PRINTED: 11/30/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
,		495353	B. WING			Į.	C 16/2022
NAME OF PI	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2022
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HERITAGI	E HALL BLACKSTONE			BL.A	ACKSTONE, VA 23824		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F	000			
	survey was conducte (VA00056785- unsub deficiency) was inves	edicare/Medicaid abbreviated and 11/16/22. One complaint instantiated with a related stigated during the survey. The for compliance with 42 at Long Term Care					
E 607	145 at the time of the included four current #1, #2, #3, and #4).	30 bed certified facility was a survey. The survey sample resident reviews (Residents	E	607	F607		
F 607 SS=D	CFR(s): 483.12(b)(1) §483.12(b) The facilit	-(5)(ii)(iii)	F	007	Corrective Action(s): A thorough investigation of the incid reported to the grievance form dated 5/2/22 from Resident #1 has been completed. Findings of the investigat have been reported to the OLC and o	ion	
	§483.12(b)(1) Prohib neglect, and exploita misappropriation of re				required agencies. One on one education has been comp with the Social Services Director regarding the policy for reporting		
	to investigate any su	-			allegations of abuse within 2 hours. The DON of the facility of the facilit who handled the investigation is no lemployed at the building.		
	§483.12(b)(3) Include paragraph §483.95,	e training as required at	:				**************************************
	§483.12(b)(4) Establ QAPI program requir	ish coordination with the ed under §483.75.					
	facilities in accordance	e reporting of crimes r-funded long-term care ce with section 1150B of the d procedures must include					
	,	the following elements.					
LABORATORY	L / DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		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 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.

ADMINISTRATOR

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND FLAN OF	CONCLUTION		A. BUILDING			С		
		495353	B. WING		-	1	/16/2022	
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE			
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HERITAG	E HALL BLACKSTONE			E	BLACKSTONE, VA 23824			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 607	employee rights, as (3) of the Act. §483.12(b)(5)(iii) Pr retaliation, as define (2) of the Act. This REQUIREMEN by: Based on staff inter review, and clinical residents in the survabuse policy for report of the facility failed to to report occurrence A review of the facility failed to the report occurrence A review of the facility failed to the report occurrence A review of the facility failed to the report occurrence A review of the facility failed to the report occurrence A review of the facility failed to the report occurrence A review of the facility failed to the report occurrence A review of the facility failed to the report occurrence A review of the facility failed to the report occurrence A review of the facility failed to the review of the failed to the r	sting a conspicuous notice of defined at section 1150B(d) ohibiting and preventing d at section 1150B(d)(1) and T is not met as evidenced view, facility document record review, it was ity staff failed for one of four rey sample, to implement the orting abuse, Resident #1.	F	607	Identification of Deficient Practic Corrective Action(s): All residents to may have been pot affected. A 100% review of all Fa Incident & Accident Forms for the previous 90 days has been complet identify residents at risk. Any/all for reportable occurrences will be reviewed to ensure an FRI has been completed timely and an internal investigation with appropriate notic of outcomes to the State agencies, attending physician and responsibl parties has occurred. Systemic Change(s): The Policy & Procedure for reportic investigating abuse, neglect, misappropriation of resident proper injuries or unusual/unknown occur has been reviewed. No changes are warranted at this time. All staff will be inserviced and issuccopies of the Abuse and Investigating Policy and Procedure. These educatinservices will focus on, identifying reporting, and investigating incider allegations of abuse, neglect or mistreatment of residents timely. As a resident to resident altercations a misappropriation of resident proper are reported.	entially cility ed to indings fication and ed ty and rences ed on tional sts and as well and		
	1/22/21 with diagno limited to: CAD (cor anemia, non-trauma non-Alzheimer's del	Imitted to the facility on ses that included but were not onary artery disease), atic brain dysfunction, mentia, COPD (chronic ary disease) and diabetes.			Monitoring: The Administrator is responsible for compliance. The administrator will review all facility incident reports the ensure that requirements for a thore investigation have been met. Negating findings will be addressed at the tindiscovery.	o ough tive		
	assessment, a quar	DS (minimum data set) terly assessment, with an reference date) of 9/6/22, as scoring a 15 out of 15 on			The QA committeee will review all not less than quarterly to ensure the been reported timely. Any negative findings will be corrected at time or	y have		

MARE OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE A	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IOTATICIOATION MUMPED.		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
MARE OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE DO SAIN ST BLACKSTONE, VA 23824 SUMMARY STATEMENT OF DEFICIENCIES GEACH DEFICIENCY MAST SER PRECEDED BY PULL REGULATORY OR ISC IDENTIFYING INFORMATION) 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 eating. A review of the comprehensivo care plan with a date of 1/22/21 and revision date of 8/29/22, revealed, "PROBLEM NIEED: 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 o all other required agencies within specific imerfames. Immediately, but not later than 24 hours after the allegation in movive abuse or result in serious bodily injury, or not later than 24 hours if the events that causes the allegation do not involve abuse and not result in serious bodily injury, or not later than 24 hours if the events that cause the allegation in wrote abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation in review as conducted on 11/16/22 at 11:10			495353	B. WING _			1		
FREENZ RECUENCY NET DESCRIPTION OF THE PRECEDED BY FULL TAG CONTINUED FROM LISC IDENTIFYING INFORMATION) 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, demental 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 in smade, if the events that caused the allegation in smade, if the events that caused the allegation in one abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation in one to involve abuse and not result in serious bodily injury." An interview was conducted on 11/16/22 at 11:10.					900	0 S MAIN ST			
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, demental 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 poicy 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 in wrolve 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	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	,	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION	
AM, with OSM (other staff member) #1, the director of social services. When asked who followed up with Resident #1 regarding his	F 607	the BIMS (brief intendindicating the resider impaired. A review of G-functional status of requiring total dependant bathing; extensive addressing and hygien eating. A review of the complete of 1/22/21 and revealed, "PROBLET for diagnosis of suicidisorder, psychosis, disturbances, depresaccusations against Monitor and docume Report increased nephysician. Maintain clutter and safety has the facility's policy to Exploitation" dated "Reporting/Respons procedures that incluviolations to the Administration of the Administration	view for mental status) score, int was not cognitively if the MDS Section coded the resident as idence for transfer and sistance for bed mobility, in an all imited assistance for borehensive care plan with a revision date of 8/29/22, included ideations, anxiety dementia with behavioral siston. Makes paranoid staff. APPROACHES: and behavior as needed. Segative behavior to the resident environment free of interestance. In the facility will have written under reporting of all alleged in inistrator, state agency, adult and to all other required cific timeframes. It later than 2 hours after the face or result in serious bodily an 24 hours if the events that in do not involve abuse and not der staff member) #1, the revices. When asked who	F	607	taken as warranted.	be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l''	IPLE CONSTRUCT		COMPLETED		
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F 607	Sunday (5/1/22), I supervisor, who tol She gave me her son Monday (5/2/22 he told me the storshe was assigned him and he felt like with her finger. His sexually assaulted DON (director of not statements and had on actual physiciday was briefed the allegation." The Dothis. When asks we abuse, OSM #1 stated, "At the time nursing supervisor asked to read and provided to OSM #2 When asked to de "The resident state (4/29/22) evening Sunday (5/1/22) at anything in report this before. I asses see any broken skabnormalities. The talked with him an informed the DON she files reports to of abuse, RN #2 s	lassault, OSM #1 stated, "On talked with the nursing dime what the resident stated. Itatement in writing. I came in all, talked with the resident and y, the CNA was caring for him, to him and she was cleaning he was sexually assaulted as perception was that he was a lidid my investigation with the tarsing), we got written dithe NP (nurse practitioner) and assessment. Later in the at they could not prove the ON said nursing will handle the reports allegations of ated, "The administrator or the estate, I do not do this." Sonducted on 11/16/22 at 11:30 atered nurse) #2, the infection can asked her role, RN #2 of this event, I was the on the weekend." RN #2 was verify the statement she etc. RN #2 verified statement. It is the events, RN #2 stated, and reported it to me on a 11:54 AM. I had not heard nor had the resident told me assed his rectal area, did not in, no redness or any are resident was calm when I did had no other concerns. I on Sunday." When asked if a agencies related to allegations tated, "No, I follow my chain of the DON and administrator.	F	607				
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: J6	BD11	Facility ID: VA0	108	If continuation	n sheet Page 4 of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C		
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	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, Z 900 S MAIN ST BLACKSTONE, VA 23824			
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F 607		will report. I do not report	F	607			
	PM, with ASM (admir the administrator. W responsible to report #1 stated, "At that tin responsibility to repo Department of Health Certification) and oth sent an initial or final incident) but will look policy states, reportir of abuse. The directo because she felt that allegation was not su	iducted on 11/16/22 at 12:15 inistrative staff member) #1, hen asked who was allegations of abuse, ASM ne it was the DON's rt to VDH-OLC (Virginia n-Office Licensure ers. I do not see where we FRI (facility reported again." ASM #1 stated the ng within 2 hours of allegation or of nursing did not report after the investigation, the abstantiated, there was no abuse and the resident's					
F 609 SS=D	are no records of a Feither initially or final 11/16/21 at 12:50 PM of the finding. No further information Reporting of Alleged CFR(s): 483.12(b)(5) §483.12(c) in responsed to the final	o(i)(A)(B)(c)(1)(4) se to allegations of abuse, or mistreatment, the facility that all alleged violations	F	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	·	-	
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F 609	hours after the allegathat cause the allegates serious bodily injury, the events that cause abuse and do not retthe administrator of to officials (including to adult protective servifor jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the designated represent accordance with State Survey Agency, with incident, and if the atendate appropriate corrective This REQUIREMENT by: Based on staff interreview, and clinical redetermined the facility allegation of abuse in State Agency for one survey sample, Resident claims included The facility failed to to the State Agency. A review of the facility failed to the State Agency in the facility failed to the State Agency.	ately, but not later than 2 ation is made, if the events ation involve abuse or result in or not later than 24 hours if e the allegation do not involve sult in serious bodily injury, to the facility and to other the State Survey Agency and ices where state law provides g-term care facilities) in te law through established It the results of all administrator or his or her atative and to other officials in te law, including to the State in 5 working days of the lleged violation is verified the action must be taken. This not met as evidenced I is not met as evidenced	F	609	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 complete 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 long employed at the building. Identification of Deficient Practices a Corrective Action(s): All residents to may have been potentia 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 finding 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.	ed ger nd		

AND DUAN OF CORRECTION INCIDENTIFICATION AND REPORT		1''	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDIN	·			c
		495353	B. WING			1	1/16/2022
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
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F 609	cleaning him." Resident #1 was a 1/22/21 with diagr limited to: CAD (or anemia, non-traur non-Alzheimer's dobstructive pulmor. The facility's police Exploitation" dated "Reporting/Respo	admitted to the facility on closes that included but were not coronary artery disease), matic brain dysfunction, dementia, COPD (chronic mary disease) and diabetes. The facility will have written acclude reporting of all alleged diministrator, state agency, adult is and to all other required opecific timeframes. The events that caused the abuse or result in serious bodily than 24 hours if the events that on do not involve abuse and not	F		Systemic Change(s): The Policy & Procedure for reporting investigating abuse, neglect, misappropriation of resident property injuries or unusual/unknown occurrer 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 education inservices will focus on, identifying, reporting, and investigating incidents allegations of abuse, neglect or mistreatment of residents timely. As as resident to resident altercations and misappropriation of resident property are reported. Monitoring: The Administrator is responsible for compliance. The administrator will review all facility incident reports to ensure that reporting requirements head the time of discovery. The QA committee will review all F not less than quarterly to ensure they been reported timely. Any negative findings will be corrected at time of discovery and disciplinary action wit taken as warranted. Completion Date:12/23/22	and nees I I I I I I I I I I I I I I I I I I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	-70000			11	/16/2022	
	E HALL BLACKSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824			
(VA) ID	SUMMADV ST	ATEMENT OF DEFICIENCIES	<u> </u>				
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F 609	Continued From page	÷ 7	F	609			
	do any actual physica day was briefed that t allegation." OSM #1 will handle this. When allegations of abuse,						
	An interview was cone AM, with RN (register preventionist. When a stated, "At the time of nursing supervisor on asked to read and ver provided to OSM #1. When asked to detail "The resident stated to (4/29/22) evening and Sunday (5/1/22) at 11 anything in report nor this before. I assesse see any broken skin, I abnormalities. The retalked with him and ha informed the DON on she files reports to state allegations of abuse, I my chain of command	the weekend." RN #2 was rify the statement she RN #2 verified statement. the events, RN #2 stated, his happened on Friday I reported it to me on :54 AM. I had not heard had the resident told me and his rectal area, did not no redness or any esident was calm when I and no other concerns. I Sunday." When asked if ate agencies related to RN #2 stated, "No, I follow II, inform the DON and III yone of them will report. I					
	PM, with ASM (adminithe administrator. Whe responsible to report a #1 stated, "At that time	allegations of abuse, ASM e it was the DON's t to VDH-OLC (Virginia					

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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	ROVIDER OR SUPPLIER E HALL BLACKSTONE			STREET ADDRESS, CITY, STATE, ZIP COD 900 S MAIN ST BLACKSTONE, VA 23824	Œ	11	/16/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	,	N SHOULD BE E APPROPRIA	: TE	(X5) COMPLETION DATE
F 609	Certification) and other sent an initial or final lincident) but will look policy states, reporting of abuse. The director because she felt that allegation was not subphysical evidence of a story was not matchin. On 11/16/22 at 12:46 are no records of an Feither initially or final as	ers. I do not see where we FRI (facility reported again." ASM #1 stated, the g within 2 hours of allegation of nursing did not report after the investigation, the estantiated, there was no abuse and the resident's g up. PM, ASM #1 stated, "There RI being sent to your office	F 6	609			