DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/28/2021 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495261 B. WING NAME OF PROVIDER OR SUPPLIER 01/22/2021 STREET ADDRESS, CITY, STATE, ZIP CODE 122 MORVEN PARK ROAD NW HERITAGE HALL LEESBURG LEESBURG, VA 20176 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) E 000 Initial Comments E 000 An unannounced abbreviated Emergency Preparedness COVID-19 Focused Survey was conducted 1/21/21-1/22/21. The facility was in substantial compliance with 42 CFR Part 483.73. Requirement for Long-Term Care Facilities. F 000 **INITIAL COMMENTS** F 000 An unannounced abbreviated COVID-19 Focused Survey was conducted 1/21/21-1/22/21. Complaints (VA00050599, VA00050587) were investigated during the survey. Corrections are required for compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s). The census in this 164 certified bed facility was 111. Of the 111 current residents, 21 residents were currently positive for the COVID-19 virus. The survey sample consisted of eight current resident reviews (Residents #2 through #9) and one closed resident review (Resident #1). F607 F 607 Develop/Implement Abuse/Neglect Policies Corrective Action(s): F 607 SS=D CFR(s): 483.12(b)(1)-(3) A thorough investigation of the incident reported to the SA and other required §483.12(b) The facility must develop and agencies on 1/13/21 has been completed. implement written policies and procedures that: Findings of the investigation have been reported to the SA and other required §483.12(b)(1) Prohibit and prevent abuse, agencies. neglect, and exploitation of residents and One on one education has been completed misappropriation of resident property, with the DON and Assistant Administrator regarding the policy for reporting allegations of abuse within 2 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and hours. One on one education has been completed with the VP of regional operations by the §483.12(b)(3) Include training as required at VP of Clinical Services for reporting paragraph §483.95.

(X6) DATE 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.

This REQUIREMENT is not met as evidenced

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

allegations of abuse within 2 hours.

TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA			OMB N	OMB NO. 0938-0391	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER SE HALL LEESBURG			STREET ADDRESS, CITY, STATE, ZIP O 122 MORVEN PARK ROAD NW LEESBURG, VA 20176	CODE	1/22/2021	
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	Based on observation document review, and was determined that to implement its policy to abuse for one of eight sample, Resident #7. report an allegation of #7 within two hours. The findings include: Resident #7 was admit 11/28/2020 with diagnoin limited to: recent broked dementia (1), and delut most recent MDS (min admission assessment reference date) of 12/4 coded as being moder daily decisions, having BIMS (brief interview for coded as expressing fettired more than once of the was coded as having delusions during the located as requiring the staff for all activities of unsteady for balance, a and walker for locomotion on 1/21/21 at 12:29 p.r. observed sitting on the room. Resident #7 did reinterview questions from A review of the FRI (facts submitted by the facility	n, staff interview, facility of clinical record review, it the facility staff failed to preport an allegation of residents in the survey. The facility staff failed to sexual abuse for Resident of the sexual abuse for Resident of the sexual abuse for Resident of the sexual abuse for making scored 10 out of 15 on the formental status). He was sealing down and feeling uring the lookback period. The was extensive assistance of daily living, as being and as using a wheelchair on. In the sexual abuse for Resident of the sexual abuse for making scored 10 out of 15 on the sexual abuse for making scored 10	F	Identification of Deficie Corrective Action(s): All residents who may ha potentially affected. A 10 all Facility Incident & Ac the previous 90 days has to identify residents at ris findings of reportable occ reviewed to ensure an FR completed timely and an investigation with approp of outcomes to the State a attending physician and re parties has occurred. Systemic Change(s): The Policy & Procedure f investigating abuse, negle misappropriation of reside injuries or unusual/unknow has been reviewed. No ch warranted at this time. All staff will be inserviced copies of the Abuse and In Policy and Procedure. The in-services will focus on, reporting, and investigatin allegations of abuse, negle mistreatment of residents as resident to resident alter misappropriation of reside are reported.	nt Practices and ave been 00% review of coident Forms for been completed ik. Any/all currences will be I has been internal irriate notification agencies, esponsible for reporting and ect, ent property and wn occurrences anges are d and issued investigation ese educational identifying, ag incidents and ect or timely. As well reations and	FEB 0 5 2021	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/28/2021 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 495261 B. WING 01/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 122 MORVEN PARK ROAD NW HERITAGE HALL LEESBURG LEESBURG, VA 20176 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 2 F 607 sexual abuse...Report date: 1/13/21...Incident date: 1/12/21...On 1/9/21 [Resident #7] stated there was a creepy man standing at the end of his bed. The DON looked around and there were Monitoring: no men around and she continued to try to The Administrator is responsible for reassure [Resident #7] that he was safe. [ASM compliance. The QA committee will (administrative staff member) #2, the director of review all FRI's not less than quarterly to nursing] called the spouse and she stated that ensure they have been reported timely. Any negative findings will be corrected at 'He has those delusions; they have been going on time of discovery and disciplinary action for years.' On 1/12/21 [Resident #7] called the police and told them he had been sexually will be taken as warranted. abused. The social worker went to his room and Completion Date: February 26th, 2021 spoke to [Resident #7] and there was no one there bothering him and he was stating it occurred at work last week. She kept reassuring him that he was safe. He states there is a tall, white man, and there were only female employees working on that unit. Resident assessed and there were no injuries. Staff is providing frequent psychosocial checks for his health and wellness. Full investigation to follow. FINAL: DON [Director of Nursing] spoke with [name of Detective]. Detective did not open a case based on resident accusations and validity. There had not been any males taking care of resident on the unit meeting resident's observation. Resident had reported a large white male named Earl, creepy (sic) staring at him. [Resident #7] was assessed by NP (nurse practitioner) and there was no injury. Ongoing confusion noted. [Resident #7] was also assessed to assure all psychosocial needs are being met. Resident is able to voice his needs and voices no complaints or concerns. Social Services will continue to follow up and assess as needed to ensure [Resident #7]'s needs are being met. Social Services will continue to follow up and

assess as needed to assure needs are being met. [Name of APS 9adult protective services)

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 122 MORVEN PARK ROAD NW LEESBURG, VA 20176	01/22/20	<u> </u>
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F 607	staff member] also and medications, as reportsAPS also not in any danger of A review of Resider	reviewed resident's diagnoses s well as inconsistencies in concluded that resident was	F 607			
	which was dated 1/a full physical assess bruising or other evinote documented: "On 1/22/21 at 11:03 member) #4, the son She stated that at the described in the about the administrator worked allegation. She stated interviewed, and oth interviewed. She stated evidence, including I dementia and delusidetermined the alleg by the resident was a con 1/22/21 at 11:11 administrator, was in the time of the incide me." She added a rewas also in the buildi	13/21. The note documented as ment of the resident, with no idence of injury or abuse. The Confusion continues." a.m., OSM (other staff cial worker, was interviewed. We time of the incident over referenced FRI, ASM #1, as out sick. She stated she DN, and a regional dittogether to investigate the ed staff members were er residents were also ted that based on the Resident #7's history of ons, the facility staff ation of sexual abuse made			FEB 0 5 202	RECEVED
	incident. She stated A nursing) reported tha police, and had told A assaulted "last week ASM #2 reported this	ASM #2, (the director of t Resident #7 had called the ASM #4 that he had been at work." ASM #4 stated information to her on completed the FRI and sent				a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE 495261		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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	it to the state agency On 1/22/21 at 11:31 interviewed. She stat 6:00 p.m. on 1/12/21 #4 that Resident #7 h told them that there we standing in his room. had gone to Residen no one there. ASM # provided reassurance him that he was safe, administrator had provided reassurance him that he was safe, administrator had provided reassurance him that he was safe, administrator had provided reassurance him that he was safe, administrator had provided reassurance him that he was safe, administrator had provided the incident knew we had 24 hour. On 1/22/21 at 3:00 p. these concerns. She facility at the time the did not have first-hand timing of the report to A review of the facility Exploitation Prevention in part: "Sexual Abuse of any type with a resignalleged violations involved and the provided residual provided in parts alleged violations involved and the provided residual provided res	a.m., ASM #2, the DON, was seed that at approximately, she was informed by ASM and contacted the police and was currently a male. She stated she and ASM #4 the #7's room and had found 2 stated she and ASM #4 to Resident #7, assuring. She stated that a regional vided guidance to her and to be investigation, and the ent. ASM #2 stated, "We see to report it." m., ASM #1 was notified of stated she was not in the FRI was submitted, and she do knowledge about the the SA. policy, "Abuse, Neglect and in and Reporting," revealed, et is non-consensual contact dent Ensure that all	F 6		S D	RECEIV FEB 05 2
	events that cause the result in serious bodily No further information References:	allegation is made, if the allegation involve abuse or injury." was provided prior to exit. dual and permanent loss of			POTO POTO	ECEIVED FEB 05 2021

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	brain function. This or It affects memory, thir and behavior." This in website https://medlineplus.go (2) "A delusion is a fix inaccurate interpretation despite evidence to the congruent with one's congruent with one of the congruent with one's congruent with one of the congruent with one's congruent with one or more that can take place in the but are possible) delus month or more, that has another physiological, medical condition or ar condition. An individual consideration before congruent before congruent website https://www.ncbi.nlm.ni Reporting of Alleged Vi CFR(s): 483.12(c)(1)(4). §483.12(c) In response neglect, exploitation, or must:	ccurs with certain diseases. Inking, language, judgment, formation is taken from the V/ency/article/000746.htm. In de false belief based on an on of an external reality the contrary. The belief is not culture or subculture, and knows it to be falseThe hald disorder occurs when a recenon-bizarre (situations real life, although not real althought for one is no explanation by substance-induced, by other mental health I's cultural beliefs merit borning to the diagnosis. Spect the content of atton is taken from the the diagnosis of abuse, mistreatment, the facility at all alleged violations of account of the diagnosis of the di	F 609	F609 Corrective Action(s): A thorough investigation of the increported to the SA and other requi	red pleted. been red mpleted for in 2 mpleted by the

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Event ID: VJJP11

Facility ID: VA0115

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STATEMENT	OF DEFICIENCIES	WEDICAID SERVICES			OMB	NO. 0938-0391
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HERITAG	E HALL LEESBURG			122 MORVEN PARK ROAD N LEESBURG, VA 20176		
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	the events that cause abuse and do not res the administrator of the officials (including to adult protective service for jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the adesignated represents accordance with State Survey Agency, within incident, and if the alle appropriate corrective This REQUIREMENT by: Based on observation document review, and was determined that the report an allegation of later than 2 hours after for one of eight resident #7. The facial allegation of sexual ab Resident #7 to the State officials. The findings include: Resident #7 was admitted to: recent broke dementia (1), and delumost recent MDS (minited dimission assessments)	or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other the State Survey Agency and the state I aw provides the results of all disconsisted and to other officials in the law, including to the State of Sworking days of the aged violation is verified action must be taken. It is not met as evidenced action and the survey, facility clinical record review, it is not met as evidenced at the allegation was made and the survey sample, it is staff failed to report an use within two hours for the Survey Agency other the survey Agency other and the survey of stroke, sional disorder (2). On the second in the survey of stroke, sional disorder (2). On the	F	Identification of D Corrective Actions All residents who m potentially affected all Facility Incident the previous 90 day to identify residents findings of reportab reviewed to ensure completed timely a investigation with a of outcomes to the 8 attending physician parties has occurred Systemic Change(s The Policy & Proce investigating abuse, misappropriation of injuries or unusual/t has been reviewed. I warranted at this tim All staff will be inse copies of the Abuse Policy and Procedur in-services will focu reporting, and invest allegations of abuse, mistreatment of resider as resident to resider	reficient Practices and (s): hay have been A 100% review of A Accident Forms for s has been completed at risk. Any/all ble occurrences will be an FRI has been and an internal ppropriate notification State agencies, and responsible ble clipical discovered and heglect, resident property and henknown occurrences No changes are he. reviced and issued and Investigation be These educational s on, identifying, higating incidents and heglect or dents timely. As well	

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Event ID: VJJP11

Facility ID: VA0115

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	coded as being mode daily decisions, havin BIMS (brief interview coded as expressing tired more than once the was coded as have delusions during the located as requiring the staff for all activities of unsteady for balance, and walker for locomo On 1/21/21 at 12:29 p. observed sitting on the room. Resident #7 did interview questions from A review of the FRI (fasubmitted by the facilit 1/13/21 revealed, in pasexual abuseReport date: 1/12/21On 1/9/there was a creepy math is bed. The DON look no men around and shareassure [Resident #7] (administrative staff menursing] called the spool 'He has those delusions for years.' On 1/12/21 [police and told them he abused. The social wor spoke to [Resident #7] there bothering him and	g scored 10 out of 15 on the for mental status). He was feeling down and feeling during the lookback period. ing no hallucinations or pokback period. He was a extensive assistance of fadily living, as being and as using a wheelchair tion. The side of his bed in his not respond to attempted and the surveyor. Cility reported incident) by to the state agency on art: "Incident: Allegation of date: 1/13/21Incident 21 [Resident #7] stated an standing at the end of the daround and there were the continued to try to that he was safe. [ASM the smber) #2, the director of use and she stated that so, they have been going on Resident #7] called the shad been sexually ker went to his room and and there was no one of the was stating it the each only female that unit. Resident the status is the each only female that unit. Resident	Fé	Monitoring: The Administrator is responsite compliance. The QA committee review all FRI's not less than densure they have been reported. Any negative findings will be time of discovery and disciplin will be taken as warranted. Completion Date: February	ee will quarterly to d timely. corrected at nary action

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Event ID: VJJP11

Facility ID: VA0115



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F 609	Continued From pa	age 8	F 6	00		-	
		psychosocial checks for his	1 0	09			
	health and wellness	s. Full investigation to follow.					
	FINAL: DON [Direct	etor of Nursing] spoke with					
	[name of Detective]]. Detective did not open a					
	case based on resid	dent accusations and validity.					
	There had not been	n any males taking care of					
	resident on the unit	meeting resident's					
	observation. Reside	ent had reported a large white					
	male named Earl, c	reepy (sic) staring at him.					
	[Resident #7] was a	assessed by NP (nurse					
	practitioner) and there was no injury. Ongoing						
	confusion noted. [R	esident #7] was also					
	assessed to assure	all psychosocial needs are					
	being met. Residen	t is able to voice his needs					
	and voices no comp	plaints or concerns. Social					
	Services will continu	ue to follow up and assess as					
	needed to ensure [F	Resident #7]'s needs are being					
	met. Social Services	s will continue to follow up and					
	assess as needed to	o assure needs are being					
	oteff manufactural	9adult protective services)					
	and medications	eviewed resident's diagnoses					
	reports ADS also a	well as inconsistencies in oncluded that resident was					
	not in any danger of	immediate have !!					
	not in any danger of	irrinediate narm.					
	A review of Resident	t #7's clinical record revealed					
	a note from ASM #3.	the NP (nurse practitioner)					
	which was dated 1/1	3/21. The note documented					
	a full physical assess	sment of the resident, with no					
	bruising or other evid	dence of injury or abuse. The					
	note documented: "C	Confusion continues."					
	On 1/22/21 at 11:02	a.m., OSM (other staff					
	member) #4 the soc	ial worker, was interviewed.					
	She stated that at the	e time of the incident					
	described in the above	ve referenced FRI, ASM #1,					
	the administrator wa	is out sick. She stated she					
	and ASM #2, the DO	N and a regional					
	administrator worked	together to investigate the					
		to investigate the	1			1	

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Event ID: VJJP11

Facility ID: VA0115

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495261		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
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	interviewed, and oth interviewed. She state vidence, including dementia and delusidetermined the alleg by the resident was also in the time of the incide me." She added a rewas also in the buildiregarding the investigincident. She stated nursing) reported that police, and had told assaulted "last week ASM #2 reported this 1/12/21, and that she it to the state agency On 1/22/21 at 11:31 a interviewed. She state 6:00 p.m. on 1/12/21, #4 that Resident #7 hold them that there we standing in his room. Had gone to Resident mo one there. ASM #2 provided reassurance mim that he was safe. The administrator had provided regording of the incide knew we had 24 hours. On 1/22/21 at 3:00 p.r.	ed staff members were also atted that based on the Resident #7's history of ons, the facility staff pation of sexual abuse made unsubstantiated. a.m., ASM #4, the assistant atterviewed. She stated that at ent, "It was just [ASM #2] and agional corporate manager ing and provided guidance agation and reporting of this ASM #2, (the director of at Resident #7 had called the ASM #4 that he had been at work." ASM #4 stated information to her on a completed the FRI and sent on 1/13/21. a.m., ASM #2, the DON, was ed that at approximately she was informed by ASM and contacted the police and was currently a male She stated she and ASM #4 at 7's room and had found a stated she and ASM #4 at to Resident #7, assuring She stated that a regional wided guidance to her and to a investigation, and the nt. ASM #2 stated, "We is to report it."	F 609		
t	hese concerns. She s	stated she was not in the		RECEIVE	W.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER		122	REET ADDRESS, CITY, STATE, ZIP CODE MORVEN PARK ROAD NW ESBURG, VA 20176	01/22/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
	facility at the time the did not have first-had timing of the report of the facility of the facility exploitation Prevent in part: "Sexual Abust of any type with a realleged violations in exploitation or mistre unknown source and property, are reported than 2 hours after the events that cause the result in serious bodd. No further information. This control of the factor of the	the FRI was submitted, and she and knowledge about the to the SA. Ity policy, "Abuse, Neglect and altion and Reporting," revealed, use' is non-consensual contact esidentEnsure that all volving abuse, neglect, eatment, including injuries of dimisappropriation of resident ed immediately, but not later e allegation is made, if the e allegation involve abuse or illy injury." In was provided prior to exit. It adual and permanent loss of eccurs with certain diseases. inking, language, judgment, information is taken from the eov/ency/article/000746.htm. It was belief based on an antion of an external reality the contrary. The belief is not culture or subculture, and the knows it to be falseThe conal disorder occurs when a core non-bizarre (situations in real life, although not real usional thought for one mas no explanation by	F 609			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495261	B. WING		C 01/22/2021
	ROVIDER OR SUPPLIER E HALL LEESBURG		122	EET ADDRESS, CITY, STATE, ZIP CODE MORVEN PARK ROAD NW ESBURG, VA 20176	1 01/22/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 609	consideration before Cultural beliefs also delusions." This info website	ge 11 e coming to the diagnosis. impact the content of rmation is taken from the h.nih.gov/books/NBK539855/	F 609		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VJJP11

Facility ID: VA0115

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