STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495353	A. BUILDING _____ B. WING _____	C 11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSTONE	900 S MAIN ST BLACKSTONE, VA 23824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 11/16/22. One complaint (VA00056785- unsubstantiated with a related deficiency) was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 180 bed certified facility was 145 at the time of the survey. The survey sample included four current resident reviews (Residents #1, #2, #3, and #4).	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.	F 607	**F607** **Corrective Action(s):** A thorough investigation of the incident reported to the grievance form dated 5/2/22 from Resident #1 has been completed. Findings of the investigation have been reported to the OLC and other required agencies. One on one education has been completed with the Social Services Director regarding the policy for reporting allegations of abuse within 2 hours. The DON of the facility of the facility who handled the investigation is no longer employed at the building.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 12/14/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 607	Continued From page 1 §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed for one of four residents in the survey sample, to implement the abuse policy for reporting abuse, Resident #1. The findings include: The facility failed to implement their abuse policy to report occurrences according to regulations. A review of the facility grievance form, dated 5/2/22, revealed "Detail of complaint/grievance: Resident claims that he was assaulted with a paper towel while being changed and cleaned. Resident claims CNA (certified nursing assistant) inserted paper towels in his rectum while she was cleaning him." Resident #1 was admitted to the facility on 1/22/21 with diagnoses that included but were not limited to: CAD (coronary artery disease), anemia, non-traumatic brain dysfunction, non-Alzheimer's dementia, COPD (chronic obstructive pulmonary disease) and diabetes. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 9/6/22, coded the resident as scoring a 15 out of 15 on	F 607	**Identification of Deficient Practices and Corrective Action(s):** All residents to may have been potentially affected. A 100% review of all Facility Incident & Accident Forms for the previous 90 days has been completed to identify residents at risk. Any/all findings of reportable occurrences will be reviewed to ensure an FRI has been completed timely and an internal investigation with appropriate notification of outcomes to the State agencies, attending physician and responsible parties has occurred. **Systemic Change(s):** The Policy & Procedure for reporting and investigating abuse, neglect, misappropriation of resident property and injuries or unusual/unknown occurrences has been reviewed. No changes are warranted at this time. All staff will be inserviced and issued copies of the Abuse and Investigation Policy and Procedure. These educational inservices will focus on, identifying, reporting, and investigating incidents and allegations of abuse, neglect or mistreatment of residents timely. As well as resident to resident altercations and misappropriation of resident property that are reported. **Monitoring:** The Administrator is responsible for compliance. The administrator will review all facility incident reports to ensure that requirements for a thorough investigation have been met. Negative findings will be addressed at the time of discovery. The QA committeee will review all FRI's not less than quarterly to ensure they have been reported timely. Any negative findings will be corrected at time of	

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F 607	Continued From page 2 the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring total dependence for transfer and bathing; extensive assistance for bed mobility, dressing and hygiene and limited assistance for eating. A review of the comprehensive care plan with a date of 1/22/21 and revision date of 8/29/22, revealed, "PROBLEM /NEED: Potential for injury for diagnosis of suicidal ideations, anxiety disorder, psychosis, dementia with behavioral disturbances, depression. Makes paranoid accusations against staff. APPROACHES: Monitor and document behavior as needed. Report increased negative behavior to the physician. Maintain resident environment free of clutter and safety hazards." The facility's policy titled "Abuse, Neglect and Exploitation" dated 10/24/22, included: "Reporting/Response: the facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specific timeframes. Immediately, but not later than 2 hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and not result in serious bodily injury." An interview was conducted on 11/16/22 at 11:10 AM, with OSM (other staff member) #1, the director of social services. When asked who followed up with Resident #1 regarding his	F 607	discovery and disciplinary action will be taken as warranted. **Completion Date:12/23/22**	

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F 607	Continued From page 3	F 607		

allegation of sexual assault, OSM #1 stated, "On Sunday (5/1/22), I talked with the nursing supervisor, who told me what the resident stated. She gave me her statement in writing. I came in on Monday (5/2/22), talked with the resident and he told me the story, the CNA was caring for him, she was assigned to him and she was cleaning him and he felt like he was sexually assaulted with her finger. His perception was that he was sexually assaulted. I did my investigation with the DON (director of nursing), we got written statements and had the NP (nurse practitioner) do an actual physical assessment. Later in the day was briefed that they could not prove the allegation." The DON said nursing will handle this. When asks who reports allegations of abuse, OSM #1 stated, "The administrator or the DON report it to the state, I do not do this."

An interview was conducted on 11/16/22 at 11:30 AM, with RN (registered nurse) #2, the infection preventionist. When asked her role, RN #2 stated, "At the time of this event, I was the nursing supervisor on the weekend." RN #2 was asked to read and verify the statement she provided to OSM #1. RN #2 verified statement. When asked to detail the events, RN #2 stated, "The resident stated this happened on Friday (4/29/22) evening and reported it to me on Sunday (5/1/22) at 11:54 AM. I had not heard anything in report nor had the resident told me this before. I assessed his rectal area, did not see any broken skin, no redness or any abnormalities. The resident was calm when I talked with him and had no other concerns. I informed the DON on Sunday." When asked if she files reports to agencies related to allegations of abuse, RN #2 stated, "No, I follow my chain of command, inform the DON and administrator.

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F 607	Continued From page 4 Normally one of them will report. I do not report outside of the facility." An interview was conducted on 11/16/22 at 12:15 PM, with ASM (administrative staff member) #1, the administrator. When asked who was responsible to report allegations of abuse, ASM #1 stated, "At that time it was the DON's responsibility to report to VDH-OLC (Virginia Department of Health-Office Licensure Certification) and others. I do not see where we sent an initial or final FRI (facility reported incident) but will look again." ASM #1 stated the policy states, reporting within 2 hours of allegation of abuse. The director of nursing did not report because she felt that after the investigation, the allegation was not substantiated, there was no physical evidence of abuse and the resident's story was not matching up. On 11/16/22 at 12:46 PM, ASM #1 stated, "There are no records of a FRI being sent to your office either initially or final after investigation." On 11/16/21 at 12:50 PM, ASM #1, was made aware of the finding. No further information was provided prior to exit.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609		

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F 609	Continued From page 5 are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to report an allegation of abuse in a timely manner to the State Agency for one of four residents in the survey sample, Resident #1. The findings include: The facility failed to report an allegation of abuse to the State Agency. A review of the facility grievance form, dated 5/2/22, revealed "Detail of complaint/grievance: Resident claims that he was assaulted with a paper towel while being changed and cleaned. Resident claims CNA (certified nursing assistant)	F 609	**F609** **Corrective Action(s):** The incident reported on the grievance form dated 5/2/22 from Resident #1 has been reported to the OLC and other required agencies as an FRI. A thorough investigation of the incident reported to the grievance form dated 5/2/22 from Resident #1 has been completed. Findings of the investigation have been reported to the OLC and other required agencies. The findings of the investigation have been reported to OLC and other required agencies One on one education has been completed with the Social Services Director regarding the policy for reporting allegations of abuse within 2 hours. The DON of the facility of the facility who handled the investigation is no longer employed at the building. **Identification of Deficient Practices and Corrective Action(s):** All residents to may have been potentially affected. A 100% review of all Facility Incident & Accident Forms for the previous 90 days has been completed to identify residents at risk. Any/all findings of reportable occurrences will be reviewed to ensure an FRI has been completed timely and an internal investigation with appropriate notification of outcomes to the State agencies, attending physician and responsible parties has occurred.	

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F 609	Continued From page 6 inserted paper towels in his rectum while she was cleaning him." Resident #1 was admitted to the facility on 1/22/21 with diagnoses that included but were not limited to: CAD (coronary artery disease), anemia, non-traumatic brain dysfunction, non-Alzheimer's dementia, COPD (chronic obstructive pulmonary disease) and diabetes. The facility's policy titled "Abuse, Neglect and Exploitation" dated 10/24/22, revealed, "Reporting/Response: the facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specific timeframes. Immediately, but not later than 2 hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and not result in serious bodily injury." An interview was conducted on 11/16/22 at 11:10 AM, with OSM (other staff member) #1, the director of social services. When asked who followed up with Resident #1 regarding his allegation of sexual assault, OSM #1 stated, "On Sunday (5/1/22), I talked with the nursing supervisor, who told me what the resident stated. She gave me her statement in writing. I came in on Monday (5/2/22), talked with the resident and he told me the story, the CNA was caring for him, she was assigned to him and she was cleaning him and he felt like he was sexually assaulted with her finger. His perception was that he was sexually assaulted. I did my investigation with the DON (director of nursing), we got written	F 609	**Systemic Change(s):** The Policy & Procedure for reporting and investigating abuse, neglect, misappropriation of resident property and injuries or unusual/unknown occurrences has been reviewed. No changes are warranted at this time. All staff will be inserviced and issued copies of the Abuse and Investigation Policy and Procedure. These educational inservices will focus on, identifying, reporting, and investigating incidents and allegations of abuse, neglect or mistreatment of residents timely. As well as resident to resident altercations and misappropriation of resident property that are reported. **Monitoring:** The Administrator is responsible for compliance. The administrator will review all facility incident reports to ensure that reporting requirements have been met. Negative findings will be addressed at the time of discovery. The QA committee will review all FRI's not less than quarterly to ensure they have been reported timely. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. **Completion Date:12/23/22**	

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F 609	Continued From page 7	F 609		

statements and had the NP (nurse practitioner) do any actual physical assessment. Later in the day was briefed that they could not prove the allegation." OSM #1 stated the DON said nursing will handle this. When asked who reports allegations of abuse, OSM #1 stated, "The administrator or the DON report it to the state, I do not do this."

An interview was conducted on 11/16/22 at 11:30 AM, with RN (registered nurse) #2, the infection preventionist. When asked her role, RN #2 stated, "At the time of this event, I was the nursing supervisor on the weekend." RN #2 was asked to read and verify the statement she provided to OSM #1. RN #2 verified statement. When asked to detail the events, RN #2 stated, "The resident stated this happened on Friday (4/29/22) evening and reported it to me on Sunday (5/1/22) at 11:54 AM. I had not heard anything in report nor had the resident told me this before. I assessed his rectal area, did not see any broken skin, no redness or any abnormalities. The resident was calm when I talked with him and had no other concerns. I informed the DON on Sunday." When asked if she files reports to state agencies related to allegations of abuse, RN #2 stated, "No, I follow my chain of command, inform the DON and administrator. Normally one of them will report. I do not report outside of the facility."

An interview was conducted on 11/16/22 at 12:15 PM, with ASM (administrative staff member) #1, the administrator. When asked who was responsible to report allegations of abuse, ASM #1 stated, "At that time it was the DON's responsibility to report to VDH-OLC (Virginia Department of Health-Office Licensure

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F 609	Continued From page 8 Certification) and others. I do not see where we sent an initial or final FRI (facility reported incident) but will look again." ASM #1 stated, the policy states, reporting within 2 hours of allegation of abuse. The director of nursing did not report because she felt that after the investigation, the allegation was not substantiated, there was no physical evidence of abuse and the resident's story was not matching up. On 11/16/22 at 12:46 PM, ASM #1 stated, "There are no records of an FRI being sent to your office either initially or final after investigation." No further information was provided prior to exit.	F 609		