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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. BUILDING _____ B. WING _____	C 12/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 12/30/2019. Three complaints [VA00047387, VA00047472 and VA00047328] were investigated during the survey and unsubstantiated. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirement(s). The census in this 180 certified bed facility was 161 at the time of the survey. The survey sample consisted of six current resident reviews (Residents #1 through #4, #6, and #7) and one closed record review (Resident #5).	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to implement an accurate policy for the immediate reporting of all allegations of abuse for two of seven residents, Resident #1 and Resident #7. The facility failed to ensure the abuse policy was	F 607	F607 1. Facility will modify current policy to emphasize immediate (or within 2 hours) reporting of allegation of abuse according to regulations. 2. Each resident has the potential of being affected. 3. Staff will be re-educated on reporting allegations involving abuse or result in serious bodily injury no later than 2 hours after the allegation	1/25/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacie Shue LNHA
TITLE: Executive Director
(X6) DATE: 1/17/2020

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 607	Continued From page 1 developed and implemented to include immediate (or within two hours), reporting of all allegations of abuse according to regulations. A facility reported incident documented Resident #1 pushed Resident #7 to the floor and documented the incident as occurring on 9/20/19 at 10:00 PM. The facility fax documented reporting of the incident to VDH-OLC (Virginia Department of Health-Office of Licensure / Certifications) on 9/21/19 at 2:41 PM. The findings include: Resident #1, the aggressor, was admitted to the facility on 10/5/18 with diagnosis that included but were not limited to: tachycardia [abnormally rapid heart rate. (1)]; dementia [progressive state of mental decline, often accompanied by disorientation (2)], and mitral valve prolapse [mitral valve leaflets bulge into the left atrium when the left ventricle contracts, sometimes allowing leakage of small amounts of blood into the atrium (3)]. Resident #1's most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/4/19, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. Resident #7, the recipient, was admitted to the facility on 8/3/18 with diagnosis that included but were not limited to: bipolar (mental disorder characterized by periods of mania and depression) (4), dementia (progressive state of mental decline, often accompanied by disorientation) (5), and Hypertension (high blood pressure) (6). Resident #7's most recent MDS (minimum data set) assessment, a quarterly	F 607	is made, or no 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 other officials. 4. Audits will be conducted to ensure allegations involving abuse or result in serious bodily injury will be reported no later than 2 hours after the allegation is made, or no 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 other officials weekly times 10 weeks. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance. Compliance Date: 1/25/2020	

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F 607	Continued From page 2 assessment, with an ARD (assessment reference date) of 9/30/19, coded the resident as scoring an 8 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired cognitively. The facility policy dated 2/2017, titled "Resident Abuse-Resident to Resident" documents abuse as "willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or pain, or mental anguish." The Elder Justice Act portion (dated 1/2017) of the facility's abuse policy documents, "If the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately, but not later than two hours after forming the suspicion. If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion immediately, but not later than 24 hours after forming the suspicion." The facility's final investigation, dated 9/21/19, of the abuse / mistreatment regarding Resident #1 and Resident #7 concludes, "Based on the investigation, it is confirmed that 'Resident #1' pushed 'Resident #7' to the floor substantiating the allegation of abuse/mistreatment." An interview was conducted on 12/30/19 at 2:15 PM with ASM (administrative staff member) #2, the director of nursing, regarding abuse. ASM #2 stated, "If there is physical emotional or sexual touching or intimidation, that's abuse." When asked if one resident pushing another resident was abuse, ASM #2 stated, "Yes, that is abuse." When asked about the required reporting for allegations of abuse, ASM #2 stated, "Immediately report to the physician, nurse	F 607		

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F 607	Continued From page 3 practitioner, RP (responsible party), the State and APS (adult protective services)." When asked the time frame for reporting allegations of abuse, ASM #2 stated, "I believe within 24 hours if no serious injury." Administrative staff members (ASM) # 1, the administrator and (ASM) # 2, the director of nursing, were made aware of the above concerns on 12/30/19 at 4:20 PM. ASM #1 stated, "We follow our policy for reporting and I believe we have 24 hours to report if there is no injury." No further information was provided prior to exit.	F 607		