PRINTED: 09/23/2020 FORM APPROVED

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495300	B. WING		09/10/2020
	ROVIDER OR SUPPLIER FE HALL KING GEORG	E	10	TREET ADDRESS, CITY, STATE, ZIP CODE 9051 FOXES WAY ING GEORGE, VA 22485	03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDEFICIENCY)	D BE COMPLETIO
E 000	Initial Comments		E 000		
	9-10-2020. The factoring street with 42 preparedness regulation. The Centers for Me	sed Emergency Preparedness sted onsite 9-9-2020 through clity was in substantial CFR Part 483.73 emergency lations, and has implemented dicare & Medicaid Services ease Control recommended of for COVID-19.			
	The census in this 189 at the time of the	30 certified bed facility was			Ī
F 000	INITIAL COMMENT		F 000	e e	
	Control Survey and was conducted 9-9-	COVID-19 Focused Infection Abbreviated complaint survey 2020 through 9-10-2020. Lired for compliance with 42 ral Long Term Care			
200	483.80 infection con implemented The Co Medicaid Services a Control recommenda	was not cited at 42 CFR Part trol regulations, and has enters for Medicare & nd Centers for Disease ed practices to prepare for aplaint was investigated	S S S	F607 Corrective Action(s): A thorough investigation of resident allegation of staff abuse has been completed. An FRI has been completed and appropriate notification of state ager has taken place.	1
	89 at the time of the consisted of 4 Resid #2, #3, #4).	30 certified bed facility was survey. The survey sample ent reviews (Residents #1,	SECTIVE SECTIVE	Corrective discipline, if indicated by findings of the investigation, has bee completed. Findings of the investigation reported to the appropriate agencies.	en ition
F 607	Develop/implement / CFR(s): 483,12(b)(1)	Abuse/Neglect Policies I-(3)	F 607	Resident #2's attending physician an responsible party have been made as of the incident and an incident/accident	vare
1	11.00.00017	ty must develop and licies and procedures that: SUPPLIER REPRESENTATIVE'S SIGNATURE		form has been completed.	1 1 1

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 e 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

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Event ID: 383511

Facility IC: VA0103

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495300			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		E SURVEY APLETED C 9/10/2020	
	ROVIDER OR SUPPLIER E HALL KING GEORGE		100	REET ADDRESS, CITY, STATE, ZIP CODE 051 FOXES WAY NG GEORGE, VA 22485		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	neglect, and exploita misappropriation of r §483.12(b)(2) Establ to investigate any sur §483.12(b)(3) Include paragraph §483.95, This REQUIREMENT by: Based on staff interview, and in the coinvestigation, the fact their abuse policy for a survey sample of 4. The findings included For Resident #2, the implement their abuse allegation of abuse at Resident from their a course of an investigation with hypoxia, major dichronic pain syndrom Resident #2's most re (MDS) with an Assess (ARD) of 03/12/2020 assessment. Resident BIMS (brief interview)	it and prevent abuse, tion of residents and esident property, ish policies and procedures challegations, and a training as required at is not met as evidenced riew, facility documentation urse of a complaint a resident (Resident #2) in Residents. It: facility staff failed to implement a Resident (Resident #2) in Residents. It: facility staff failed to e policy by not reporting an and failure to protect the alion. Initted to the facility on moses including but not posis, acute respiratory failure epressive disorder, and it. Initted to the facility on moses including but not posis, acute respiratory failure epressive disorder, and it. In it was coded as a quarterly it is a was coded as a quarterly it is a was coded as having a for mental status) score of esident #2 was cognitively	F 607	Identification of Deficient Prace Corrective Action(s): All residents may have been pote affected. A 100% review of all F Incident & Accident Forms for the previous 60 days has been review identify residents at risk. Any/all negative findings of reportable occurrences identified will be revenue an FRI has been complete internal investigation with appropriation of outcomes to the Stagencies, attending physician and responsible parties has occurred. Systemic Change(s): The Policy & Procedure for report investigating abuse, neglect, misappropriation of resident proptinjuries or unusual/unknown occurred has been reviewed. No changes at warranted at this time. All staff will be inserviced and issucopies of the Abuse and Investigat Policy and Procedure. These educinservices will focus on preventio identifying, reporting, and investigated and allegations of abuse or mistreatment of residents that a reported. As well as resident to realtercations and misappropriation resident property that are reported. Monitoring: The Administrator is responsible to compliance. All resident to reside incidents, resident abuse and negle allegations, unusual occurrences a injuries of unknown originwill be reported via FRI and thoroughly investigated/reviewed by the administrator.	entially Pacility ne ved to d and an oriate ate ting and mertyand	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495300	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C	
NAME OF D	ROVIDER OR SUPPLIER	433300			1 0	9/10/2020
DESCRIPTION OF THE PROPERTY OF	HALL KING GEORGE		-63	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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	dressing, eating toiled On 9/9/2020 Surveyor provide all FRI's (facing grievances for the part documents revealed Resident #2's grievant staff member. On 9/9/2020 during the Administrator provide ring binder and stated use". Review of the office and stated use". Review of the office and the submitted. The form complained that one shatched an inhaler fiscratching his palm. nurse hit him but recassed which part of hindicated "date complained that complained that one shatched an inhaler fiscratching his palm. nurse hit him but recassed which part of hindicated "date complained that complained that one shatched an inhaler fiscratching his palm. On 9/9/2020 at 5:39 Fithe Administrator to end Administrator stated, keep if I look into it I know the I look into it I k	for bed mobility, transfers, ting and personal hygiene. or A asked the facility to lity reported incidents) and ast year. Review of these no information about note of being abused by a see late morning the facility of Surveyor A with a red 3 d, "these are for internal documents revealed a sted 12/12/2019 which had not grievance logs previously stated, "Resident #2 of the nurses (LPN C) from his hand and ended up Resident #2 also said the anted that statement when I have been stated to the state, he seed if he considered this an e said "yes". When asked if exported, the Administrator A asked if it was reported said "this wasn't, when I	F 607		Vice sure ve been ttending gencies have ny negative time of tor will of all low-up ained. All investigated. eported to the tee for review, ons for , and/or	
	heard of it I had passo decided to investigate addressed it". When	ed the reporting period. I and based on the findings I asked if the alleged				

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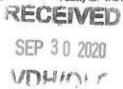


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVE COMPLETED	
		495300	B. WING			C 9/10/2020
	ROVIDER OR SUPPLIER E HALL KING GEORGE		1005	EET ADDRESS, CITY, STATE, ZIP COD 1 FOXES WAY G GEORGE, VA 22485		3/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	from the premises who being conducted, the changed her assignmed Resident #2". The algorithm on the premises and access to Resident # abuse while an invest determine if abuse has determine if abuse has revealed no document abuse or any staff resident who was a staff of the change of the clinical revealed no document abuse or any staff resident who was a staff of the conducted with RN A abuse policy/process had been mistreated A stated, "I would immare ok, I would separ needed, intervene and chain of command. It is report to the state [restated, "the Director of the stated, "the Director of the unable to reach them then I would file the mext steps, RN A state but I would send the conducted with LPN C was aware of Resident #2 made. Labused or mistreated asked if she was susy while an investigation."	was suspended or removed hile the investigation was administrator stated "no, we nent to not take care of leged perpetrator remained therefore continued to have 2 following an allegation of tigation was ongoing to ad occurred. Trecord for Resident #2 hattion of the allegation of sponse. To AM an interview was a RN a was asked about the if a Resident reported they by a staff member, and RN mediately make sure they atte them and whomever if d make sure to report to the We have a 2 hour window to When asked who makes the ferring to the OLC], RN A of Nursing, Administrator or Nursing, I've never been but if I can not reach them eport". When asked the ed "I've never had it happen	F 607			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495300 B. WING 09/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10051 FOXES WAY HERITAGE HALL KING GEORGE KING GEORGE, VA 22485 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 4 F 607 removed from the assignment of Resident #2 and that Resident #2 had approached the musing station following the incident trying to apologize but she didn't engage in conversation with the Resident. Review of the facility policy titled, "Abuse, Neglect and Exploitation Preventing and Reporting" stated, "The Administrator, Director of Nursing or facility appointed designee should report allegations or suspected abuse, neglect or exploitation immediately to: Administrator, OLC, other state Agencies in accordance with state law". "8. The facility will make efforts to protect all residents after alleged abuse, neglect and/or exploitation". "13 c. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in process". The facility Administrator was made aware of the concerns during the end of day meetings held on 9/9/2020 and again on 9/10/2020. F609 Corrective Action(s): No further information was provided. A thorough investigation of resident #2's allegation of staff abuse has been COMPLAINT DEFICIENCY. completed. F 609 F 609 Reporting of Alleged Violations An FRI has been completed and CFR(s): 483.12(c)(1)(4) SS=D appropriate notification of state agencies has taken place. §483.12(c) In response to allegations of abuse, Corrective discipline, if indicated by the neglect, exploitation, or mistreatment, the facility findings of the investigation, has been must: completed. Findings of the investigation have been reported to the appropriate agencies. §483.12(c)(1) Ensure that all alleged violations Resident #2's attending physician and involving abuse, neglect, exploitation or responsible party have been made aware mistreatment, including injuries of unknown of the incident and an incident/accident source and misappropriation of resident property, form has been completed. are reported immediately, but not later than 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING	
		495300	B. WING		C 09/10/2020
	PROVIDER OR SUPPLIER	GE	1005	EET ADDRESS, CITY, STATE, ZIP CODE 1 FOXES WAY G GEORGE, VA 22485	1 03/10/2020
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
F 609	hours after the all that cause the alles serious bodily injusted events that cause and do not the administrator officials (including adult protective set for jurisdiction in leaccordance with sprocedures. §483.12(c)(4) Reginvestigations to the designated represaccordance with Survey Agency, wincident, and if the appropriate correct This REQUIREMED by: Based on staff infacility documental complaint investigation facility documental complaint investigation in the stage of the sesidents. The findings inclusive for Resident #2, an allegation of all of Licensure and of Protective Services. Resident #2 was a 09/27/2020 with delimited to Spinal signal and the services are serviced.	egation is made, if the events egation involve abuse or result in lary, or not later than 24 hours if lause the allegation do not involve result in serious bodily injury, to of the facility and to other to the State Survey Agency and ervices where state law provides ong-term care facilities) in State law through established fort the results of all the administrator or his or her sentative and to other officials in State law, including to the State within 5 working days of the etalleged violation is verified etive action must be taken. ENT is not met as evidenced terview, clinical record review, tion, and in the course of a lation, the facility staff failed to on of abuse to state agencies for lent #2) in a survey sample of 4 ded: the facility staff failed to report ouse to the state agency (Office Certification (OLC)) and Adult	F 609	Identification of Deficient Prace Corrective Action(s): All residents may have been pote affected. A 100% review of all F Incident & Accident Forms for the previous 60 days has been review identify residents at risk. Any/all negative findings of reportable occurrences identified will be revensure an FRI has been completed internal investigation with appropentification of outcomes to the Stagencies, attending physician and responsible parties has occurred. Systemic Change(s): The Policy & Procedure for reportinvestigating abuse, neglect, misappropriation of resident propinjuries or unusual/unknown occur has been reviewed. No changes at warranted at this time. All staff will be inserviced and issecopies of the Abuse and Investigating and Procedure. These eductinservices will focus on prevention identifying, reporting, and investigating incidents and allegations of abuse, or mistreatment of residents that at reported. As well as resident to resident property that are reported. Monitoring: The Administrator is responsible for compliance. All resident to resident incidents, resident abuse and negleallegations, unusual occurrences at injuries of unknown origin will be reported via FRI and thoroughly investigated/reviewed by the administrator.	intially facility are red to diewed



STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		OF CORRECTION IDENTIFICATION NUMBER: A. BU		(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY IPLETED
		495300	B. WING			9/10/2020
	ROVIDER OR SUPPLIER		100	REET ADDRESS, CITY, STATE, ZIP COD 051 FOXES WAY NG GEORGE, VA 22485		5/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 609	(MDS) with an Asset (ARD) of 03/12/202 assessment. Reside BIMS (brief intervier 15, which indicated intact. Resident #2 required supervision dressing, eating toil On 9/9/2020 Survey Administrator to produce the progression of the progression	recent Minimum Data Set essment Reference Date 0 was coded as a quarterly ent #2 was coded as having a w for mental status) score of Resident #2 was cognitively was coded as having n for bed mobility, transfers, leting and personal hygiene. yor A asked the facility evide all Facility Reported the past year and all least year. There was no FRI	F 609	The findings of those investible reviewed by the Regional President of Operations to elappropriate investigations had completed and that the RP, a physicians and appropriate abeen notified as required. At findings will be corrected at discovery and the administrate receive disciplinary action a Confidential files of all reported and all follow-up documents maintained. All incidents we thoroughly investigated. Agfindings will be reported to a Assurance Committee for reanalysis, and recommendation changes in policy, procedure facility practice. Completion Date: 10/15/20	I Vice insure ave been attending agencies have ny negative itime of ator will as warranted, orted incidents ation will be gregate the Quality eview, ons for e, and/or	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	INSTRUCTION		E SURVEY MPLETED
		495300	B. WING		05	9/10/2020
	ROVIDER OR SUPPLIER E HALL KING GEORG	E	1005	ET ADDRESS, CITY, STATE, ZIP CO 1 FOXES WAY 3 GEORGE, VA 22485		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 609	report to the state [stated, "the Director of unable to reach the then I would file the On 9/9/2020 at 5:30 the Administrator to Administrator state keep if I look into it records". The Adm allegations were re responded "no". I a allegation of abuse it should have beer said "yes". Survey and the Administrat heard of it I had pai decided to investiga addressed it". Review of the facilit and Exploitation Pr stated, "The Admin facility appointed de allegations or suspe exploitation immedi other state Agencie law". The facility Administ concerns regarding allegation of abuse	When asked who makes the referring to the OLC], RN A or of Nursing, Administrator or of Nursing, I've never been are but if I can not reach them, a report". PM when Surveyor A asked of explain the red binder, the did, "this is our grievance book, I I keep records for our internal inistrator was asked if these ported to the state, he asked if he considered this and, he said "yes". When asked if it reported, the Administrator for A asked if it was reported for said "this wasn't, when I asked the reporting period. I hate and based on the findings I was policy titled, "Abuse, Neglect eventing and Reporting" istrator, Director of Nursing or esignee should report exted abuse, neglect or eately to: Administrator, OLC, as in accordance with state of the failure to report the for Resident #2 during the sheld on 9/9/2020 and again	F 609			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495300			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		B. WING		09/10/2020	
	PROVIDER OR SUPPLIER SE HALL KING GEORGE		1005	EET ADDRESS, CITY, STATE, ZIP CODE 51 FOXES WAY G GEORGE, VA 22485	1 03/10/2020
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 609 F 908 SS=D	COMPLAINT DEFICE Essential Equipment CFR(s): 483.90(d)(2) §483.90(d)(2) Maintal and patient care equi- condition. This REQUIREMENT by: Based on staff intervial facility documentation complaint investigation maintain care equipm #4) in a survey samp The findings included Resident #4 was adm 07/14/2018 with diag limited to benign neo- chronic diastolic cong major depressive dis Resident #2's most re (MDS) with an Asses (ARD) of 06/24/2020 assessment. Residen BIMS (brief interview 15, which indicated Fintact. Resident #4 w required limited assis personal hygiene and On 9/9/2020 Surveyor record of Resident #4 Administration Recor orders. There was a	IENCY. , Safe Operating Condition ain all mechanical, electrical, ipment in safe operating If is not met as evidenced view, clinical record review, n, and in the course of a con, the facility staff failed to ment 1 Resident (Resident ele of 4 Residents. It: mitted to the facility on moses including but not plasm of ascending colon, gestive heart failure, and order. ecent Minimum Data Set is ment Reference Date was coded as a quarterly ent #4 was coded as having a for mental status) score of Resident #4 was cognitively was coded as having stance of staff for transfers,	F 609	F908 Corrective Action(s): Resident #4's attending physician has been notified that the sequential compression device ordered for administration BID was not applied as ordered on 8/19/20, 8/20/20, 8/22-28/due to the device not working. Identification of Deficient Practices Corrective Action(s): All residents to may have been potent affected. A 100% review of all reside for the past 30 days has been complete identify residents who had physician ordered treatment equipment which w inoperable. Any/all negative findings have been addressed through physician notificat physician initiated change in orders or repair/replacement of the inoperable equipment. Systemic Change(s): All nursing staff have been inserviced the procedure for reporting inoperable equipment; physician notification of inoperable equipment; and vendor notification for repair/replacement of the equipment.	and ially int's ed to ras tion,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		495300	B. WING		09/10/202	20
	ROVIDER OR SUPPLIER E HALL KING GEORG	E	100	REET ADDRESS, CITY, STATE, ZIP CODE 51 FOXES WAY IG GEORGE, VA 22485	03/10/202	.0
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPL	K5) PLETION ATE
F 908	for one hour twice a 2020 revealed that device was not sign 8/19/2020- note inc 8/20/2020- note inc 8/23/2020- note reamet" 8/22/2020- note reamet" and "was held 8/24/2020- note reamet" 8/25/2020- note inc and another note reamet" 8/26/2020- note reamet" 8/26/2020- note reamet" 8/28/2020- note reamet and the bing administer recalled they had to then had to replace added that this is not maintenance is able the supply company 0n 9/9/2020 in the assurption of the SCD replacement and the leg garments portion day. A second doct	es to bilateral lower extremities a day]." The TAR for August on the following dates the ned off as being administered: dicated "on hold til repaired" ad "Special requirement not dicated "Broken" ad "Special requirement not dicated "SCD not available" ad, "Out of order" ad "Special requirement not now and Assistant Director of the nasked about the SCD's ared the ADON stated that she or replace the hose twice and the machine. The ADON to equipment that the facility at to repair so they have to call	F 908	Monitoring: The Director of Nursing is responsible to the DON/designce will conduct week reviews of all physician ordered to equipment to ensure it is functional. Negative findings will addressed at the time of discovery Aggregate findings will be reported Quality Assurance Committee for analysis, and recommendations for changes in policy, procedure, and facility practice. Completion Date: 10/15/2020	be /. ed to the review,	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495300				PLE CONSTRUCTION G	0	(X3) DATE SURVEY COMPLETED	
		B. WING			C 09/10/2020		
HERITAGI	ROVIDER OR SUPPLIER E HALL KING GEORGI			STREET ADDRESS, CITY, STATE, ZIP CO 10051 FOXES WAY KING GEORGE, VA 22485	ODE	09/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 908	called the supplier a for the SCD machin concern that from 8 facility staff had bee #4 with the SCD's a due to the equipme had no evidence of 6 days to make any "on the 24 hour rep [garments] they did working". During the end of dand again on 9/10/2 and DON were made	again and requested a pump he. Surveyor A shared the l/22/2020 to 8/28/2020 the en unable to provide Resident his ordered by the physician int being broken. The facility any measures being taken for repairs. Employee E stated, ort they had it was the hose had tell me it was the pump not have meetings held on 9/9/2020 held to be a stated of the concern of held the	F 96	08			

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