO	생님님 물로 보고 말을 가고 있다.	STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 656	Continued From p	page 51	F 656				
	develop a compre	6, the facility staff failed to chensive care plan for the services needs of depression					
	12-18-18. Diagno anxiety, heart disc	admitted to the facility on oses included; depression, ease, diabetes, high blood onic obstructive pulmonary					
	was a quarterly as reference date (A was coded with a (BIMS) score of 1 impairment and reactivities of daily I assessment was of 12-25-18 which and both docume	Minimum Data Set assessment seessment with an assessment #6 RD) of 3-26-19. Resident #6 Brief Interview of Mental Status 3 indicating little to no cognitive equiring assistance with physicaliving. The full admission MDS also reviewed with an ARD date revealed a BIMS score of 13, nts did not code depression nor ses to be treated or care lesident.					
	4-2-19, at 1:00 p.i During the intervie The Resident stat her family often, a from another state than family. The family members li facility, and were working. The Resever talked with the	conducted with Resident #6 on m., and on 4-3-19 at 12:00 p.m. ews, Resident #6 was tearful. ted that she did not get to see and had just moved to Virginia e, and had no friends here other Resident went on to say the lived quite a distance from the busy raising children, and sident was asked if she had ne social worker about her stated "no, I only saw her twice					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495300	B. WING		C 04/05/2019
NAME OF I	PROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE	
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116.111171	2L HALL HING GLOI		KIN	NG GEORGE, VA 22485	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION
F 656	Continued From page	age 52	F 656		
	move out of my roo was so disruptive." When asked if she the social worker, rather see a docto	ne here, and the day I had to om because my room mate "I haven't seen her since." was interested in talking with Resident #6 stated "no, I would r." When asked if she meant a psychiatrist, she stated "yes".			
	social services not services director (\$ 12-19-18, and ten routine admission, SSD did not docum	cal record was reviewed. The es indicated that the social SSD) did visit the Resident on days later on 12-29-18 for and "14 day" follow up. The nent seeing the Resident again epare for the quarterly MDS			
	The SSD documer 3-18-19;	nted the following entry on			
	this quarter in beha appears anxious, r very pleasant and often, but tends to things of unimporta overall care and tre	o change to the resident during aviors or mood. The resident nervous in conversation but is nice. Residents son visits complain about "little things" or ance in regards to residents eatment. The resident tends to socially withdrawn by nature."			
	and nervousness (documented before reason. She also as unimportant, an assessment, or ph	o change, yet describes anxiety which had not been e) without assessing for a describes the family complaints id, without any psychological ysicians evaluation, describes ocially withdrawn by nature."			
		esident was moved to another all discipline notes in the			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	, cov	E SURVEY APLETED
		495300	B. WING _		ing the first of the contract of	C /05/2019
	PROVIDER OR SUPPLIER GE HALL KING GEOF	ige :		STREET ADDRESS, CITY, STATE, ZIP COI 10051 FOXES WAY KING GEORGE, VA 22485		<u></u>
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656			F 65	6		
		not reveal any documentation be move, or how the Resident nove.				
	social work notes, medication admini	nents were reviewed, to include physician notes, nursing notes stration notes, and MDS revealed that the Resident had ors.				
	to the dates of sun the documents rev "medical history", v 12-20-18. This firs Resident as negati and went on to doc person/place/time.	were reviewed from admission yey. There were 4 visits, and ealed the first visit as a which was a 3 page form dated it visit document described the ve for psychiatric problems, cument, alert and oriented to Depression and anxiety were				
	On 2-7-19, 2-21-19 the Resident and d "recert" visits for sl 3-26-19 was a sick been diagnosed wi visits have any doc heading on the doc	diagnoses written on the form. a, and 3-26-19 the doctor saw locumented the first 2 visits as dilled care. The final visit on visit, as the Resident had the pneumonia. None of these cumentation under the "psyche" cument, and they were left				
	conducted. All oth and documented a	sment in this area was er headings were assessed s such. No psychiatric in was ever conducted.				
	to the time of surve	ng notes since admission, and by revealed no assessment or epression or anxiety.				
	Records (MAR's) v following (4) psych	and Medication Administration were reviewed and revealed the oactive medications were istered during Resident #6's				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	COV	(X3) DATE SURVEY COMPLETED C	
		495300	B. WING			/05/2019	
	PROVIDER OR SUPPLIER BE HALL KING GEOR	in aliana di tratago de la tratago de la Argenta de Calenda. La companya de la granda de la companya de la comp	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	Continued From postay;	age 54	F 65	6			
	Zoloft 125 millig a.m. for depression continued through	rams (mg) every day at 9:00 n. Ordered 12-19-18, and survey.					
	a.m., 2:00 p.m., ar	nree times per day at 10:00 id 9:00 p.m. for anxiety. and continued through survey					
	anxiety. Ordered	very 6 hours as needed for 2-19-18, discontinued d 12-25-18 to stop 2-15-19.					
		very day at 9:00 a.m. for 16-19, and continued through					
	paper copy with re on the nursing unit plans revealed no ever devised for th	e plan in the computer, and the visions from the care plan book were reviewed. The 2 care comprehensive care plan was e Resident's depression, ioral health care needs.					
	Employee H, the M was conducted. W determine when ar implemented, Empinterventions." She intervention either resolved. When as intervention, Employee H sta are kept in a book	10 AM, an interview with IDS/ Care Plan Coordinator hen asked about how to intervention on the care was loyee H stated, "We don't date went on to say the continues or it would be ked about a resolved byee H stated, "I would delete ated the paper copy care plans on the unit, updated on the ally entered into the computer.					
	At the end of day n	neeting on 4-3-19, the Director					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495300	B. WING		04/0) 5/2019
	PROVIDER OR SUPPLIE SE HALL KING GEO		10	TREET ADDRESS, CITY, STATE, ZIP CODE 2051 FOXES WAY ING GEORGE, VA 22485		
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F 656		and the first of the first of the control of the co	F 656			
II.657. SS≡D	that it did not app providing for Resineeds. It was revenueds. It was revenueds. It was revenued to be care planned, not psychiatric assess interventions. The asked to provide they stated they with any informat. The Administrator concern again on Resident #6, and everything we have able to be provided Care Plan Timing CFR(s): 483.21(b) Comp.	r and DON were notified of the 4-4-19 at 11:00 a.m. regarding the DON stated "you have ve." No further information was ed. and Revision	F 657	F657 Corrective Action(s): Resident #63's comprehensive care pland C.N.A. closet care plan has been reviewed and revised to reflect Resider 63's current Code status. A Facility Incident & Accident Form was complefor this incident.	nt .	
	be- (i) Developed with the comprehensing (ii) Prepared by a includes but is not (A) The attending (B) A registered resident. (C) A nurse aideresident. (D) A member of (E) To the extent the resident and An explanation medical record if	nin 7 days after completion of ve assessment. n interdisciplinary team, that it limited to		Resident #49's comprehensive care play has been reviewed and revised to reflew appropriate goals with measurable time frames and interventions and approach with dates they were initiated and/or discontinued or changed. A Facility Incident & Accident Form was completed for this incident. Resident #68's comprehensive care play has been reviewed and revised to reflew appropriate goals with measurable time frames and interventions and approach with dates they were initiated and/or discontinued or changed. A Facility Incident & Accident Form was completed for this incident.	et es eted an et et es	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
	a produce at the fig. This belief is that the first of the first contraction of	495300	B. WING		04/05/2019
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F 057					
F 657		Mark Mark and a constant of a first season of the season of	F 657	Identification of Deficient Practices	
		r the development of the		& Corrective Action(s):	
	resident's care pl			Any/all residents may have potentiall	У
		riate staff or professionals in		been affected. A 100% review of all	
daras.		ermined by the resident's needs		resident comprehensive care plans wi	
	or as requested b			conducted by the RCC and/or design	e to
		revised by the interdisciplinary		identify residents at risk. Residents	
		assessment, including both the		identified at risk as having an inaccur	ate
	comprehensive a	and quarterly review	2. "	comprehensive care plan with no	
	assessments.	회사님 교육을 하장이 다 생각을 들고 있다.		measurable goals or dated intervention will be corrected at time of discovery	
	This REQUIREM	ENT is not met as evidenced		a Risk Management Incident & Accident	
	by:			Form will be completed for each inci	
	Based on observ	vation, staff interviews, clinical		identified.	nem
	record reviews, a	and facility documentation, the		Richtinea.	
	facility staff failed	to revise resident-centered care		Systemic Changes:	Alexandria de la compansión de la compan
	plans for 3 reside	ents (Resident #63, Resident		The assessment process will continue	· to
		8) in a sample size of 30		be utilized as the primary tool for	***
	residents.	선물 시민이 보고 있다는 그렇게 그렇게 그렇게 다른다.		developing comprehensive plans of c	are
				The RCC is responsible for implement	otino
	1. For Resident #	63, the facility staff failed to		the RAI Process. The nursing assessm	nent
		lan to reflect current code status		process as evidenced by the 24 Hours	
	from "Full Code"		La Talenti Ski	Report and documentation in the med	
				record/physician orders will be used	
	2. For Resident	4 49, the facility staff failed to		develop and revise comprehensive pl	
		ites of problems and		of care. The Regional Nurse Consulta	
		ed on the careplan when revised.		will provide in-service training to the	
				interdisciplinary care plan team on th	
	3. For Resident	# 68, the facility staff failed to		mandate to develop individualized ca	ire
		ites of problems and	- Maria - 2 in	plans within 7 days of the completion	ıof
		ed on the careplan when revised.		the comprehensive assessment and/or	
				revisions to the comprehensive care p	olan
		한 경우들에 있는 그를 하고 만든 것을 때 하는데?	1	as indicated with any changes in resid	
	The findings incl	uded:		condition.	
	THE INTUINGS IN			and the carrier of the contract of the carrier	
	to the facility on but not limited to myocardial infarc infarction, hyper	68-year old female, was admitted 04/02/2015. Diagnoses include Non-ST elevation (NSTEMI) ction, heart failure, cerebral tension, diabetes, and			
	hemiplegia.	사는 사람들로 하는 사람들이 불어보다 하다.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495300	B. WING		C 04/05/2019	
	PROVIDER OR SUPPLIER GE HALL KING GEOF	항공통 회사 기계 회사 기가 연락하다고 있다.	STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY 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 COMPLETION	
F 657	Resident #63's month had an Assessment Pesician Procession of possible 15 indictions in the period of possible 15 indictions of possible 17 indictions of possible 15 indictio	ost recent Minimum Data Set ont Reference Date (ARD) of as coded as a quarterly dent #63 was coded with a Brief al Status (BIMS) score of 3 out licative of severe cognitive tional status for bed mobility, g, and personal hygiene were all g extensive assistance from tatus for eating was coded as ion from staff. 4:15 PM, the current in the electronic health record A physician's order dated nented, "Resident Hospice care ispice company name]." A dated 11/26/2018 documented,		Monitoring: The RCC and DON are responsible maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization coinciding with the carealendar to monitor for compliance. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will reported to the Quality Assurance Committee for review, analysis, are recommendations for change in fare policy, procedure, and/or practice. Completion Date: May 20, 2019	re plan 'e. reported tte e be and cility	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTH A. BUILDING	PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED	
		495300	B. WING			C /05/2019
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		03/2018
HERITAC	GE HALL KING GEOF	RGE		10051 FOXES WAY KING GEORGE, VA 22485		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 657	entered Resident#	age 58 63's room and CNA C then #63's closet door to show a	F 65	7		
	document entitled, included Resident (handwritten). It als	, "CNA Care Plan" which #63's name and room number so included Resident #63's				
	the paper, it was d current as of this d side of the CNA Ca	o ADLs. On the left hand side of locumented, "Information is late: 10-31-18." On the top left are Plan, it was documented				
	This surveyor then #63's code status	C then closed the closet door, n asked CNA C what Resident was and she stated, "She's a of the CNA Care Plan was				
	requested and CN ask the nurse.	A C stated she would have to				
	surveyor and CNA station. After speal to Resident #63's r	approximately 4:45 PM, this C walked to the nurse's king with a nurse, CNA C went room to retrieve the CNA Care				
	Resident #63's har Durable Do Not Re this surveyor, "Do	door. The staff nurse got rd chart and displayed the esuscitate Order and stated to you realize this resident is on a DNR?" CNA C returned with				
	the CNA Care Plan B looked at the doo care plan) wasn't u	n and handed it to LPN B. LPN curnent and stated, "It (closet updated."				
	and the electronic	ble Do Not Resuscitate order care plan were requested.				
	Resuscitate docum 11/20/18 and signe party, and a witnes electronic care plan problem entitled, "F to perform ADLs (A	4:55 PM, a Durable Do Not nent was provided. It was dated by physician, responsible as. A paper copy of the n was provided. Under the Resident #63] has an inability Activities of Daily Living) ondary to muscle spasms, HTM				

NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485	(X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER 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	(X5) COMPLETION
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	COMPLETION
Service of the servic	
F 657 Continued From page 59 (hypertension), CVA (cerebral vascular accident), hemiparesis, RAKA (right above-the-knee amputation), depression. Resident refuses meals & supplements at time.", "Full Code" was crossed out and "DNR" was added (handwritten and not dated or initialed). Employee L stated the most updated version of the care plan is on paper kept on the unit. Employee L stated the most updated version of the care plan is on paper kept on the unit. Employee L stated electronic care plans (what is seen on the computer) are updated quarterly. On 04/05/19 at 10:10 AM, an interview with Employee H, the MDS, Care Plan Coordinator was conducted. When asked about how to determine when an intervention on a care plan was implemented, Employee H stated, "We don't date interventions." She went on to say the intervention either continues or it would be resolved. When asked about a resolved intervention, Employee H stated, "I would delete it." Employee H stated, "I would delete it." Employee H stated, the paper copy care plans are kept in a book on the unit, updated on the paper, and eventually entered into the computer. When asked about the CNA (closet) care plans, Employee H stated, closet care plans are also updated as needed. The facility policy entitled, "Advanced Directives" was reviewed. Section 7 documented, "Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record." Section 10 documented, "The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advanced directive." In summary, there was conflicting information regarding Advanced Directives on the electronic	

	IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495300	B. WING		04	C /05/2019	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 657	Continued From p care plan, the pap closet care plan to	er copy care plan, and the CNA	F 657				
	DON and Administ	approximately 2:30 PM, the trator were notified of findings of further information or					
	document the date	19, the facility staff failed to s of problems and on the careplan when revised.					
	to the facility on 12 but were not limited Hypertension, Mali	1 year old male, was admitted 1/1/2017. Diagnoses included d to: Alzheimer's Disease, gnant Neoplasm of Prostate, Reflux Disease, Dementia, Anxiety.					
	(MDS) was a quart Assessment Refer The MDS coded R Interview for Menta indicating severe c # 49 was coded as assistance of one s Daily Living except person for bathing.	ost recent Minimum Data Set erly assessment with an ence Date (ARD) of 2/1/2019. esident # 49 with a BIMS (Brief al Status) score of "3" out of 15, ognitive impairment. Resident requiring limited to extensive staff person for Activities of total assistance of one staff Resident # 49 was coded as inent of bowel and bladder.					
	Resident #49 was a 12/1/2017. A revier record was conductive to the conductive record was conductive record wa	2:30 PM, review of the clinical ted. admitted to the facility on w of Resident # 49's clinical ted during the survey. e plan, revised on 02/27/2019,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		495300	B. WING			C 04/05/2010	
	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE		STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485)4/05/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 657	Alzheimer's Disea	It # 49 had a diagnosis of use and dementia resulting in S. One of the interventions	F 657				
	ADLS (Activities of secondary to Alzh there was a proble "occasionally refuragitated and at tin	n: *Has inability to perform of Daily Living) independently eimer's disease, dementia, em added by handwriting: ses scheduled shower, become nes aggressive. There was no handwritten note was added.					
	"Encourage res (r	entions that were handwritten: esident) to take showers. esident) in a calm manner."					
	care plan under of	interventions handwritten on the ther problems. There were no problems or interventions were					
	Employee H, the I was conducted. W determine when a implemented, Employee H state H stated the pape book on the unit, I eventually entered	c:10 AM, an interview with MDS/ Care Plan Coordinator /hen asked about how to n intervention on the care was ployee H stated, "We don't date uployee H state the intervention nue or it would be resolved. It a resolved intervention, d, "I would delete it." Employee or copy care plans were kept in a updated on the paper, and I into the computer.					
	There was no way interventions were care plan needed	to determine when added to the care plan or if the to be revised.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE		STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485)4/05/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 657	On 4/5/2019 during facility Administrate were informed of the	y the end of day debriefing, the or and the Director of Nursing ne findings. The Director of interventions and revisions	F 65	7			
	document the date interventions listed Resident # 68, a 9 to the facility on 12 but were not limited Hypertension, Major	on the careplan when revised. I year old female was admitted /1/2017. Diagnoses included I to: Alzheimer's Disease, or Depressive Disorder, Reflux Disease, Dementia,					
	(MDS) was a quart Assessment Refer The MDS coded Re Interview for Menta indicating severe of # 68 was coded as of one to two staff p Living except total for Bathing. Resid	est recent Minimum Data Set erly assessment with an ence Date (ARD) of 2/21/2019. esident # 68 with a BIMS (Brief Il Status) score of "3" out of 15, ognitive impairment. Resident requiring extensive assistance persons for Activities of Daily assistance of one staff person ent # 68 was coded as ent of bowel and bladder.					
	4/4/2019. A review of Resider conducted during the care plan, revised of the care plan, revised	al record was conducted on ht # 68's clinical record was he survey. Resident #68's on 02/27/2019, read that ha diagnosis of Alzheimer's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	(B) C. D. Marcollo, D. G. C. Marcollo, M. A. Carter, A. Carter, A. A. A. Carter, A. C		
	495300	B. WING		O4	C /05/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE			STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE
Disease and demetimes. One of the "Reorient as need Another problem I foot" and " (L) (lef "Treat as ordered Ted hose per order maintain skin integt to BLE (Bilateral L day." There was no doc problems or intervicare plan under ot dates of when the added. On 04/05/19 at 10 Employee H, the M, was conducted. V determine when as implemented, Emplinterventions." Em would either contir When asked about Employee H stated the paper book on the unit, the eventually entered.	entia resulting in confusion at interventions listed was ed." isted was: "Bunion to right inner to tot skin integrity" to bunion on right inner foot. It is to bunion on right inner foot to prity, weekly weights, Aquaphor ower Extremities) every other urmentation of when the entions were added to the entions were added to the interventions were interventions were interventions were intervention on the care was ployee H stated, "We don't date ployee H state the intervention or it would be resolved. It a resolved intervention, it, "I would delete it." Employee copy care plans were kept in a pdated on the paper, and into the computer.				
Care plan needed on 4/5/2019 during	o be revised. The end of day debriefing, the				
	PROVIDER OR SUPPLIEF SE HALL KING GEO SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From p Disease and deme times. One of the "Reorient as need Another problem li foot" and " (L) (lef "Treat as ordered Ted hose per orde maintain skin integ to BLE (Bilateral L day." There was no doce problems or interv careplan. There were other i care plan under ot dates of when the added. On 04/05/19 at 10: Employee H, the N ,was conducted. V determine when as implemented, Emp interventions." Em would either contir When asked abou Employee H stated H stated the paper book on the unit, u eventually entered There was no way interventions were care plan needed i On 4/5/2019 during	A95300 PROVIDER OR SUPPLIER SE HALL KING GEORGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 63 Disease and dementia resulting in confusion at times. One of the interventions listed was "Reorient as needed." Another problem listed was: "Bunion to right inner foot" and " (L) (left) foot skin integrity" "Treat as ordered to bunion on right inner foot. Ted hose per order, treat as ordered to left foot to maintain skin integrity, weekly weights, Aquaphor to BLE (Bilateral Lower Extremities) every other day." There was no documentation of when the problems or interventions were added to the care plan under other problems. There were no dates of when the problems or interventions were	PROVIDER OR SUPPLIER SE HALL KING GEORGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 63 Disease and dementia resulting in confusion at times. One of the interventions listed was "Reorient as needed." Another problem listed was: "Bunion to right inner foot" and "(L) (left) foot skin integrity" Treat as ordered to bunion on right inner foot. Ted hose per order, treat as ordered to left foot to maintain skin integrity, weekly weights, Aquaphor to BLE (Bilateral Lower Extremities) every other day." There was no documentation of when the problems or interventions were added to the careplan. There were other interventions handwritten on the care plan under other problems. There were no dates of when the problems or interventions were added. On 04/05/19 at 10:10 AM, an interview with Employee H, the MDS/ Care Plan Coordinator ,was conducted. When asked about how to determine when an intervention on the care was implemented, Employee H stated, "We don't date interventions." Employee H state the intervention would either continue or it would be resolved. When asked about a resolved intervention, Employee H stated, "I would delete it." Employee H stated the paper copy care plans were kept in a book on the unit, updated on the paper, and eventually entered into the computer. There was no way to determine when interventions were added to the care plan or if the care plan needed to be revised. On 4/5/2019 during the end of day debriefing, the	PROVIDER OR SUPPLIER BE HALL KING GEORGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LS: DENTIFYME INFORMATION) Continued From page 63 Disease and dementia resulting in confusion at times. One of the interventions listed was: "Bunion to right inner foot" and "(L) (left) foot skin integrity" "Treat as ordered to bunion on right inner foot. Ted hose per order, treat as ordered to left foot to maintain skin integrity, weekly weights, Aquaphor to BLE (Bilateral Lower Extremities) every other day." There were other interventions were added to the careplan under other problems or intervientions were added. On 04/05/19 at 10:10 AM, an interview with Employee H, the MDS/ Care Plan Coordinator, was conducted. 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		495300	B. WING		0.4/0	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE		STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485)5/2019	
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	informed of the fir stated the interver dated. The facility provided Services Provided CFR(s): 483.21(b) §483.21(b) §483.21(b) (3) Con The services provided outlined by the mustification of the services of the professional standard redications for 1 sample of 30 Res	adings. The Director of Nursing nations and revisions should be and no further information. I Meet Professional Standards (3)(i) Imprehensive Care Plans ided or arranged by the facility, comprehensive care plan, and standards of quality. ENT is not met as evidenced ation, staff interview and clinical facility staff failed to maintain lards when administering Resident (#97) in a survey idents. the facility staff failed to no (an anti-coagulant), Daily, as	F 658		wed d. A as	
	to the facility on 6, limited to Anemia, (Alzheimer's Type Depression. The most recent I was a PPI 5 Day a reference date (A was coded as have	de: n 84 year old woman admitted /22/17 with diagnoses of but not Hypertension, Dementia) History of Stroke, Anxiety and Minimum Data Set assessment assessment with an assessment RD) of 3/12/19 Resident #97 ring a (Brief Interview of Mental re of 3, indicating severe		& Accident form will be completed for each negative finding.	or	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495300	B. WING		04/05/2019
	PROVIDER OR SUPPLIER BE HALL KING GEO			TREET ADDRESS, CITY, STATE, ZIP CODE 0051 FOXES WAY ING GEORGE, VA 22485	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY).	D BE COMPLETION
F.658	cognitive impairm as requiring 1 per aspects of ADL's for transfers. On 4/5/19 during on noted that Reside Midline Catheter (administration.). 2:30 PM. The orders read: Heparin flush 10 Legarin flush midline with Normal Saline QE. The order appear Administration Refor 6:30 AM, 2:30 daily) The first dose was 3/17/19 and continual administered three duration of the moder addition to the original saline & Heparin Continue Date That order was tired.	ent. Resident # 97 was coded son physical assistance for all and a physical assist of 2 staff and timed for medication and the orders began on 3/17/18 at a part of the orders began on 3/17/18 at a part of the force of the force of the force of the force of the orders began of the force of the orders began of the orders began of the force of the orders began of the force of the orders and the orders of the orders are and the orders. Something the force of the orders of the orders of the orders of the orders of the orders. Something the force of the orders of the orders of the orders of the orders of the orders.	F 658	Systemic Change(s): The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcribing and administering physician ordered medications per physician order. Licenstaff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for medication administration to include administering Heparin and Saline Flush orders as ordered. Monitoring: The DON is responsible for maintaining compliance. The DON and/or ADON teview medication orders weekly coinciding with the care plan calendar order to maintain compliance. Any/all negative findings will be corrected at the of discovery and disciplinary action where taken as needed. Aggregate finding of these audits will be reported to the Quality Assurance Committee quarters for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: May 20, 2019	g nsed e g mig will in ime ill iss

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	COM	E SURVEY MPLETED		
		495300	B. WING		10. 1 0. km 30	/05/2019	
	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE			STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485			
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F 658	Continued From pa then it was disconti		F 658				
	A third order was in to the Heparin Flus	itiated on 3/18/19 in addition h order.	THE CONTRACTOR OF THE CONTRACT				
	That order stated:						
	Clarification order: Normal Saline Flus Flush Midline with hours [Every 12 ho	10 ML NS [normal saline] Q 12	2				
	imitated until the 19 9:00 PM. This order	ten on the 18th but not oth and timed for 9:00 AM and or was signed off as daily for the duration of the					
	The Physicians ord	er sheet for April read:					
	Heparin flush 10 Ur Flush midline with i Normal Saline QD	leparin [an Anti-Coagulant] &					
		parin order was timed and M 2:30 PM and 10:30 PM for					
	Also on April Physic	cians Orders was:					
	Clarification order:						
	Normal Saline Flus Flush Midline with 1 hours [Every 12 ho	0 ML NS [normal saline] Q 12					
	The Normal Saline AM and 9:00 PM.	order was signed off at 9:00					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495300	B. WING	C 04/05/2019	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE		STF 100 KIN	04/03/2019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y 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)	BE COMPLETION
F 658.	many times a day flushed and stated She then elaborat 6:30 AM, Day shif does it at 10:30 Pl The facility cited L	PM LPN E was asked how does the Residents Midline get I that it was done every shift. ed that "Night shift does it at t at 2:30 PM and Evening shift M."	F 658		
F 661 SS≒D	given from Lipping which reads: To prevent medication administ medication errors an inconsistency if the right medication time of the right medication errors an inconsistency if the right dose if the right patients. The right time of the right doce if the right doce in the right d	ent: e int: e imentation ation was provided, ary b(2)(i)-(iv)	F 661	'F661 Corrective Action(s): Resident #104's attending physician been notified that the facility coeff for	has
	When the facility a must have a disch but is not limited to (i) A recapitulation includes, but is not illness/treatment radiology, and con	anticipates discharge, a resident narge summary that includes, o, the following: of the resident's stay that of limited to, diagnoses, course of or therapy, and pertinent lab,		been notified that the facility staff fai to accurately complete a discharge summary and recapitulation of Resid #104 stay at the facility. Facility Inci & Accident Form was completed for incident.	ent dent

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		E SURVEY PLETED	
	TE T	495300	B. WING_			05/2019
	PROVIDER OR SUPPLIE GE HALL KING GEO			STREET ADDRESS, CITY, STATE, ZIP CO 10051 FOXES WAY KING GEORGE, VA 22485		
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F 661	include items in p the time of the dis release to authori the consent of the representative. (iii) Reconciliation medications (both over-the-counter) (iv) A post-discha developed with th and, with the resi representative(s) adjust to his or he post-discharge pl the individual plai that have been m care and any pos non-medical serv This REQUIREM by: Based on facility clinical record rev complete a disch recapitulation of the For Resident #10 complete a disch described the clir recapitulation of the The findings inclu- Resident #104, 5 facility on 11/1/18 The resident's dia limited to, legal b	aragraph (b)(1) of §483.20, at scharge that is available for zed persons and agencies, with a resident or resident's of all pre-discharge the resident's post-discharge a prescribed and arge plan of care that is a participation of the resident dent's consent, the resident which will assist the resident to be new living environment. The an of care must indicate where as to reside, any arrangements ade for the resident's follow up t-discharge medical and ices. ENT is not met as evidenced documentation review and view, the facility failed to arge summary that included a the resident's stay. 4, the facility staff failed to arge summary that accurately lical status of the resident and a the resident's stay.	F 66	Identification of Deficient Practices/Corrective Action(s All other discharged residents been potentially affected. The ADON and/or Medical Record will review the last 30 days of residents to identify residents a residents identified at risk will corrected at time of discovery Incident & Accident form will completed for each negative fin attending physician will be not each inaccurate discharge summaranted at this time. All Definanagers and Medical Recordinserviced on the Policy and Proceedinserviced on the Policy and Proceedinserviced on the Policy and Proceedinserviced on the Policy and Proceeding of the residents stay. Monitoring: The DON is responsible for maccompliance. The DON, ADON Medical Records will perform chart audits weekly of discharge summaries and recapitulation or residents stay. Any/all negative from these audits will be corrected of discovery and disciplinary as be taken as needed. Aggregate of these audits will be reported Quality Assurance Committee for review, analysis, and recommendations for change in policy, procedure, and/or pract Completion Date: May 20, 20.	may have DON, s Clerk discharge at risk. All be and an be nding. The iffied of mary. are has s are partment s will be rocedure ammaries capitulation aintaining f and/or discharge ge of the e findings cted at time ction will e findings to the quarterly in facility ice.	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495300	B. WING		04	C /05/2019	
	PROVIDER OR SUPPLIER BE HALL KING GEO		STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485			<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 661	disease.	eficit and athsel [sic] heart	F 661				
	Data Set) (an assi (assessment refer as a 60 day asses coded as having a memory status) so cognitive impairme Resident #104 wa dependent on staf	nost recent MDS (Minimum essment tool) with an ARD ence date) of 1/1/19 was coded sment. Resident #104 was BIMS (brief interview for core of 4, indicating severe ent. Functional status for a coded as being totally for transfers, locomotion, and personal hygiene.					
	Review of the Rec dated 1/10/19 by v interdisciplinary te director, director of manager was income had no response v 1. the reason for a 2. treatment provid 3. progress 4. reason for disch 5. mental and psyc 6. cognitive status	apitulation of resident stay various members of the am to include, social services of nursing and certified dietary implete. The following items vritten: dmission ded harge/discharge diagnosis chosocial status					
	Drug therapy required order sheet) noted Review of the disciple physician on 1/15/nursing on 1/10/19 1. functional status 2. dental condition	ired had "P.O.S." (physician's on the line. harge summary signed by the 19 and signed by the director o revealed the following: s: "alert to self"					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	COV	(X3) DATE SURVEY COMPLETED C	
		495300	B. WING			
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE			STR 100 KIN	1/05/2019		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 661	Continued From p	age 70	F 661			
	explanation	tial: "limited" with no				
	sheet)	"P.O.S." [sic] (physician's order				
	6. Condition at the	time of discharge: blank				
	Summary and Pla	lity policy titled, "Discharge n" revised December 2016 rge summary will include a				
	recapitulation of the	ne resident's stay at this facility ary of the resident's status at th	e			
	regulations govern	in accordance with established ning release of resident s permitted by the resident. The				
	discharge summa the resident's: a. c	ry shall include a description of current diagnosis, b. medical				
	therapy since ente	of illness, treatment and/or ered the facility, d. current gy, consultation, and diagnosti				
	test results; e. phy	gy, consultation, and diagnosti sical and mental functional perform activities of daily living				
	g. sensory and ph nutritional status a	ysical impairments, h. and requirements, i. special				
	psychosocial statu	cedures, j. mental and us (ability to deal with life, tionships and goals, make				
	healthcare decision behavior and moo	ns, and indicators of resident d); k. discharge potential, l.				
	and desire to take	n. activities potential (the ability part in activity pursuits which ve physical, mental, and				
	psychosocial well- potential (the abilit	being); n. rehabilitation ty to improve independence in				
	functional status ti programs); o. cog	hrough restorative care nitive status (the ability to				
	of and respond to medication therap	cide, remember, and be aware safety hazards) and p. y (all prescription and nedications taken by the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495300	(X2) MULTIPLE A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C			
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F 661	administration, and effects that would be resident)." The Administrator of informed of the fact discharge summar current clinical state	age 71 dosage, frequency of I recognition of significant side oe most likely to occur in the and Director of Nursing were ility staff to complete a y that accurately describes the us of the resident and a e resident's stay on 4/4/19 at	F 661				
F 676 SS=D	S483.24(a) Based assessment of a resident's needs at provide the necess ensure that a resid daily living do not do f the individual's of that such diminution includes the facility \$483.24(a)(1) A restreatment and servor her ability to can living, including the of this section §483.24(b) Activities The facility must praccordance with pactivities of daily living including the office of the section of the section of the section of the facility must praccordance with pactivities of daily living including the section of the s	ng (ADLs)/Mntn Abilities (1)(b)(1)-(S)(i)-(iii) on the comprehensive esident and consistent with the esident and services to the end's abilities in activities of liminish unless circumstances en was unavoidable. This rensuring that: Isident is given the appropriate rices to maintain or improve his ry out the activities of daily living. The es of daily living. The estimate of the services in a cargraph (a) for the following	F 676	Corrective Action(s): Resident #55's Bowel and Bladder stath has been reassessed by the nursing department. A restorative bowel programas been established to reestablish bowe continence and the use of the commod for all bowel movements. His comprehensive care plan has been revito reflect his current bowel program. Identification of Deficient Practices Corrective Action(s): All other residents requiring toileting assistance may have potentially been affected. The DON, ADON and/or Uni Managers will review each resident's current bowel and Bladder status to include appropriate interventions to me their resident specific needs. The reside comprehensive care plans will be revisto reflect their current needs to promot maintain their current bowel and bladd function to promote continence of bow and bladder.	am vel e sed & it eet ents eed e or er		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495300	B. WING		C 04/05/2019
NAME OF F	PROVIDER OR SUPPLIER		S	REET ADDRESS, CITY, STATE, ZIP CODE	
HERITAG	E HALL KING GEOR	GE	ta a ta ta l i	1051 FOXES WAY ING GEORGE, VA 22485	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT 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 APPR DEFICIENCY)	ULD BE COMPLETION
F 676	grooming, and oral §483.24(b)(2) Mobincluding walking, §483.24(b)(3) Elim §483.24(b)(4) Dinir snacks, §483.24(b)(5) Com (i) Speech, (ii) Language, (iii) Other functiona This REQUIREME by: Based on resident review, the facility necessary care an resident's abilities idiminish for one re survey sample of 3 The facility staff fai assistance in ADL: maintain a residen #55. The findings included. Resident #55, a 55 facility on 2/1/19. included, but were	care, ility-transfer and ambulation, ination-toileting, ing-eating, including meals and imunication, including Il communication systems. NT is not met as evidenced interview and clinical record staff failed to provide d services to ensure that a in activities of daily living do not sident (Resident #55) in a it or residents. Iled to provide care and is (Activities of daily living) to it's continence for Resident	F 676	Systemic Change(s): The facility policy and procedure I been reviewed and no changes are warranted at this time. The DON a designee will provide ongoing instraining to the licensed staff and C staff to address the importance of providing assistance to residents d bowel and bladder care and accura following and maintaining a Bowel Bladder continence program. Monitoring: The DON is responsible for maint compliance. The DON and/or desi will perform weekly audits to ensutheir bowel and bladder needs are addressed. Any/all negative findin be reported to the DON for immed correction. Detail findings of thes will be reported to the Quality Ass Committee for review, analysis, as recommendations for changes in figolicy, procedure, and/or practice. Completion Date: May 20, 2019	and/or ervice NA uring ately el and aining gnee are that being gs will liate ac audits surance and acility
		st recent MDS with an ARD ence date) of 2/8/19 was coded			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILOII	TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		495300	B. WING		and the state of t	05/2019	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE				STREET ADDRESS, CITY, STATE, Z 10051 FOXES WAY KING GEORGE, VA 22485	ATE, ZIP 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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 676	coded as having a Memory Status) so resident was cognifor transfers, dress hygiene, was code extensive assistant Review of the Nurs dated 2/1/19 is code continent of bowel with Resident #55 resident stated, "I kmakes it easier for and let them know get in my chair and baseline careplan is assistance of one stoileting and is concareplan dated 2/1, "assisted toileting." Review of the "Bow 2/2/19-4/4/19 show movement on 70 of occurrences 66 of an adult brief. Surveyor A conduction 4/3/19 at approximaterview, CNA M is is continent, he has when he needs chairs.	ssessment. The resident was BIMS (Brief Interview for ore of 15, indicating the tively intact. Functional status ing, toilet use and personal das Resident #55 required ce of staff. Ing Admission Assessment led that the resident is movements. In an interview on 4/5/19 at 9:34am the know when I need to go but it everyone if I use this diaper when it needs changing. I can go to the bathroom." The indicates resident requires staff person for transfers and tinent of bowel. The CNA /19 indicates resident needs I wel & Bladder Report from red Resident #55 had a bowel of those days. Of the 70 those were incontinent, using the tated, "[Resident #55's name] is a foley, he will let me know anged, he just uses his brief."	F 6				
	made aware of the provide ADL assist	and Director of Nursing were findings of staff failing to ance to maintain bowel ident #55 during end of the /19.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495300	B. WING		C 04/05/2010		
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE			STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY KING GEORGE, VA 22485				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 676 F 684 SS=D	applies to all treatr facility residents. E assessment of a rethat residents receaccordance with p practice, the comp care plan, and the This REQUIREME by: Based on observation in the complaint investigation of the complaint investigation of the complaint investigation of the condition. It was record Resident #03/25/2019 and 15 (11.84% weight lost the facility on 05 but not limited to a	f care i fundamental principle that ment and care provided to Based on the comprehensive esident, the facility must ensure eive treatment and care in rofessional standards of prehensive person-centered residents' choices. ENT is not met as evidenced ation, resident interview, staff ecord review, and facility riew, and in the course of a ation, the facility staff failed to ure and services for one #45) in a sample size of 30 45, the facility failed to identify, provider for a potential change is documented in the clinical 45 weighed 226.4 pounds on 99.6 pounds on 04/01/2019 es in 6 days).	F 684		cred 00% ed oe ir		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 495300			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		B. WING			04/05/2019		
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL KING GEORGE			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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 684	fibrillation, and de Resident #45's m set) with an ARD 01/25/2019 was of Brief Interview for out of possible 19 cognitive impairm of more than 109 coded as "No or On 04/03/2019 a observed in his rewatching TV in months of the nurse's note than 109 coded as "No or On 04/03/2019 a record was revied dated 03/25/2019 value 226.4 pour at 11:32 AM doc indicative of an 10 The nurse's note There was no do assessing the will the nurse of the course of the	ementia. Host recent MDS (minimum data (assessment reference date) of coded as a quarterly review. The r Mental Status was coded as 9 indicative of moderate nent. Weight gain or weight loss 6 in the past 6 months was unknown." 19:10 AM, Resident #45 was com seated in his wheelchair o apparent distress. 11:43 AM, the electronic clinical wed for weight status. An entry 9 at 1:49 PM documented the nds. An entry dated 04/01/2019 umented the value 199.6 pounds 1.84% weight loss in 6 days.		684	Systemic Change(s): The facility policy and procedures hav been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by th 24 Hour Report and documentation in medical record /physician orders rema the source document for the developm and monitoring of the provision of carwhich includes, obtaining accurate weights per MD order. The DON and/Regional nurse consultant will inservice all licensed nursing staff and C.N.A. so on the procedure for obtaining physici ordered weights and the review proces by the QA nurse for physician notificate weight changes. Monitoring: The DON will be responsible for maintaining compliance. The DON and QA nurse will perform weekly review all weekly weights to monitor for compliance. Any/all negative findings or errors will be corrected at time of discovery and disciplinary action will taken as needed. Aggregate findings these audits will be reported to the Quality Assurance Committee quarter for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: May 20, 2019	e the ins ent e, /or ce taff an ss ation	