PRINTED: 12/14/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495174	B. WING				С
NAME OF I	PROVIDER OR SUPPLIER	495174	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	12/	07/2022
					2978 CENTREVILLE ROAD		
DULLES	HEALTH & REHAB C	ENIER		ŀ	HERNDON, VA 20171		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 0	000			
	standard survey wa 12/7/22. Correction with 42 CFR Part 4 requirements. Two during the survey.	Medicare/Medicaid abbreviated as conducted 12/5/22 through as are required for compliance 83 Federal Long Term Care complaints were investigated [VA00057031: A00057025: substantiated with					
F 585 SS=E	147 at the time of the consisted of 25 resignificances		F 5	585			
	grievances to the fathat hears grievance reprisal and without reprisal. Such griev respect to care and furnished as well as furnished, the behalf	ces. esident has the right to voice acility or other agency or entity es without discrimination or ances include those with treatment which has been so that which has not been vior of staff and of other r concerns regarding their LTC					
	facility must make	esident has the right to and the prompt efforts by the facility to the resident may have, in s paragraph.					
		acility must make information evance or complaint available					
	§483.10(j)(4) The fa	acility must establish a					
I ABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		TITLE		(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

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495174	B. WING		C <b>12/07/2022</b>	
	PROVIDER OR SUPPLIER HEALTH & REHAB C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2978 CENTREVILLE ROAD HERNDON, VA 20171		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
F 585	of all grievances recontained in this paraprovider must give to the resident. The include: (i) Notifying resident postings in promine facility of the right to (meaning spoken) or grievances anonymof the grievance and the independent entities be filed, that is address (mailing an number; a reasonal completing the revisto obtain a written or grievance; and the independent entities be filed, that is, the Quality Improveme Agency and State Is program or protectic (ii) Identifying a Grieresponsible for overeceiving and track conclusions; leading by the facility; main information associate example, the identity grievances submittively written grievance decoordinating with stancessary in light of (iii) As necessary, the prevent further potents.	ensure the prompt resolution garding the residents' rights aragraph. Upon request, the a copy of the grievance policy grievance policy must at individually or through ent locations throughout the offile grievances orally or in writing; the right to file mously; the contact information ficial with whom a grievance, his or her name, business and email) and business phone ble expected time frame for ew of the grievance; the right decision regarding his or her contact information of s with whom grievances may pertinent State agency, and Organization, State Survey Long-Term Care Ombudsman on and advocacy system; evance Official who is reseeing the grievance process, ing grievances through to their g any necessary investigations taining the confidentiality of all ated with grievances, for the resident for those ed anonymously, issuing ecisions to the resident; and tate and federal agencies as if specific allegations; aking immediate action to ential violations of any resident led violation is being	F 5	585		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495174	B. WING				C 07/2022
	PROVIDER OR SUPPLIER	ENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1978 CENTREVILLE ROAD HERNDON, VA 20171		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	(iv) Consistent with reporting all alleged abuse, including injand/or misapproprianyone furnishing sprovider, to the adras required by Stat (v) Ensuring that all include the date the summary statementhe steps taken to issummary of the peregarding the resid as to whether the gonfirmed, any contaken by the facility and the date the wing (vi) Taking appropriaccordance with Stof the residents' rigor if an outside entithe State Survey And Organization, or local confirms a violation rights within its area (vii) Maintaining eversult of all grievand 3 years from the issued complaint investigates on Residentinterview, clinical redocumentation revicomplaint investigates and taken abuse of the residential redocumentation revicomplaint investigates and taken abuse of the residential respond to, and taken abuse of the residential respond to, and taken abuse of the residential respond to, and taken abuse of the residential responding to	s §483.12(c)(1), immediately d violations involving neglect, juries of unknown source, ation of resident property, by services on behalf of the ministrator of the provider; and	F	585			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	COM	E SURVEY IPLETED
		495174	B. WING				C <b>07/2022</b>
	PROVIDER OR SUPPLIER HEALTH & REHAB C	ENTER		29	TREET ADDRESS, CITY, STATE, ZIP CODE 078 CENTREVILLE ROAD ERNDON, VA 20171	,	0172022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 585	The findings included. The facility staff fail manner to ensure regarding the lack of the control of the facility staff do not answer iii. On 8/12/22 Resident on the facility of the facility	ed: ed to respond in an effective esolution of ongoing concerns of call bell responses. course of a complaint ew of grievance forms from evealed concerns reported to ngoing issues of facility staff all lights. The grievance the following: ent #18 reported that her call red for a long time. dent #11's family reported that her call light promptly. ident #11's family reported that regards to the resident call ident #10's family reported call bell was taken away from ld she uses it too much and eff. dent #20 reported that she call at 3:45 AM, and it wasn't taff responded to her request. sident #22's family reached	F 5	585			
	vi. On 11/18/22, Re out to facility staff to had pressed her ca minutes before staff	sident #22's family reached o notify them that Resident #22 III bell and it was over 30 if responded to the call bell.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C		
		495174	B. WING_		12	2/07/2022
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2978 CENTREVILLE ROAD HERNDON, VA 20171		
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F 585	Continued From pa	age 4	F 58	35		
		resident #14 reported that the respond to her call bell.				
	confirmed that the kind of report or log	II, the maintenance director facility is unable to provide any g to indicate how long call bells e the staff respond or				
	Resident interviews the following:	s were conducted and revealed				
	conducted with Re the call bells Resid AM and not heard see it and say, 'Oh heated up,' so they	11 PM, an interview was sident #20. When asked about ent #20 said, "I've used it at 4 from anyone until 9 AM. They, she just wants something don't' even come." Resident y, "I've quit using the call bell t answer it."				
	conducted with Re reported that, "I do helps me when I us my son on the pho someone to come on to say, "The oth calling with the call phone so he could am so thankful I ca	PM, an interview was sident #14. Resident #14 n't like to complain but no one se my call bell. I have to call ne and get him to call to get help me." The resident went er night I was calling and bell, I kept my son on the see how long it takes them. I an call my son so he can get me when I need it."				
	conducted with Re that "several times number to get som	20 AM, an interview was sident #22. Resident #22 said I've had to call the main eone to come in to help me dn't answer the call bell."				

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F 585	iv. On 12/7/22 at apinterview was cond response to the facility staff.  v. On 12/7/22 at 9: conducted with Response to the call bell response. The night shift for the call bell on and wai anymore so I got up and came back. It before anyone came This has happened Staff were interview following was noted i. On 12/6/22 at 9:1 conducted with CN K. CNA K stated the Residents to get in needs they may have to answer call the immediately. She swithin 1 minute."  ii. On 12/7/22 at 8:4 conducted with CN always say they call hight- sometimes it	pproximately 8:30 AM, an ucted with Resident #20 in ident's request. When asked onse, the Resident said, "I've AM, and they didn't come until it #20 stated she has reported in 15 AM, an interview was sident #6. When asked about se time, the Resident said, olds me from getting up on my led of falls. One night I cut my led 20 minutes. I couldn't wait to and went to the bathroom was 2 hours and 18 minutes in to see what I needed. several times."	F 58	35		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG	СОМ	(X3) DATE SURVEY COMPLETED C	
		495174	B. WING _			07/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2978 CENTREVILLE ROAD HERNDON, VA 20171	,		
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F 585	iii. On 12/7/22 at 9 conducted with LP LPN C was asked Residents ever repassistance, and it respond, or they disaid, "At times whe for water because iv. On 12/7/22 at 9 conducted with Em Employee E confir receive phone call families reporting the and staff are not receive phone call families reporting the and staff are not receive phone call families reporting the and try to get some Residents the ongoing thing, and and try to get some A review of the fact Accessibility and The part: "All employee call light are responsibled."  A review of the fact in part: "All information any resulting action Grievance/Concerthe grievance inversal the grievance inversal the grievance inversal the grievance, will keep the condition with the designee, will keep the sale of the sal	AM, an interview was N (licensed practical nurse) C. about call bells and if port that they have called for took a long time for staff to idn't respond at all. LPN C en I come in, they all are asking they didn't get any overnight."  :59 AM, an interview was apployee E, the receptionist, med that frequently she will be from the Residents and that Residents need assistance asponding to the call lights, the calls are more frequent from the residents, but that it is an she will always call the station	F 58	55			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	COM	E SURVEY PLETED
		495174	B. WING			C 07/2022
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2978 CENTREVILLE ROAD HERNDON, VA 20171	12/	0172022
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F 585	held with the facility Nursing and Corporasked if they had id	of 12/7/22, a meeting was Administrator, Director of rate Clinical Specialist. When lentified any concerns or with regards to call lights, they	F 58	5		
	was a significant nu staff not responding Resident interviews ongoing issue. The last time call lights 2022, but they have	"Surveyor B told them there umber of complaints regarding to call bells, and during s, many reported this is an Administrator stated that the were a focus was September e an upcoming Quality next week and can look into				
E 007	multiple in-services with regards to call November and aga contained approxim		5.00			
F 607 SS=E	CFR(s): 483.12(b)( §483.12(b) The fac	t Abuse/Neglect Policies 1)-(5)(ii)(iii) ility must develop and policies and procedures that:	F 60			
		ibit and prevent abuse, tation of residents and resident property,				
		blish policies and procedures uch allegations, and				
	§483.12(b)(3) Incluparagraph §483.95	de training as required at ,				

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F 607	QAPI program requised successive	blish coordination with the uired under §483.75.  ure reporting of crimes lly-funded long-term care ance with section 1150B of the and procedures must include to the following elements.  Posting a conspicuous notice of a defined at section 1150B(d)  Prohibiting and preventing and preventing and at section 1150B(d)(1) and NT is not met as evidenced erview, facility documentation ourse of a complaint acility staff failed to implement for 7 Residents (Resident #15, and 14), in a survey sample of	F 6	07		
	facility staff failed to	15, 11, 16, 13, 14, and 12, the o implement their abuse policy				
	on 12/5/22, during investigation it was Residents had reported facility staff, and	the course of a complaint determined that multiple orted allegations of abuse to d the facility staff failed to gation regarding the				

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	PROVIDER OR SUPPLIER HEALTH & REHAB C	ENTER		STREET ADDRESS, CITY, STATE, ZIP ( 2978 CENTREVILLE ROAD HERNDON, VA 20171		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 607	assigned CNA (cerwas very argument Review of the griev E had written a staff morning while pass front of [room number talking loud. I calle outside which he [Chappened and told outside and he said alert and let me tell into resident's room medications and reyelling at her for pushe wanted was a nurse that staff doe through. She continues that staff doe through abuse by ranyone speaks to refrighten and my whill it. Resident #11's systaff member on 8/with the way staff tread, "Last night a when she want to a grievance form was supporting evidence conducted. The "grievander form good customer sunderstanding verbrights as well. UM [responsible party]/	I reported on 10/25/22 that an tified nursing assistant(CNA H) ative and unprofessional. ance form revealed that LPN tement that read, "In the sing medications standing in our redacted], I heard staff d him immediately to come CNA H] did. I asked him what him I could hear him from I, Let me talk this resident is her the truthThis nurse went in to give her her scheduled sident told her that a staff was atting on her call light, when all cup of water, crying telling this is in the known what she has been in a loud voice I become ole day is spoil[sic]"  Douse had reported to a facility 12/22, that he "is not happy reat his wife." The complaint is staff told his wife to shut up the sk question [sic]" A secompleted and contained no be of any investigation being dievance official follow up of care with staff and educated service and techniques with relized. Educated on resident's [unit manager] spoke with RP spouse and patient at bedside ressed to satisfactory with all	F 60	07		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION DING	` '	OMPLETED
		495174	B. WING		,	C 1 <b>2/07/2022</b>
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP OF 2978 CENTREVILLE ROAD HERNDON, VA 20171		LIOTIZOLL
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 607	iii. A grievance was 9/8/22, who reported that "[CNA B's name with her while charactitude." The grieval Resident reported upon interview. The provided with a countries iv. Resident #13 restaff member was care. He was angred The facility's response caring for reside provided that an interview was care. The facility's response was an interview on caring for reside provided that an interview was care. The facility's response was an interview on the provided that an interview was an interview on the provided that an interview was an interview on the provided that an interview was a	is filed by Resident #16 on and to a facility staff member are redacted] was not gentle aging her and the CNA had an ance form indicated that the the same to the unit manager are CNA was educated and unseling form that indicated	F6	507		
	Resident felt haras treated like an anin conduct an investig course of a compla noted in facility doc #12's family reporte that the Resident "and treated like an was written by Emp	2, whose family reported the sed by nursing staff and nal, the facility staff failed to gation. On 12/5/22, during the sint investigation, Surveyor B sumentation that Resident ed to facility staff on 8/18/22 felt harassed by nursing staff animal." The grievance form bloyee H, the social services there was no grievance				

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	PROVIDER OR SUPPLIER HEALTH & REHAB C	ENTER		29	REET ADDRESS, CITY, STATE, ZIP CODE 78 CENTREVILLE ROAD ERNDON, VA 20171	, - <del></del> -	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 607	follow-up noted on second grievance frompleted by anoth allegations of the Rharassed by nursin animal were not no Therefore, this alleg follow-up/investigated.  On 12/5/22 and 12/reported incidents, files, and grievance were reviewed. The evidence that the awere investigated.  On 12/5/22 and 12/were conducted for There was no documented	the form. Attached was a form dated the same day, her staff member. The desident feeling that she was g staff and treated like an ted on the second form. It gation had no dion, etc.  6/22, review of the facility facility provided investigation as for the above Residents are was no supporting bove allegations of abuse and the down of the above Residents. It is desired as a social worker. It is a social worker.		507			

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 2978 CENTREVILLE ROAD HERNDON, VA 20171			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 607	Director/Employee and neglect and exaministrator in action of the investigation. C. T. Committee will conducted and confine with exaministrator in action of the investigation of	e H. Employee H defined abuse explained that anyone can report the Resident, a family member, a visitor. Employee H stated ministrator investigates and will ocial Services Department to H said she maintains a folder mation and other investigation office. Employee H was asked the files she may have that took 2022 to the present. On M, Employee H returned to aid she had not conducted any had no such documents for the me.  Sility policy, "Abuse Prevention," V. Investigation: A. Designated ely review and investigate all or allegations. B. include collecting physical and ence which may include taking ecessary, interviewing f with personal knowledge of ged incident, requesting s, collecting relevant evidence, each step taken during the he Quality Assurance nduct analysis for trends. D. ive bodies, such as the local acted as directed by the ecordance with state and local licy. E. Investigations will be mpleted within 5 working days, incident or allegation. In the ation has not been completed a nitted to the state licensing and ning as much information as is	F	607			

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F 607	investigations until On 12/7/22 at 10:2 facility Administrator Corporate Clinical aconcerns were shathe Administrator scomplaints should investigation. They additional document to indicate that inventional document indicate that inventional document facility notified the submitted all document facility notified the submitted all document facility staff failed policy with regards abuse to the state abuse to the state protective services i. Resident #15 had assigned CNA (CN and unprofessional ii. Resident #12's fa abuse on 8/18/22, harassed by nursing animal."  iii. Resident #2's fa allegation of abuse	complete"  O AM, a meeting with the or, Director of Nursing and Specialist was held. These ared with the facility staff, and tated that the above have prompted an year were asked to provide any not or evidence they may have estigations were conducted. The survey team they had mentation they had to provide.  Deficiency.  15, 12, 2, 11, 16, 13, and 14, and to implement their abuse to reporting allegations of survey agency and adult.  Deficiency argumentative of the survey argumentative.	F 6	07		

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		495174	B. WING				07/2022
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F 607	iv. Resident #11's san allegation of abundappy with the way complaint read, "Lashut up when she way complaint read, "Lashut up when she way complaint read, "Lashut up when she way care. He was anging her and the way care. He was angry vii. Resident #14's 11/25/22, "3-11 shift patient's forehead."  For each of the abordacility staff failed to allegations were reagency and adult pure on 12/6/22 at 4:12 conducted with the Director/Employee and neglect and exabuse, including the a staff member, or that the facility Admat times ask the Soassist. Employee hereporting of allegation and indicated that the handled that.  A review of the facility Admat times ask the Soassist. Employee hereporting of allegations was the soassist.	spouse reported to facility staff use on 8/12/22, that he "is not staff treat his wife." The ast night a staff told his wife to want to ask question [sic]"  ad a grievance on 9/8/22, f member, that "[CNA B's is not gentle with her while he CNA had an attitude."  ported on 10/27/22, "a male wery rough while providing and very curt with patient."  family member reported on the CNA was pushing on the control of the state survey rotective services.  PM, an interview was	F6	607			

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		STREET ADDRESS, CITY, STATE, ZIP CODE 2978 CENTREVILLE ROAD HERNDON, VA 20171		0112022	
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE	
se, neglect, misappropriation of on: The center Administrator, ursing), or designee must eged incidents of abuse, on, or mistreatment using the icensure & Certification Incident" form to the (OLC) and dagencies including Adult is (APS) and local law all report with results of the dwith the OLC within 5 working incident"  10 AM, a meeting was held with trator, Director of Nursing and Specialist, and they were made dings. They were asked to onal documents or evidence indicate that the allegations he state survey agency and rivices.  Ition was received, and the survey team they had mentation they had to provide.  Indeed Violations (5)(i)(A)(B)(c)(1)(4)  In onse to allegations of abuse, on, or mistreatment, the facility our that all alleged violations eglect, exploitation or					
	DENTIFICATION NUMBER:	A BUILDIN  495174  B. WING  ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)  Age 15  See, neglect, misappropriation of on: The center Administrator, ursing), or designee must eged incidents of abuse, on, or mistreatment using the icensure & Certification Incident" form to the (OLC) and dagencies including Adult is (APS) and local law all report with results of the dwith the OLC within 5 working incident"  A BUILDIN  A BUILDIN  B. WING  DREFIX TAG  F 60  F 60	A BUILDING  495174  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  2978 CENTREVILLE ROAD HERNDON, VA 20171  ID PREFIX TAG  PROVIDER'S PLAN OF CORRE  **P MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  age 15  Be, neglect, misappropriation of on: The center Administrator, ursing), or designee must eged incidents of abuse, on, or mistreatment using the icensure & Certification Incident" form to the (OLC) and dagencies including Adult is (APS) and local law all report with results of the did with the OLC within 5 working incident"  A A BUILDING  STREET ADDRESS, CITY, STATE, ZIP CODE  2978 CENTREVILLE ROAD  PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)  F 607  F 607  F 607  PREFIX TAG  PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)  F 607  PREFIX TAG  PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)  PREFIX TAG  PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)  F 607  PREFIX TAG  PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)  PREFIX TAG  PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)  PREFIX TAG  PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)  PREFIX TAG  PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)  PREFIX TAG  PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)  PREFIX TAG  PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP PROVIDER'S PROVID	A BUILDING  A STREET ADDRESS, CITY, STATE, ZIP CODE  2973 CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  2973 CENTREVILLE ROAD  HERNDON, VA 20171  ATEMENT OF DEFICIENCIES  IP PROVIDER'S PLAN OF CORRECTION  IEACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  F 607  se, neglect, misappropriation of on: The center Administrator, ursing), or designee must eged incidents of abuse, on, or mistreatment using the icensure & Certification lincident" form to the (OLC) and d agencies including Adult s (APS) and local law all report with results of the d with the OLC within 5 working 1 incident"  10 AM, a meeting was held with trator, Director of Nursing and Specialist, and they were made fings. They were asked to anal documents or evidence indicate that the allegations he state survey agency and rvices.  11 to was received, and the survey team they had mentation they had to provide.  12 deficiency, and Violations (5)(i)(A)(B)(c)(1)(4)  13 onse to allegations of abuse, on, or mistreatment, the facility are that all alleged violations egglect, exploitation or unding injuries of unknown	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495174	B. WING			12/0	07/2022
	PROVIDER OR SUPPLIER HEALTH & REHAB C	ENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE  978 CENTREVILLE ROAD  IERNDON, VA 20171		
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F 609	hours after the alleg that cause the alleg serious bodily injury the events that cause and do not rethe administrator of officials (including the accordance with St.)  §483.12(c)(4) Repositive stigations to the designated represe accordance with St. Survey Agency, with incident, and if the appropriate correct. This REQUIREMENT by:  Based on Resident clinical record review and during the state Survey Agency and certification and Administration an	diately, but not later than 2 gation is made, if the events gation involve abuse or result in a control of the facility and to other the facility and to other to the State Survey Agency and vices where state law provides and the results of all the administrator or his or her entative and to other other the results of all the administrator or his or her entative and to other officials in the facility and to other officials in the facility and to other officials in the law, including to the State and 5 working days of the falleged violation is verified alleged violation is verified alleged violation is verified at action must be taken. The interview, staff interview, we, facility documentation the course of a complaint acility staff failed to report to gency/Office of Licensure and lult protective services and neglect for 7 Residents 2, 11, 16, 13 and 14) in a 5 Residents.	F	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	TIPLE CONSTRUCTION NG	` ′	(X3) DATE SURVEY COMPLETED	
		495174	B. WING		12	C 2/ <b>07/2022</b>	
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2978 CENTREVILLE ROAD HERNDON, VA 20171			
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F 609	On 12/5/22, during investigation it was had reported on 10 (certified nursing a argumentative and grievance form rev practical nurse) E I read, "In the morni standing in front of heard staff talking to come outside whim what happene from outside and h resident is alert, ar nurse went into resscheduled medic that a staff was yel call light, when all scrying telling this n what she has been years of age I was father and since th loud voice I becoms spoil[sic]."  Review of the griev counselled and ediour resident and the customer service." this allegation had survey agency or a On 12/5/22, in the Resident #15. Reswas verbally, ment child and has PTS disorder) and bipol had any problems	the course of a complaint determined that Resident #15 b/25/22 that an assigned CNA sistant), CNA H, was very unprofessional. Review of the ealed that LPN (licensed had written a statement that ng while passing medications [room number redacted], I loud. I called him immediately hich he [CNA H] did. I asked d and told him I could hear him e said, 'Let me talk. This had let me tell her the truth.' This sident's room to give her stations and resident told her ling at her for putting on her she wanted was a cup of water, but the tast staff doesn't know through. She continues, 'At 7 sexually abuse by my own en if anyone speaks to me in a e frighten and my whole day is by a care indicated, "associate is ucated to be professional with the eat them with respect and good. There was no evidence that been reported to the state adult protective services.  Safternoon, Surveyor B met with sident #15 verbalized that she ally, and sexually abused as a D (post-traumatic stress ar. When asked if she has with staff mistreating her she ne but we have worked it out	F6	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495174	B. WING				07/2022
	PROVIDER OR SUPPLIER HEALTH & REHAB C	ENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1978 CENTREVILLE ROAD HERNDON, VA 20171		0172022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE
F 609	and he apologized.  On 12/6/22, Survey employee file for Cl noted that CNA H h Form" dated 10/26/Verbal.". Detailed d [patient] reported a redacted] was very unprofessional. Accounselled and eduour resident and treservice"  On 12/7/22, Survey Administrator, Direct Clinical Director and facility staff was aslevidence with regarabuse being report or adult protective staff was aslevidence with regarabuse being report or adult protective staff was aslevidence with regarabuse being report or adult protective staff was aslevidence with regarabuse being reported in the facil Prevention," reveal Reporting/Responsing report all alleged in exploitation: The confidence of Licensure Reported Incident other required ager Services (APS) and report with results of the OLC within 5 wi incident"	for B asked to review the NA H. Upon review it was ad an "Associate Counseling 22, that read, "First Incident-escription of Incident: "Pt ssigned CNA [CNA H name argumentative and tion Taken: Associate was acation to be professional with eat them with good customer for B met with the facility ctor of Nursing and Corporate d discussed this incident. The ked to provide any additional reds to this incident/allegation of ed to the state survey agency services.  It policy titled; "Abuse ed, in part: "VII. e. A. Allegations of abuse,	F6	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP 2978 CENTREVILLE ROAD HERNDON, VA 20171			
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F 609	Continued From pa	age 19	F 60	09			
	allegation of abuse report the allegation to the Office of Lice adult protective ser On 12/5/22, during investigation, Survedocumentation that reported to facility Resident "felt harattreated like an anim written by Employed director. However, follow-up noted on second grievance to completed by anothallegations of the Fharassed by nursing animal were not not There was no indicated.	the course of a complaint eyor B noted in facility to Resident #12's family staff on 8/18/22 that the seed by nursing staff and nal." The grievance form was the H, the social services there was no grievance the form. Attached was a form dated the same day, the staff member. The Resident feeling that she was a graff and treated like an outed on the second form. Seation that this allegation was the survey agency or adult					
	revealed that she had facility and, therefore interviewed. Review revealed an entry of that read, "UM [uniteam met with resist concerns along with patient concerns waddressed, pain makes was reviewed and order and consultations."	cal record for Resident #12 had been discharged from the re, was not able to be w of the progress notes on 8/18/22 at 15:19 (3:19 p.m.) t manager] along with care dent and family to discuss h plan of care as ordered. ere acknowledged and anagement and bowel regimen order changes initiated per md tion. plan of care reviewed with des. all parties involved					

		IDENTIFICATION NITIMBED:		PLE CONSTRUCTION  G	COM	(X3) DATE SURVEY COMPLETED C	
		495174	B. WING			07/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2978 CENTREVILLE ROAD HERNDON, VA 20171			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 609	concerns as well. In note made no mer harassed and treat Resident #12's clim Medicare/5 day as set) was conducted assessment, Resident the brief intervision the facility Administ Corporate Clinical reports were review allegation of feeling animal. The Admindefinitely an emotion prompt an investign we would send a Facility staff we additional informate that this allegation survey agency or a facility had nothing. No additional information and adultional information of abuse and adult protective.	anding of plan of care and care resident remains stable." The ation of the report of "feeling ted like an animal."  Inical chart revealed that a sessment/MDS (minimum data d 8/12/22. During this dent #12 scored a 12 out of 15 ew for mental status, which ely impaired cognition.  O AM, during an interview with trator, Director of Nursing and Specialist, several Resident wed, to include Resident #12's g harassed and treated like an inistrator said, "There is onal component. It would ation and based on the findings "RI [facility reported incident]." ere asked to provide any ion they may have to indicate was reported to the state adult protective services. The to provide.  The mation was provided.  The provide of the staff hurting her cility staff failed to report the extra to the state survey agency exervices.  The an entrance conference held	F 609				
	were asked to prov	ninistrator, the facility staff vide all facility reported om August 2022 through					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495174	B. WING				C <b>07/2022</b>
	PROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2978 CENTREVILLE ROAD HERNDON, VA 20171	,	01/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 609	December 2022. FRI's, which were On 12/5/22, during allegation, Surveyof family reported to be reported they were they turned her side noted on a grievant "Grievance Official see attached'. The statement that reapatient to discuss that staff was hurting shoulders when provide to side. Paties taff to stop hurting that she did not thin hurting her. SW and explained what the she could assist if the staff from hurting would have helped Resident #2 had be and was not availar record review was revealed that Residus sessment/MDS on 11/30/22. This #2 as having had a status score of 12 Resident #2 had many the entire clinical reviewed with no services.	The facility staff provided 2 not regarding Resident #2.  If the course of a complaint or B noted that Resident #2's facility staff that the "patient hurting her during care, when the to side." The complaint was note form and in the section for I Follow-up" it read, "Please here was attached a typed do, "SW (social worker met with the concerns. Patient stated and her on her neck and oviding care/turning her from the stayed that she asked the gold her [sic]. Patient did state and the staff was intentionally sked patient, if they staff had be were going to do and how that would have helped preventing her. Patient said yes that	F6	609			
	11/25/22.	PM Surveyor R met with the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	495174	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	12/0	07/2022
	HEALTH & REHAB C	ENTER		2	978 CENTREVILLE ROAD IERNDON, VA 20171		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	When asked about Resident #2, the Addaughter called whimeeting, and we week when the CNA was on her stroke affect mother called the dishe was in her chaitelling the CNA (CN she wasn't paying a rushing through."  During the above in she was asked if a if that would be an administrator said, gets that kind of coresident and get dethey feel like it was allegation."  On 12/7/22 at 10:20 the facility Administ Corporate Clinical Sinterview, the Admin when Residents regallegation of abuse, reporting is required that all documentat reveal this was don to provide any addition. No further information Resident #2's allegation of the corporate that the allegation of the corporate that all documentat reveal this was don to provide any additional that the allegation of the corporate that the corporate that the allegation of the corporate that the cor	r and Director of Nursing. the allegation regarding diministrator said, "The file we were in morning ent to talk with the patient. Is turning her, she was leaning ted side and it hurt her. The aughter. When we went in, r eating, she said she was lA J) she was hurting her, and attention and feels like she was terview with the Administrator, Resident says staff are rough, allegation of abuse. The "Yes, usually social worker incern and will interview the tails, ask if they feel safe, if intentional. It's still an  O AM, a meeting was held with rator, Director of Nursing and Expecialist. During this inistrator acknowledged that bort staff are rough, it is an and an investigation and d. The facility was advised ion provided thus far doesn't e. The facility was instructed	F	309			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP O 2978 CENTREVILLE ROAD HERNDON, VA 20171			
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F 609	facility staff an alleg staff failed to report report the results of the report report the results of the report the results of the report the results of the report investigation, the facility any Facility Report investigations concept resent. The facility which involved Results of the resu	1, whose spouse reported to gation of abuse, the facility to the allegation and failed to fan investigation.  The entrance conference held ininistrator and Director of staff were asked to provide the ded incidents (FRI's) and directed from August through the try provided 2 FRI's, neither of sident #11.  The course of a complaint the eyor B determined that the had reported to a facility 12/22, that he "is not happy the reat his wife." The complaint staff told his wife to shut up ask question [sic]" A se completed and contained no se of any investigation being rievance official follow up" of care with staff and educated service and techniques with balized. Educated on resident's [unit manager] spoke with RP (spouse and patient at bedside essed to satisfactory with all d."	F 6	,			
	clinical record reve 10/11/22, a MDS (r assessment tool) v #11 had a BIMS (b	interviewed. Review of the aled that on 8/17/22 and on minimum data set) (an was conducted, and Resident rief interview for mental status) a assessments. This score					

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		495174	B. WING				C 07/2022
	PROVIDER OR SUPPLIER HEALTH & REHAB C	ENTER	ı	29	TREET ADDRESS, CITY, STATE, ZIP CODE 978 CENTREVILLE ROAD IERNDON, VA 20171	1 12/	0112022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	indicated that Resic questions correctly Both assessments #11 not having any was no documentar with regards to the #11 had a care plar read, "[Resident #1 adjusting to a new admission." Twith this care plan rexpress/discuss feer reassurance and suffiends and other sufficients and other	dent #11 had answered all and was cognitively intact. were also coded as Resident symptoms of delirium. There tion within the progress notes above allegation. Resident initiated on 8/11/22, that 1's name redacted] is environment r/t [related to] the interventions associated read, " Allow patient/resident to elings and provide apport, encourage family, apport persons to visit., and other patients/residents on the 11's spouse reported and it was recorded on a rm. The details of the n Monday 8/15/22 at 7 PM; room and changed my PM & stated, "This is the last to to get brief changed until facility staff wrote on the this grievance was resolved follow-up read, "CNA and staff with good customer services tient's rights and lis with understanding and has right to call for s and assistance at all times." ence of the education provided gation into who the CNA was and this and then neglected to		609			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495174	B. WING _		12	C /07/2022
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP 2978 CENTREVILLE ROAD HERNDON, VA 20171		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 609	Administrator was evidence of any invregarding the above Administrator state Administrator, who no further document No evidence of the reported to the state protective services conclusion of the services conclu	asked to provide any and all vestigation and reports made to allegations. The sid she had called the former is out on leave, and they had nots to provide.  allegation of abuse being the survey agency or adult was provided prior to the urvey.  O AM, during an interview with trator, Director of Nursing and Specialist, several Resident Resident #11's allegation of up" were discussed. The or acknowledged that this could se" and an investigation should ted. When asked, "What if a is taken away or they are toldinge for the night?" The pediately said, "Oh that's povided no further evidence with at #11's allegations prior to the ted they had submitted all	F 60	9		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C		
		495174	B. WING_		12	/07/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2978 CENTREVILLE ROAD HERNDON, VA 20171	•	
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F 609	#16 on 9/8/22, who member, that "[CN gentle with her whi had an attitude." That the Resident ranager upon integrated and provided with indicated "First Incomported the allegated days of the results survey agency or a comported the allegated about the allegated and MDS that was a completed 11/29/2 score of 14, which cognitively intact. with regards to the comports were review allegation of a staff an attitude. The Ahave to look into it.	reported to a facility staff A B's name redacted] was not le changing her and the CNA he grievance form indicated eported the same to the unit erview. The CNA was educated a counseling form that ident- In-service."  ence that the facility staff ation nor filed a report within 5 of an investigation to the state adult protective services.  afternoon, Surveyor B met with eir room. Resident #16 was bove noted allegation. responded to questions by and indicated that no one had her about her complaint. It #16's clinical record revealed a quarterly assessment 2. Resident #16 had a BIMs indicated the Resident was There were no progress notes allegation.  O AM, during an interview with trator, Director of Nursing and Specialist, several Resident wed, to include Resident #16's f not being gentle and having dministrator stated, "We would	F 60	09		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED C	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2978 CENTREVILLE ROAD HERNDON, VA 20171			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 609	Continued From pa	age 27	F 60	9			
	abuse, the facility sallegation and resustate survey agence. On 12/5/22, during investigation, Survestigation,	3 who reported an allegation of staff failed to report the alts of an investigation to the ey and adult protective services.  I the course of a complaint eyor B determined through the Resident #13 reported on staff member was very rough et. He was angry and very curt facility's response was, "Staff caring for resident." There was led that the allegation was the survey agency and adult to the the alternative and investigation were reported.  There was also no evidence an investigation were reported.  There was also no evidence an investigation were reported.  There was also no evidence an investigation were reported.  There was also no evidence an investigation were reported.  There was also no evidence an investigation were reported.  There was also no evidence an investigation were reported.  There was also no evidence an investigation were reported.  There was also no evidence an investigation were reported.  There was also no evidence an investigation were reported.  There was also no evidence an investigation were reported.  There was also no evidence an investigation were reported.  There was also no evidence an investigation were reported.  There was also no evidence an investigation were reported.  There was also no evidence an investigation were reported.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C		
		495174	B. WING _			) 07/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2978 CENTREVILLE ROAD HERNDON, VA 20171	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 609	allegations of abus "OLC (Office of Lic survey agency), Ac Ombudsman.  The facility staff pregards to Resider survey exit and state evidence they had  7. For Resident #1 possible abuse rep	er stated that reports of or se have to be reported to the sensure and Certification) (state dult Protective services and the ovided no further evidence with at #13's allegations prior to the sted they had submitted all 4, who had an allegation of ported by a family member, the	F 60	9		
	on 12/5/22, during investigation, Surv facility records that reported on 11/25/2 pushing on patient response was, "fre by staff. Adhere a family concerns as should identify their they can be of help with care and explanations."	o report the allegation to the cy and adult protective services.  The course of a complaint eyor B determined through the Resident #14's family member 22, "3-11 shift CNA was "s forehead." The facility's equent rounding recommended and respond to patient and a soon as possible. Staff maselves with name and how of the Staff instructed to be gentled ain care proceeding before				
	Resident #14. Re staff treatment. Re rough, I tell them I them push me on them, they get frustraknow that I would ranyone." Resident	M, Surveyor B met with a sident #14 was asked about esident #14 said, "They are ley I'm 75, be easy. I've had the back of my head to move ated. I feel safe but I don't recommend this place to the talk asked if she knew if ated her concerns, and				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C	
		495174	B. WING		l l	7/2022
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2978 CENTREVILLE ROAD  HERNDON, VA 20171	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 609	Review of Resident she had an admission completed 11/30/2. Resident #14 had a indicated she was  On 12/7/22 at 10:2 the facility Adminision Corporate Clinical reports were review allegation of a staff forehead. The Adrithe staff member is said it was during of forehead. When a would be if it had be investigation was obe on the grievance details	t #14's clinical record revealed sion MDS/assessment 2. During this assessment a BIMS score of 14, which cognitively intact.  O AM, during an interview with trator, Director of Nursing and Specialist, several Resident wed, to include Resident #14's pushing on the patient's ministrator was able to identify by name who was involved, and care she pressed against her sked where documentation een reported, and if an conducted, she said, "it would be form." There were no such ance form to indicate any een conducted. No evidence cate the allegation had been the agency or adult protective dovided no further evidence with at #14's allegations prior to the ted they had submitted all	F 609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495174	B. WING				C <b>07/2022</b>
	PROVIDER OR SUPPLIER	ENTER		2978	EET ADDRESS, CITY, STATE, ZIP CODE  8 CENTREVILLE ROAD  RNDON, VA 20171	12/	0112022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 609	go into the room ar When asked if this documented, Emplexplained it would be notes. When aske specifically use the considered abuse,  On 12/6/22 at 4:12 conducted with the Director/Employee and neglect and exabuse, including the a staff member, or that the facility Admat times ask the Scassist. Employee be reporting of allegatiand indicated that thandled that. Empfolder with interview investigation documents for the During an end of da Administrator, Directlinical Specialist, above findings, and additional document to indicate that the the state survey agservices.	and follow-up on what they said." conversation gets oyee G said, "yes" and further oe in the Resident's progress d if a Resident or family must word abuse for it to be Employee G said "no."	F6	609			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		495174	B. WING			12/	07/2022
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DULLES	HEALTH & REHAB C	FNTFR			978 CENTREVILLE ROAD		
DOLLLO	TIERETT & RETIRE O	ENTER		Н	IERNDON, VA 20171		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
		,			DEFICIENCY)		
F 609	facility notified the	ge 31 survey team they had nentation they had to provide.	F 6	609			
	Complaint related of Investigate/Prevent CFR(s): 483.12(c)(c)	/Correct Alleged Violation	F 6	310			
		onse to allegations of abuse, n, or mistreatment, the facility					
	§483.12(c)(2) Have violations are thoro	e evidence that all alleged ughly investigated.					
		ent further potential abuse, n, or mistreatment while the rogress.					
	designated represe accordance with St Survey Agency, with incident, and if the appropriate correct	ort the results of all e administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken.  NT is not met as evidenced					
	Based on Residen clinical record revie review and in the co investigation, the fa allegations of abuse	t interview, staff interviews, ew, facility documentation ourse of a complaint acility staff failed to investigate e/neglect for 6 Residents 16, 13, 14 and 12) in a survey lents.					
	The findings include	ed:					
	1. For Resident #15	5, who had an allegation of					

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F 610	abuse, the facility s complete and through on 12/5/22, during investigation it was had reported on 10 (certified nursing as argumentative and grievance form reversation of the argumentation	taff failed to conduct a	F 61			

AND PLAN OF CORRECTION IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C		
		495174	B. WING _			07/2022	
	PROVIDER OR SUPPLIER HEALTH & REHAB (	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2978 CENTREVILLE ROAD HERNDON, VA 20171	•		
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F 610	child and has PTSI disorder) and bipol had any problems said, "There was o and he apologized. Review of the clinic revealed that she had a set) (an asses 11/16/22. On this a BIMS (brief intervation of 15, which intact. The progreshad no documenta of abuse. Review revealed a focus at Concernsmisinterinitiated 6/11/18 and Interventions for the not limited to: "Of or negative behaviores and bipolicy and bipolicy in the concerns of the con	D (post-traumatic stress ar. When asked if she has with staff mistreating her, she ne, but we have worked it out "  cal record for Resident #15 had a quarterly MDS (minimum assessment) conducted on assessment Resident #15 had view for mental status) score of a indicated she was cognitively as notes were reviewed and tion with regards to the report of Resident #15's care plan rea that read, "Behavior expreting the truth" that was d revised on 9/9/20. is care plan included but were been promptly, Observe/assess tive behaviors. Report for	F 61	0			
	employee file for C noted that CNA H is Form" dated 10/26 Verbal.". Detailed of [patient] reported a redacted] was very unprofessional. Ac counselled and edu our resident and tra service" There we had been suspend investigation.	yor B asked to review the NA H. Upon review it was nad an "Associate Counseling /22, that read, "First Incident-description of Incident: "Pt assigned CNA [CNA H name argumentative and ction Taken: Associate was ucation to be professional with eat them with good customer was no evidence that CNA H ed during the course of an					

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	PROVIDER OR SUPPLIER HEALTH & REHAB (	CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2978 CENTREVILLE ROAD HERNDON, VA 20171		
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F 610	Administrator, Dire Clinical Director an facility staff was ad an investigation be Administrator state manager come talk On 12/7/22 at 10:5 came to the confer Surveyor B about F B said, "It happene when I came in, I h the Resident and a her, she had calme gets very upset and down. She [Reside and said [CNA H's another room, the felt like she wasn't be having a norma he apologized- she feels he is a good was taken off the sweek. I did an inte so no one repeats talked to any witne RN B stated she of the staff member, I written statement from CN from a nurse that he worked the nigh incident happened 10/31/22. The facithat CNA H is prn (	ctor of Nursing and Corporate and discussed this incident. The vised there was no evidence of ing conducted. The dishe would have the unit	F 61			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER HEALTH & REHAB C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2978 CENTREVILLE ROAD HERNDON, VA 20171	_ , . <del>_</del> .	
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F 610	when he is available didn't reveal any so 10/25-10/31. The f Surveyor B a text in supervisor's cell phe CNA H was able to scheduler knew he unable to work for a A review of the facing revealed, in part: ". Designated staff with investigate all reports and documentary etaking photographs residents and staff the incident or allegwitness statements and documenting etaking photographs residents and staff the incident or allegwitness statements and documenting etaking photographs residents and staff the incident or allegwitness statements and documenting etaking photographs residents and committee will conducted investigation. C. The Committee will conducted and comif possible, of the inevent the investigation contain possible. The Centinvestigations until No further information.	the therefore his time card sheduled shifts from facility Administrator did show message that was sent to the ione on 10/31/22, asking if work, as an indication that the had been suspended and a period of time.  It y policy, "Abuse Prevention," V. Investigation: A. Il immediately review and red incidents or allegations. It include collecting physical evidence which may include as a necessary, interviewing with personal knowledge of ged incident, requesting with personal knowledge of ged incident, requesting as collecting relevant evidence, each step taken during the ne Quality Assurance duct analysis for trends. D. We bodies, such as the local ceted as directed by the cordance with state and local ity. E. Investigations will be impleted within 5 working days, incident or allegation. In the tion has not been completed a itted to the state licensing and hing as much information as is ter shall continue complete"	F 6			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C	
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F 610	on 12/5/22, during with the facility Adn Nursing, the facility any Facility Reporte investigations conducted investigation, Surve Resident #11's spo staff member on 8/with the way staff tread, "Last night a when she want to a grievance form was supporting evidence conducted. The "gr read, "review plan on good customer sunderstanding verbrights as well. UM [responsible party]/ and concerns addressions answere Resident #11 was own was not able to be clinical record reve 10/11/22, a MDS (rassessment tool) we #11 had a BIMS (be score of 15 on both indicated that Residents and the second	the entrance conference held ninistrator and Director of staff were asked to provide ed Incidents (FRI's) and sucted from August to the typrovided 2 FRI's, neither sident #11.  The course of a complaint eyor B determined that suse had reported to a facility 12/22, that he "is not happy reat his wife." The complaint staff told his wife to shut up ask question [sic]" A secompleted and contained no se of any investigation being ievance official follow up" of care with staff and educated service and techniques with palized. Educated on resident's [unit manager] spoke with RP spouse and patient at bedside sessed to satisfactory with all	F 61			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  DULLES HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP 0 2978 CENTREVILLE ROAD HERNDON, VA 20171		70172022	
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F 610	was no documenta with regards to the #11 had a care plaread, "[Resident #1 adjusting to a new new admission." Twith this care plan express/discuss fereassurance and striends and other suntroduce to staff at the unit."  On 8/17/22, Resideanother complaint grievance form. Tread, "On Monday into the room and 7PM & stated, 'Thinight.' CNA closed call bell within read did not get brief ch facility staff wrote of grievance was resifollow-up read, "CN with good custome Patient's rights and understanding verticall for incontinence times." There was provided to staff, a CNA was that told neglected to providence of any inconducted that had conducted that had conducted that had a care plant and a care pla	above allegation. Resident n initiated on 8/11/22, that lit's name redacted] is environment r/t [related to] The interventions associated read, " Allow patient/resident to	F 61				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED		
		495174	B. WING_		12	C :/07/2022	
NAME OF PROVIDER OR SUPPLIER  DULLES HEALTH & REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODI 2978 CENTREVILLE ROAD HERNDON, VA 20171			
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F 610	stated she had cal who is out on leave documents to prove the providence of an regards to Resider to "shut up" prior to "shut u	led the former Administrator, e, and they had no further ride.  investigation was provided with at #11's allegation of being told to the conclusion of the survey.  O AM, during an interview with trator, Director of Nursing and Specialist several Resident Resident #11's allegation of up," were discussed. The or acknowledged that this could se" and an investigation should ted. When asked, "What if a is taken away or they are told nge for the night?" The ediately said, "Oh that's		,			
	Surveyor B noted a #16 on 9/8/22, who member, that "[CN gentle with her whi had an attitude." T that the Resident r manager upon inte	a grievance filed by Resident or reported to a facility staff [A B's name redacted] was not the changing her and the CNA he grievance form indicated eported the same to the unit erview. The CNA was educated a counseling form that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		LE CONSTRUCTION	CON	TE SURVEY MPLETED	
		495174	B. WING			1	/07/2022	
NAME OF PROVIDER OR SUPPLIER  DULLES HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  2978 CENTREVILLE ROAD  HERNDON, VA 20171				OTTEGEE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 610	indicated "First Inci There was no evide investigated the alle Residents had expected the Alle Residents had expected the Alle Resident #16 in the asked about the Alle Resident #16 in the asked about the Alle Resident #16 only resident #17 or properties to the On 12/7/22 at 10:20 the facility Administ Corporate Clinical Screports were review allegation of a staff an attitude. The Achave to look into it at the facility staff properties were review allegation of a staff an attitude. The Achave to look into it at the facility staff properties were resident #16 only regards to Resident #	dent- In-service."  ence that the facility staff egation to determine if other erienced the same behavior by staff.  afternoon, Surveyor B met with eir room. Resident #16 was ove noted allegation. responded to questions by and indicated that no one had er about her complaint. It #16's clinical record revealed quarterly assessment 2. Resident #16 had a BIMs indicated the Resident was There were no progress notes allegation.  D AM, during an interview with trator, Director of Nursing and Specialist, several Resident wed, to include Resident #16's not being gentle and having dministrator stated, "We would	F6	310				
	_	the course of a complaint						

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE SURVEY COMPLETED C		
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NAME OF PROVIDER OR SUPPLIER  DULLES HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP O 2978 CENTREVILLE ROAD HERNDON, VA 20171		70172022		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	N SHOULD BE	(X5) COMPLETION DATE		
investigation, Surve facility records that 10/27/22, "a male s while providing car with patient." The was in-service on cono evidence provide conducted.  Resident #13 had a facility and was not Review of the clinic documentation with incident. Resident MDS/assessment of 14, which indicate and a reliable history of 12/7/22 at 10:2 the facility Administrator and corporate Clinical areports were review allegation of a staff Administrator said, and look at willfulnemean an investigate conducted, the Administrator said, and look at willfulnemean an investigate conducted, the Administrator said, and look at willfulnemean an investigate conducted, the Administrator said, and look at willfulnemean an investigate conducted, the Administrator said, and look at willfulnemean an investigate conducted, the Administrator said, and look at willfulnemean an investigate conducted, the Administrator said, and look at willfulnemean an investigate conducted, the Administrator said, and look at willfulnemean an investigate conducted, the Administrator said, and look at willfulnemean an investigate conducted, the Administrator said, and look at willfulnemean an investigate conducted, the Administrator said, and look at willfulnemean an investigate conducted, the Administrator said, and look at willfulnemean an investigate conducted.	Resident #13 reported on staff member was very rough e. He was angry and very curt facility's response was, "Staff caring for resident." There was ed that an investigation was been discharged from the able to be interviewed. Cal record revealed no a regards to this reported #13 had an admission completed 10/24/22. During esident #13 had a BIMS score ted she was cognitively intact rian.  O AM, during an interview with trator, Director of Nursing and Specialist several Resident wed, to include Resident #13's being "rough." The "we would have to interview ess." When asked if this would cion would have to be ministrator said, "Yes."  Divided no further evidence with the #13's allegations prior to the ted they had submitted all	F 61	0				
·	· ·						
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTE PROBLEM CONTINUED FROM PAIR INVESTIGATION OF LETTE PROBLEM PAIR INVESTIGATION OF LETTE PA	APPROVIDER OR SUPPLIER  HEALTH & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 40 investigation, Surveyor B determined through facility records that Resident #13 reported on 10/27/22, "a male staff member was very rough while providing care. He was angry and very curt with patient." The facility's response was, "Staff was in-service on caring for resident." There was no evidence provided that an investigation was	A BUILDIN B. WING	ROVIDER OR SUPPLIER  ##EALTH & REHAB CENTER  ##EALTH & REHAB CENTER  ##EALTH & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 40  investigation, Surveyor B determined through facility records that Resident #13 reported on 10/27/22, amale staff member was very rough while providing care. He was angry and very curt with patient." The facility's response was, "Staff was in-service on caring for resident." There was no evidence provided that an investigation was conducted.  Resident #13 had been discharged from the facility and was not able to be interviewed. Review of the clinical record revealed no documentation with regards to this reported incident. Resident #13 had an admission MDS/assessment Resident #13 had a BIMS score of 14, which indicated she was cognitively intact and a reliable historian.  On 127/122 at 10:20 AM, during an interview with the facility Administrator, Director of Nursing and Corporate Clinical Specialist several Resident reports were reviewed, to include Resident #13's allegation of a staff being "rough." The Administrator said, "we would have to interview and look at willfulness." When asked if this would mean an investigation would have to be conducted, the Administrator said, "Yes."  The facility staff provided no further evidence with regards to Resident #13's allegations prior to the survey exit and stated they had submitted all evidence they had.  5. For Resident #14, who had an allegation of possible abuse reported by a family member, the facility staff failed to conduct an investigation.	ROVIDER OR SUPPLIER  ### HEALTH & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 40 investigation, Surveyor B determined through facility records that Resident #13 reported on 10/27/122, a male staff member was very rough while providing care. He was angry and very curt with patient." The facility's response was, "Staff was in-service on caring for resident." There was no evidence provided that an investigation was conducted.  Resident #13 had been discharged from the facility and was not able to be interviewed. Review of the clinical record revealed no documentation with regards to this reported incident. Resident #13 had an admission MDS/assessment completed 10/24/22. During this assessment Resident #13 had a BIMS score of 14, which indicated she was cognitively intact and a reliable historian.  On 127/1/22 at 10-20 AM, during an interview with the facility Administrator, Director of Nursing and Corporate Clinical Specialist several Resident #13's allegation of a staff being "rough." The Administrator said, "we would have to be conducted, the Administrator said, "we would have to be conducted, the Administrator said, "we."  The facility staff provided no further evidence with regards to Resident #13's allegation of a staff being "rough." The Administrator said, "yes."  The facility staff provided no further evidence with regards to Resident #13's allegation of the survey exit and stated they had submitted all evidence they had.  5. For Resident #14, who had an allegation of possible abuse reported by a family member, the facility staff failed to conduct an investigation.		

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NAME OF PROVIDER OR SUPPLIER  DULLES HEALTH & REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE 2978 CENTREVILLE ROAD HERNDON, VA 20171	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE	
F 610	investigation, Surv facility records tha reported on 11/25/pushing on patient response was, "free by staff. Adhere a family concerns as should identify the they can be of help with care and explicate."  On 12/6/22 at 4 PN Resident #14. Resident #14. Resident #14. Resident #14 would anyone." Resident the facility investig #14 said she was Review of Resider she had an admission completed 11/30/2 Resident #14 had indicated she was  On 12/7/22 at 10:2 the facility Administ Corporate Clinical reports were reviewallegation of a stafforehead. The Addithe staff member is said it was during forehead. When a general reported to the staff member is said it was during forehead. When a general reported to the staff member is said it was during forehead. When a general reported to the staff member is said it was during forehead. When a general reported to the staff member is said it was during forehead. When a general reported to the staff member is said it was during forehead. When a general reported to the staff member is said it was during forehead. When a general reported to the staff member is said it was during forehead. When a general reported to the staff member is said it was during forehead. When a general reported to the staff member is said it was during forehead. When a general reported to the staff member is said it was during forehead. When a general reported to the staff member is said it was during forehead.	eyor B determined through t Resident #14's family member 22, "3-11 shift CNA was 's forehead." The facility's equent rounding recommended and respond to patient and a soon as possible. Staff mselves with name and how b. Staff instructed to be gentle ain care proceeding before  M. Surveyor B met with esident #14 was asked about esident #14 said, "They are fley I'm 75, be easy. I've had the back of my head to move ated. I feel safe but I don't recommend this place to t #14 was asked if she knew if ated her concerns, Resident not aware.  At #14's clinical record revealed sion MDS/assessment 2. During this assessment a BIMS score of 14, which	F 610				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495174	B. WING_			C / <b>07/2022</b>
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2978 CENTREVILLE ROAD HERNDON, VA 20171		
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F 610	she said, "it would There were no sucto indicate any investigation, survey exit and state evidence they had.  6. For Resident #1. Resident felt harast treated like an animoduct an investigation, Survedocumentation that reported to facility Resident "felt harast reated like an animoduct an investigation, Survedocumentation that reported to facility Resident "felt harastreated like an animoduct an investigation of the Felton by Employed director. However, follow-up noted on second grievance of completed by anotal legations of the Felton by Employed allegations	be on the grievance form." h details on the grievance form estigation had been conducted. Divided no further evidence with at #14's allegations prior to the ted they had submitted all  2, whose family reported the sed by nursing staff and hal, the facility staff failed to gation.  The course of a complaint eyor B noted in facility to take the sed by nursing staff and hal." The grievance form was been the social services there was no grievance the form. Attached was a form dated the same day, her staff member. The desident feeling that she was no great on the second form. gation had no	F 6			
	revealed that she h facility and therefor interviewed. Review revealed an entry of "UM [unit manager	cal record for Resident #12 had been discharged from the re, was not able to be w of the progress notes on 8/18/22 at 15:19, that read, along with care team met amily to discuss concerns				

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F 610	along with plan of concerns were ack pain management reviewed and orde order and consulta staff nurses and ai verbalized underst concerns as well. In note made no mer harassed and treat Resident #12's clir Medicare/5 day as set) was conducted assessment, Resident #12's clir Medicare/5 day as set) was conducted assessment, Resident moderate On 12/7/22 at 10:2 the facility Administ Corporate Clinical reports, to include feeling harassed and Administrator said, emotional componinvestigation and be send a FRI [facility facility staff were an information they minvestigation had be Resident #12.	age 43 care as ordered. Patient knowledged and addressed, and bowel regimen were r changes initiated per md dition. plan of care reviewed with des. all parties involved anding of plan of care and care resident remains stable." The ation of the report of "feeling ted like an animal."  Alical chart revealed that a sessment/MDS (minimum data d 8/12/22. During this dent #12 scored a 12 out of 15 ew for mental status, which ely impaired cognition.  Alical chart revealed that a sessment/MDS (minimum data d 8/12/22. During this dent #12 scored a 12 out of 15 ew for mental status, which ely impaired cognition.  Alical chart revealed that a sessment/MDS (minimum data d 8/12/22. During this dent #12 scored a 12 out of 15 ew for mental status, which ely impaired cognition.  The session of nursing and Specialist several Resident Resident #12's allegation of and treated like an animal. The animal the computation of the findings we would reported incident]." The sked to provide any additional ay have to indicate that an arean conducted with regards to mation was provided.	F 6				
	On 12/6/22 at 10:4 conducted with Em When asked to ex G said, "It can be r	9 AM, an interview was apployee G, a social worker. plain what abuse is, Employee mental, physical, psychosocial, orms." When asked what she					

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		495174	B. WING				C 07/2022
NAME OF PROVIDER OR SUPPLIER  DULLES HEALTH & REHAB CENTER				297	REET ADDRESS, CITY, STATE, ZIP CODE 78 CENTREVILLE ROAD ERNDON, VA 20171	<u>  121</u>	0112022
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F 610	does if someone re said, "I contact my igo into the room an When asked if this documented, Emple explained it would be notes. When asked specifically use the considered abuse,  On 12/6/22 at 4:12 conducted with the Director/Employee and neglect and exabuse, including the a staff member, or that the facility Admat times ask the So assist. Employee I with interview inform documents in her of to provide any such place from August 2/12/6/22 at 4:24 PM Surveyor B and said investigations and if requested time fram During an end of da Administrator, Direct Clinical Specialist, the above findings and additional document to indicate that investigations that investigations and additional document to indicate that investigations of the second content of the second conten	ports abuse, Employee G mmediate supervisor, then I d follow-up on what they said." conversation gets byee G said, "yes" and further be in the Resident's progress d if a Resident or family must word abuse for it to be Employee G said "no."  PM, an interview was Social Services H. Employee H defined abuse plained that anyone can report e Resident, a family member, a visitor. Employee H stated inistrator investigates and will cial Services Department to H said she maintains a folder nation and other investigation ffice. Employee H was asked files she may have that took 2022 to the present. On L Employee H returned to d she had not conducted any had no such documents for the	F 6	310			

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F 610	Continued From pa	_	F 61	0			