STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted onsite 9-9-2020 through 9-10-2020. The facility was in substantial compliance with 42 CFR Part 483.73 emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 130 certified bed facility was 89 at the time of the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced A COVID-19 Focused Infection Control Survey and Abbreviated complaint survey was conducted 9-9-2020 through 9-10-2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. However, the facility was not cited at 42 CFR Part 483.80 infection control regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. One complaint was investigated during the survey. The census in this 130 certified bed facility was 89 at the time of the survey. The survey sample consisted of 4 Resident reviews (Residents #1, #2, #3, #4).	F 000		
F 607 SS=D	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:	F 607	**F607** **Corrective Action(s):** A thorough investigation ofresident #2's allegation of staff abuse has been completed. An FRI has been completed and appropriate notification of state agencies has taken place. Corrective discipline, if indicated by the findings of the investigation, has been completed. Findings of the investigation have been reported to the appropriate agencies. Resident #2's attending physician and responsible party have been made aware of the incident and an incident/accident form has been completed.	

VDH/OLC SEP 30 2020 RECEIVED

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 9/30/20

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 §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 staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to implement their abuse policy for 1 Resident (Resident #2) in a survey sample of 4 Residents. The findings included: For Resident #2, the facility staff failed to implement their abuse policy by not reporting an allegation of abuse and failure to protect the Resident from their alleged abuser during the course of an investigation. Resident #2 was admitted to the facility on 09/27/2020 with diagnoses including but not limited to Spinal stenosis, acute respiratory failure with hypoxia, major depressive disorder, and chronic pain syndrome. Resident #2's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/12/2020 was coded as a quarterly assessment. Resident #2 was coded as having a BIMS (brief interview for mental status) score of 15, which indicated Resident #2 was cognitively intact. Resident #2 was coded as having	F 607	**Identification of Deficient Practices and Corrective Action(s):** All residents may have been potentially affected. A 100% review of all Facility Incident & Accident Forms for the previous 60 days has been reviewed to identify residents at risk. Any/all negative findings of reportable occurrences identified will be reviewed to ensure an FRI has been completed and an internal investigation with appropriate notification of outcomes to the State agencies, attending physician and responsible parties has occurred. **Systemic Change(s):** The Policy & Procedure for reporting and investigating abuse, neglect, misappropriation of resident propertyand injuries or unusual/unknown occurrences has been reviewed. No changes are warranted at this time. All staff will be inserviced and issued copies of theAbuse and Investigation Policy and Procedure. These educational inservices will focus on prevention, identifying, reporting, and investigating incidents and allegations of abuse, neglect or mistreatment of residents that are reported. As well as resident to resident altercations and misappropriation of resident property that are reported. **Monitoring:** The Administrator is responsible for compliance. All resident to resident incidents, resident abuse and neglect allegations, unusual occurrences and injuries of unknown originwill bc reported via FRI and thoroughly investigated/reviewed by the administrator.	

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F 607	Continued From page 2 required supervision for bed mobility, transfers, dressing, eating toileting and personal hygiene. On 9/9/2020 Surveyor A asked the facility to provide all FRI's (facility reported incidents) and grievances for the past year. Review of these documents revealed no information about Resident #2's grievance of being abused by a staff member. On 9/9/2020 during the late morning the facility Administrator provided Surveyor A with a red 3 ring binder and stated, "these are for internal use". Review of the documents revealed a "Grievance Form" dated 12/12/2019 which had not been logged on the grievance logs previously submitted. The form stated, "Resident #2 complained that one of the nurses (LPN C) snatched an inhaler from his hand and ended up scratching his palm. Resident #2 also said the nurse hit him but recanted that statement when I asked which part of his body was hit" and indicated "date complaint/grievance occurred: 12/11/2019". On 9/9/2020 at 5:39 PM when Surveyor A asked the Administrator to explain the red binder, the Administrator stated, "this is our grievance book, I keep if I look into it I keep records for our internal records". The Administrator was asked if these allegations were reported to the state, he responded "no". I asked if he considered this an allegation of abuse, he said "yes". When asked if it should have been reported, the Administrator said "yes". Surveyor A asked if it was reported and the Administrator said "this wasn't, when I heard of it I had passed the reporting period. I decided to investigate and based on the findings I addressed it". When asked if the alleged	F 607	The findings of those investigations will be reviewed by the Regional Vice President of Operationsto ensure appropriate investigations have been completed and that the RP, attending physicians and appropriate agencies have been notified as required. Any negative findings will be corrected at time of discovery and the administrator will receive disciplinary actionas warranted.Confidential files of all reported incidents and all follow-up documentation will be maintained. All incidents will be thoroughly investigated. 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: 10/15/2020**	

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F 607	Continued From page 3	F 607		

perpetrator (LPN C) was suspended or removed from the premises while the investigation was being conducted, the Administrator stated "no, we changed her assignment to not take care of Resident #2". The alleged perpetrator remained on the premises and therefore continued to have access to Resident #2 following an allegation of abuse while an investigation was ongoing to determine if abuse had occurred.

Review of the clinical record for Resident #2 revealed no documentation of the allegation of abuse or any staff response.

On 9/10/2020 at 10:20 AM an interview was conducted with RN A. RN A was asked about the abuse policy/process if a Resident reported they had been mistreated by a staff member, and RN A stated, "I would immediately make sure they are ok, I would separate them and whomever if needed, intervene and make sure to report to the chain of command. We have a 2 hour window to report to the state". When asked who makes the report to the state [referring to the OLC], RN A stated, "the Director of Nursing, Administrator or Assistant Director of Nursing, I've never been unable to reach them but if I can not reach them then I would file the report". When asked the next steps, RN A stated "I've never had it happen but I would send the employee home".

On 9/10/2020 at 5:44 PM, an interview was conducted with LPN C, the alleged perpetrator. LPN C was aware of the allegation of abuse Resident #2 made. LPN C stated, she never abused or mistreated Resident #2. LPN C was asked if she was suspended or taken out of work while an investigation was conducted and she said no. LPN C did acknowledge that she was

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F 607	Continued From page 4 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. No further information was provided.	F 607		
F 609 SS=D	COMPLAINT DEFICIENCY. 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	F 609	**F609** **Corrective Action(s):** A thorough investigation of resident #2's allegation of staff abuse has been completed. An FRI has been completed and appropriate notification of state agencies has taken place. Corrective discipline, if indicated by the findings of the investigation, has been completed. Findings of the investigation have been reported to the appropriate agencies. Resident #2's attending physician and responsible party have been made aware of the incident and an incident/accident form has been completed.	

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F 609	Continued From page 5 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 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 staff interview, clinical record review, facility documentation, and in the course of a complaint investigation, the facility staff failed to report an allegation of abuse to state agencies for 1 Resident (Resident #2) in a survey sample of 4 Residents. The findings included: For Resident #2, the facility staff failed to report an allegation of abuse to the state agency (Office of Licensure and Certification (OLC)) and Adult Protective Services (APS). Resident #2 was admitted to the facility on 09/27/2020 with diagnoses including but not limited to Spinal stenosis, acute respiratory failure with hypoxia, major depressive disorder, and	F 609	**Identification of Deficient Practices and Corrective Action(s):** All residents may have been potentially affected. A 100% review of all Facility Incident & Accident Forms for the previous 60 days has been reviewed to identify residents at risk. Any/all negative findings of reportable occurrences identified will be reviewed to ensure an FRI has been completed and an internal investigation with appropriate notification of outcomes to the State agencies, attending physician and responsible parties has occurred. **Systemic Change(s):** The Policy & Procedure for reporting and investigating abuse, neglect, misappropriation of resident property and injuries or unusual/unknown occurrences has been reviewed. No changes are warranted at this time. All staff will be inserviced and issued copies of the Abuse and Investigation Policy and Procedure. These educational inservices will focus on prevention, identifying, reporting, and investigating incidents and allegations of abuse, neglect or mistreatment of residents that are reported. As well as resident to resident altercations and misappropriation of resident property that are reported. **Monitoring:** The Administrator is responsible for compliance. All resident to resident incidents, resident abuse and neglect allegations, unusual occurrences and injuries of unknown origin will be reported via FRI and thoroughly investigated/reviewed by the administrator.	

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F 609	Continued From page 6 chronic pain syndrome. Resident #2's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/12/2020 was coded as a quarterly assessment. Resident #2 was coded as having a BIMS (brief interview for mental status) score of 15, which indicated Resident #2 was cognitively intact. Resident #2 was coded as having required supervision for bed mobility, transfers, dressing, eating toileting and personal hygiene. On 9/9/2020 Surveyor A asked the facility Administrator to provide all Facility Reported Incidents (FRI's) for the past year and all grievances for the past year. There was no FRI regarding Resident #2. On 9/9/2020 in the late morning the facility Administrator provided Surveyor A with a red 3 ring binder and stated, "these are for internal use". Review of the documents revealed a "Grievance Form" dated 12/12/2019 which stated "Resident #2 complained that one of the nurses snatched an inhaler from his hand and ended up scratching his palm. Resident #2 also said the nurse hit him but recanted that statement when I asked which part of his body was hit" and indicated "date complaint/grievance occurred: 12/11/2019". On 9/10/2020 at 10:20 AM an interview was conducted with RN A. RN A was asked about the abuse policy/process if a Resident reported they had been mistreated by a staff member, and RN A stated, "I would immediately make sure they are ok, I would separate them and whomever if needed, intervene and make sure to report to the chain of command. We have a 2 hour window to	F 609	The findings of those investigations will be reviewed by the Regional Vice President of Operations to ensure appropriate investigations have been completed and that the RP, attending physicians and appropriate agencies have been notified as required. Any negative findings will be corrected at time of discovery and the administrator will receive disciplinary action as warranted. Confidential files of all reported incidents and all follow-up documentation will be maintained. All incidents will be thoroughly investigated. 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: 10/15/2020**	

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F 609	Continued From page 7	F 609		

report to the state". When asked who makes the report to the state [referring to the OLC], RN A stated, "the Director of Nursing, Administrator or Assistant Director of Nursing, I've never been unable to reach them but if I can not reach them, then I would file the report".

On 9/9/2020 at 5:39 PM when Surveyor A asked the Administrator to explain the red binder, the Administrator stated, "this is our grievance book, I keep if I look into it I keep records for our internal records". The Administrator was asked if these allegations were reported to the state, he responded "no". I asked if he considered this an allegation of abuse, he said "yes". When asked if it should have been reported, the Administrator said "yes". Surveyor A asked if it was reported and the Administrator said "this wasn't, when I heard of it I had passed the reporting period. I decided to investigate and based on the findings I addressed it".

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".

The facility Administrator was made aware of the concerns regarding the failure to report the allegation of abuse for Resident #2 during the end of day meetings held on 9/9/2020 and again on 9/10/2020.

No further information was provided.

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F 609	Continued From page 8 COMPLAINT DEFICIENCY.	F 609		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation, and in the course of a complaint investigation, the facility staff failed to maintain care equipment 1 Resident (Resident #4) in a survey sample of 4 Residents. The findings included: Resident #4 was admitted to the facility on 07/14/2018 with diagnoses including but not limited to benign neoplasm of ascending colon, chronic diastolic congestive heart failure, and major depressive disorder. Resident #2's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/24/2020 was coded as a quarterly assessment. Resident #4 was coded as having a BIMS (brief interview for mental status) score of 15, which indicated Resident #4 was cognitively intact. Resident #4 was coded as having required limited assistance of staff for transfers, personal hygiene and dressing. On 9/9/2020 Surveyor A reviewed the clinical record of Resident #4 to include the Treatment Administration Record (TAR) and physician orders. There was an order dated 12/5/2019 that read, "SCD's to BLE x 1 hour BID [sequential	F 908	**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, 8/22-28/20 due to the device not working. **Identification of Deficient Practices and Corrective Action(s):** All residents to may have been potentially affected. A 100% review of all resident's for the past 30 days has been completed to identify residents who had physician ordered treatment equipment which was inoperable. Any/all negative findings have been addressed through physician notification, physician initiated change in orders or repair/replacement of the inoperable equipment. **Systemic Change(s):** All nursing staff have been inserviced on the procedure for reporting inoperable equipment; physician notification of inoperable equipment; and vendor notification for repair/replacement of the equipment.	

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F 908	Continued From page 9 compression devices to bilateral lower extremities for one hour twice a day]." The TAR for August 2020 revealed that on the following dates the device was not signed off as being administered: 8/19/2020- note indicated "on hold til repaired" 8/20/2020- note read "Special requirement not met" 8/22/2020- note indicated "Broken" 8/23/2020- note read "Special requirement not met" and "was held". 8/24/2020- note read "Special requirement not met" 8/25/2020- note indicated "SCD not available" and another note read, "Out of order" 8/26/2020- note read "SCD not available". 8/27/2020- note read "Special requirement not met" 8/28/2020- note read "Special requirement not met" On 9/9/2020 at approximately 2 PM during an interview with the DON and Assistant Director of Nursing (ADON) when asked about the SCD's not being administered the ADON stated that she recalled they had to replace the hose twice and then had to replace the machine. The ADON added that this is not equipment that the facility maintenance is able to repair so they have to call the supply company. On 9/9/2020 in the afternoon the ADON provided Surveyor A with a document showing that on 8/19/2020 the facility supply person called the supplier of the SCD's and reported the need for replacement and the company had replaced the leg garments portion of the SCD's on the same day. A second document indicated that on 8/28/2020 the facility supply person (Employee E)	F 908	**Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON/designee will conduct weekly reviews of all physician ordered treatment equipment to ensure it is functional.Negative findings will be addressed at the time of discovery. 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: 10/15/2020**	

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F 908	Continued From page 10 called the supplier again and requested a pump for the SCD machine. Surveyor A shared the concern that from 8/22/2020 to 8/28/2020 the facility staff had been unable to provide Resident #4 with the SCD's as ordered by the physician due to the equipment being broken. The facility had no evidence of any measures being taken for 6 days to make any repairs. Employee E stated, "on the 24 hour report they had it was the hose [garments] they didn't tell me it was the pump not working". During the end of day meetings held on 9/9/2020 and again on 9/10/2020 the facility Administrator and DON were made aware of the concern of failure to provide a physician ordered treatment for Resident #4. No further information was provided. Complaint Related Deficiency.	F 908		