STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105692	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER ORANGE PARK	**570 WELLS RD ORANGE PARK, FL 32073**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on review of public media reports, a review of facility and clinical record reviews, and interviews with staff, the facility failed to file an immediate report for an allegation involving medical neglect to the State Survey Agency within 5 working days of the incident for 1 of 4 residents reviewed for alleged neglect (Resident 1), out of a total of 8 residents in the sample. The findings include: A complaint investigation was conducted in response to a media event in which the facility was alleged to neglect the medical needs of Resident #1 ([URL] Woman to sue nursing home, says staff put coffee grounds under dad's bed to hide smell from wound). Allegations involved facility failure to take Resident #1 to medical appointments with his physicians in the community, and had neglected the continuing care of his wounds. As a result, the complainant filed a notice of intent to file a lawsuit against the facility. A review of facility records related to the event was conducted. The findings found the facility had reported the allegations to adult protective services, who came to investigate the allegations. Their findings were that the allegations were not substantiated for the resident. Further review of the facility records found there was no immediate federal report to the State Survey Agency following facility knowledge of alleged neglect. An interview was conducted with the Administrator on 3/5/20 at 2:45 pm. He confirmed the facility had a media event related to alleged neglect of Resident #1. When asked if he had filed an immediate report with the State Survey Agency, he said he had not. The regulatory requirements were read to him. He acknowledged the requirement, stating he learned something new. The Administrator stated since it was a media event, he was not sure what to do. .
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** Based on review of public media reports, a review of facility records, and interviews with staff, the facility failed to conduct an investigation as a result of alleged medical neglect, and failed to report the results of that investigations the State Survey Agency within 5 working days of the incident, for 1 of 4 residents reviewed for alleged neglect (Resident #1), out of a total of 8 residents in the sample. The findings include: A complaint investigation was conducted in response to a media event in which the facility was alleged to neglect the medical needs of Resident #1 ([URL] Woman to sue nursing home, says staff put coffee grounds under dad's bed to hide smell from wound). Allegations involved facility failure to take Resident #1 to medical appointments with his physicians in the community, and had neglected the continuing care of his wounds. As a result, the complainant filed a notice of intent to file a lawsuit against the facility. A review of facility records related to the event was conducted. The findings found the facility had reported the allegations to adult protective services, who came to investigate the allegations. Their findings were that the allegations were not substantiated for the resident. There was no documentation of a facility-initiated investigation related to Resident 1. Further review of the facility records found no 5-day federal report was filed with the State Agency to report investigative findings related to the alleged neglectful care of Resident 1. An interview was conducted with the Administrator on 3/5/20 at 2:45 pm. He confirmed the facility had a media event related to alleged neglect of Resident 1. He explained the facility contacted adult protective services, and neglect was not substantiated. When asked if the facility conducted its own investigation, he replied no. The Administrator said the facility let (name of adult protective services agency) conduct the investigation. When asked if he had filed the required federal 5-d ay report with the state survey agency, he said he had not. The regulatory requirements were read to him. He acknowledged the requirement, stating he learned something new. The Administrator stated since it was a media event, he was not sure what to do.

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