STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495179	A. BUILDING _____ B. WING _____	C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POTOMAC FALLS HEALTH & REHAB CENTER	46531 HARRY BYRD HIGHWAY STERLING, VA 20164

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 12/3/19 through 12/5/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. 3 complaints were investigated during the survey. The census in this 150 certified bed facility was 143 at the time of the survey. The survey sample consisted of 5 current Resident reviews (Resident #1 through Resident #5) and 1 closed record review (Residents #6).	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		1/6/20

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

Electronically Signed | 12/20/2019

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

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F 609	Continued From page 1 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record review, and in the course of a complaint investigation, the facility staff failed to report an allegation of abuse to the State Agency (Office of Licensure and Certification) for 1 (Resident #1) of 6 residents in the survey sample. The findings included: Resident #1 was admitted to the facility on 05/23/2011. Diagnoses included but were not limited to, Unspecified Dementia Without Behavioral Disturbance and Major Depressive Disorder. Resident #1's Quarterly Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 11/26/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #1 as requiring extensive assistance of 1 for bed mobility, transfer, dressing, toilet use and personal hygiene, and physical help of 1 limited to transfer only with bathing. On 12/03/2019 at approximately 4:45 p.m., an interview was conducted with the Administrator and when he was asked for information concerning an incident of a certified nursing assistant (CNA) #2 pouring hot water on Resident #1, the Administrator stated, "At the last care plan	F 609	1. The two Facility Reportable Incidents report forms were submitted on 12/4/2019 for Resident number #1 after the administrator was made aware of abuse allegations. 2. Any resident has the potential to be negatively affected if the center staff fails to implement the abuse policy for the reporting of allegations of abuse. A review of progress notes for 72 hours will be conducted to identify any allegation or statement that indicates need for further investigation or reporting. 3. Director of Nursing (DON) or designee will provide in-service education/training to all staff members regarding reporting incidents related to abuse reporting guidelines so that any alleged violation can be reviewed by the Administrator and or designee to ensure timely reporting. 4. Director or Nursing (DON) or designee will audit 24 hour report to identify any allegation or statement that indicates need for further investigations or reporting daily for 4 weeks, weekly x 2 weeks then monthly x 2 months.	

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meeting the resident's daughter stated that about a year ago that an aide had left her mother (Resident #1) sitting on the toilet and she (the resident's daughter) had to wash her mother's bottom with toilet water. She was unsure of the aide's name, thought it was (Name)." The Administrator stated that he would look and see if there was any information.

On 12/04/2019 at 12:30 p.m., an interview was conducted with the Administrator and when he was asked if he located any records concerning an incident between CNA #2 and Resident #1, the Administrator stated, "I don't have anything concerning the resident and the CNA." The Administrator stated, "There was an issue with the hot water not working in the shower but no complaint of a staff member pouring hot water on the resident."

An interview was conducted with Resident #1 on 12/04/2019 at 1:00 p.m., when she was asked if anyone had poured hot or cold water on her, Resident #1 stated, "Yes, (CNA #2)." Resident #1 stated, "I had diarrhea, large diarrhea, and I was in my wheel chair. (CNA #2) filled up the bowl with hot water, I was sitting on the toilet and she poured the hot water on me to wash the diarrhea off. I told (CNA #2) that the water was hot. (CNA #2) then poured cold water on me." (Resident #1 motioned with her hands that the CNA poured the water down in the front of between her thighs.) Resident #1 then stated that she was sitting on the toilet by herself and raised up and lifted the toilet seat up and sat down in the toilet bowl and splashed water from the toilet bowl up to wash her vaginal area. The Surveyor tried to clarify with Resident #1 if she was in the bathroom alone or if the CNA was still present, but was unable to

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clarify. Resident #1 stated that she gathered up the dirty pads from her wheel chair and placed them in the garbage. When Resident #1 was asked if she had ever had an injury to her pinky finger on her right hand, Resident #2 stated, "No."

On 12/04/2019 at 3:00 p.m., an interview was conducted over the telephone with the previous Unit Manager. An email that had been sent to her from Resident #1's daughter (Responsible Party) dated August 11, 2019 was read to her as follows: "(Previous Unit Manager Name), The last time we spoke on July 29th I explained to you about (CNA #2's) behavior towards my mother. I explained on July 28th my mother had diarrhea. I had to call the (Nurse Name) for help and (Nurse Name) told my mother she could not help her. Therefore, (Nurse Name) got (CNA #2) who did not have any patience to deal with my mother. When my mother asked (CNA #2) for help washing the diarrhea off my Mom (CNA #2) filled a bowl with hot water and poured it on my mother. When my mother screamed and complained the water was too hot then (CNA #2) filled the bucket with cold water and poured it on my mother. When my mother told (CNA #2) the water was too cold, (CNA #2) put the bucket back in my mother's dresser and left my mother to attend to herself. As my Mom tried to clean herself, she had diarrhea stuck in her vaginal area. When I asked my mother what did she do to clean herself off? She told me she had to take the water from the toilet to clean her vaginal area and struggle to get off the toilet seat by herself and transfer herself to her wheel chair. Fast forward today, as (CNA #2) was trying to help my mother get in bed, as (CNA #2) was helping my mother remove her skirt over her head, my mother complained that (CNA #2)

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was very rough as she was removing the skirt off, over my mother's head, the pinky finger on my mother's right hand got sprained and it felt like (CNA #2) was choking my (?) around the neck with her skirt. (Name of Previous Unit Manager), please be advised, (CNA #2) has been removed from my mothers care a year before but now (Administrator's Name) is adamant about putting (CNA #2) back on my mothers care team. But once again, I am asking for (CNA #2) to be removed. (CNA #2) lacks the skills, patience and ability to handle a sick, disabled patient who is in need of her assistance."

When the previous Unit Manager was asked if she remembered the email, the previous Unit Manager stated, "Yes." The email was sent on a Sunday. When asked if she was working on that Sunday, the previous Unit Manager stated, "No, I opened the email up on Monday." When asked if she filled out a incident report, the previous Unit Manager stated, "No, typically we did not fill out a incident report on concerns that a family reported." The previous Unit Manager stated, "I forwarded the email to (Previous Director of Nursing Name)." When asked if she checked Resident #1's skin, the previous Unit Manager stated, "No, I did not." The previous Unit Manager stated, "(Previous Director of Nursing Name) and I spoke to (CNA #2). (CNA #2) helped clean (Resident Name) off. Hard to gauge the water temperature, water doesn't usually get that hot. (CNA #2) used a basin to clean the resident. We spoke to (CNA #2) about checking the water temperature to make sure they are adequate." When asked if she documented the conversation with (CNA #2), the previous Unit Manager stated, "No, just verbal education." When asked if there was any further investigation she stated, "No, can't remember."

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An interview was conducted with CNA #2 on 12/04/2019 at 3:10 p.m., and when she was asked if she assisted Resident #1 when she had a diarrhea stool and poured water on her to clean her up and the resident stated the water was too hot and then poured cold water on her, CNA #2 stated, "No." When asked if Resident #1 had complained to her of being rough while providing her care and injuring her pinky finger on her right hand, CNA #2 stated, "No." CNA #2 stated, "Two (2) staff go in together to care for (Resident Name). CNA #2 stated, "(Resident Name) told me that my mother is a b****." When asked if she said anything back to the resident, CNA #2 stated, "No. I reported the resident talking to me like that to Registered Nurse (RN #1), House Supervisor." When asked if she had training on working with residents with Dementia, CNA #2 stated, "Yes."

On 12/04/2019 at 3:45 p.m., an interview was conducted via telephone with the previous Director of Nursing (DON), when she was asked if she remembered receiving an email from the previous Unit Manager dated August 11, 2019 concerning an alleged incident that occurred on July 28, 2019 involving (CNA #2 and Resident #1), the previous DON stated, "No, my last day at the facility was on Friday July 26, 2019." When asked what she would do if someone reported an allegation of abuse, the previous DON stated, "I would make sure the resident was safe, report it to the Administrator and have 2 hours to report it to the state."

On 12/04/2019 at approximately 4:00 p.m., the email dated August 11, 2019 that Resident #1's daughter had sent to the previous Unit Manager

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was reviewed with the Administrator. The Administrator was made aware of the telephone interviews with the previous Unit Manager and DON. The Administrator stated, "No one knows about it. I will do a FRI (facility reported incident)."

On 12/04/2019 at approximately 5:00 p.m., copies of the completed FRI's regarding CNA #2 and Resident #1 were provided to the Surveyor.

On 12/04/2019 at approximately 5:30 p.m., a copy of Abuse and Neglect Certificate of Completion dated 05/06/2019 and a signed Acknowledgement of Mandated Reporter Status dated 07/06/2015 for the previous Unit Manager was received. A copy of Abuse and Neglect Certificate of Completion dated 05/23/2019 and a signed Acknowledgement of Mandated Reporter Status dated 02/07/2018 for CNA #2 was received.

On 12/05/2019 at approximately 11:00 a.m., the above concern was reviewed with the Administrator, Director of Nursing and Corporate Clinical Services Specialist. The facility did not present any further information about the finding.

The facility policy titled - Abuse Prevention

Policy Statement: The facility is committed to maintaining a safe and abuse-free environment for all residents and committed to a comprehensive investigation of any allegation of activities or situations that may constitute abuse. Corrective and preventive action to minimize recurrence will be developed and implemented on an individual resident and on a facility basis. Outside agencies, including regulatory agencies,

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F 609	Continued From page 7 ombudsman, protective services, police, etc. will be notified and involved as appropriate to the situation. This is a complaint deficiency.	F 609		