STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495193	A. Building B. Wing	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henrico Health & Rehabilitation Center	561 North Airport Drive Highland Springs, VA 23075

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to act promptly upon the grievances arising from Resident Council. The findings included: Resident council continues to have complaints of the same nature with no improvement month after month. The facility has not effectively addressed the concerns of the residents regarding quality of food, timeliness of medication administration, timely incontinence care, poor staff attitudes, and cleanliness of the building. A review of the Resident Council minutes revealed the following: March 2023 - Residents complained that staff have bad attitudes, medication not given in a timely manner, CNAs not providing care to dependent residents routinely during the day and night. April 2023 - Staff are rude, staff are loud at night, staff are using cell phones while providing incontinent or ADL care, diets are not being followed, and the dietary staff are rude. May 2023 - Floors, bathrooms, and sinks are not cleaned properly, alternate meals and/or sandwiches not offered, staff continue to be rude, no snacks offered at night, and retaliation of staff. June 2023 - Staff are loud at night, staff not checking/changing dependent residents, CNAs and nurses respond with I don't have you when asking for something, snacks not available at night, and CNAs not rounding. July 2023 - Food has not improved, staff continue to be rude, medications are unavailable or not ordered timely, and tray tickets do not match tray items. August 2023 - Medication times, rude staff, using phone while providing care, food items on tray do not match ticket, wrong diets served, and rooms and bathrooms had not been cleaned. On the afternoon of 09/28/2023, an interview was conducted with Employee S (Activities Director) who stated that each department is given the feedback from Resident Council to address within their department. When asked if she noticed the same issues keep arising month after month, she stated she did see a pattern. She also stated that all staff have been having education on customer service. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following are excerpts from a Facility Reported Incident that occurred on 04/27/2023. The incident was reported to the Office of Licensure and Certification by the facility Administrator: [Resident name redacted] is an [AGE] year old resident with a BIMS [Brief Interview of Mental Status] of 15 [indicating no cognitive impairment]. H admitted to the facility on [DATE] [Resident name redacted] alleged that CNA [name redacted] cursed at him saying Kiss my ass! after answering his call bell, left the room then returned repeating the same verbal allegation. Based on the findings of the allegations regarding abuse/mistreatment regarding [Resident name redacted] and [CNA name redacted] substantiated. CNA [Name redacted] has been terminated. Staff will be educated on abuse and neglect. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided. 41449

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41450 Based on clinical record review, staff interview, and facility documentation review, the facility staff failed to notify the responsible party of a change in condition for 1 Resident, Resident #362, in a sample size of 48 Residents. The findings included: For Resident #362, facility staff failed to notify the responsible party/family of a change in his condition on 07/20/2023. On 10/02/2023 at approximately 3:00 p.m., Resident #362's clinical record was reviewed in its entirety with particular attention given to physician's orders, nursing assessments, and progress notes. A progress note dated 07/20/2023 at 7:34 p.m. documented, Resident's daughter [name redacted] upset upon arrival to visit her father, nurse informed her residents blood pressure was elevated approx. noon time today, Resident pcp notified of elevation and medicated as directed, family was not notified of change in condition, daughter request that resident be transferred to hospital for evaluation, pcp notified of request, resident was taken to the ER via EMS. On 10/02/2023 at 4:15 p.m., the Clinical Nurse Consultant (CNC) was interviewed and stated, It is my expectation and facility policy that both the doctor and family are notified if a resident experiences a change in their condition, always. Review of the facility policy titled, Significant Change in Condition, with an effective date of 11/01/2019, Procedure, item 4 read, Responsible party will also be notified of a change in condition and item 9, Notification of responsible party shall be documented in the progress notes including time and name of person informed. On 10/02/2023 at the end of day meeting, the Facility Administrator and CNC were updated on the findings. No further information was provided.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain a safe, clean, comfortable, and homelike environment for residents residing on 2 of 2 units, and for Resident #363. The findings included: 1. For the facility, residents the staff failed to maintain clean shower rooms on 2 of 2 units and failed to control pests, such as bedbugs and roaches. On 09/26/2023 at 2:00 p.m. during the Resident Council meeting, the 6 residents (all the residents on that unit) present stated the shower rooms are filthy, who wants to shower in those rooms? Resident #42 stated she would rather sponge bathe daily than use the shower rooms and the other 5 participants agreed. Observations were made of the shower rooms on 09/26/2023. On 09/27/2023 and 09/29/2023, the shower rooms were not clean, and the shower stalls had orange and black stains. The shower chairs had brown stains and the floor needed repair in the North shower room. On 09/26/2023 at approximately 3:30 p.m., an interview was conducted with CNA D who was asked if she knew what the black and orange stains were in the shower stalls. CNA D stated that she thought the black stains might be dirt. When asked how often the shower stalls were cleaned, she stated that Housekeeping cleans the shower rooms, but we use the wipes and wipe down the shower chairs between each resident. From 09/25/2023 through 10/04/2023, fruit flies as well as house flies were sighted throughout the facility in residents' rooms on both units, and in the dining room. On 09/29/2023 at approximately 1:15 p.m., Surveyor E entered Resident #19's room with CNA D, and when the cabinet door and drawer were opened cockroaches ran out (approximately 5-10 insects) and were all over the sides and top of the bedside cabinet. A review of the pest control log revealed that on 08/04/2023 room numbers 32, 37, and 54 were treated for bed bugs; however, no follow-up treatment was done to ensure any eggs that have hatched were treated for, which is standard practice for bedbug treatment. On 09/28/2023, the resident in room [ROOM NUMBER] was complaining of itching, and stated he had bed bugs. The facility did treat that room on 09/29/2023. On 10/04/2023 during the end of day meeting the Administrator was made aware of the findings. No further information was provided. 41450 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. For Resident #363, the facility staff failed to provide a chair in her room at her request. On 09/26/2023 at approximately 9:30 a.m., Resident #363 was observed sitting on her bed in her room. An interview was conducted and Resident #363 stated, I have asked constantly for a chair to be put in my room since I got here a couple of weeks ago because my husband has no where to sit when he comes to visit me. He comes to see me every day and has to sit in my wheelchair; I'm not asking for much, just a chair. He should not have to use my wheelchair to be comfortable while he visits, it makes no sense at all. Resident #363's wheelchair was observed at the foot of her bed, and there was no chair in her room. On 09/27/2023 at approximately 10:30 a.m., a group interview was conducted with the Facility Administrator and the Clinical Nurse Consultant (CNC), both of whom stated that it was expected for a chair to be placed in a resident's room as part of the regular room set up or at minimum, a chair would be provided upon the resident's request. No further information was provided.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41449 Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility failed to protect the residents' right to be free from physical abuse and sexual abuse by a staff member and failed to protect the residents from continued abuse by their perpetrator, affecting 2 residents (Resident #53 and #85) in a survey sample of 48 residents, which resulted in psychosocial harm for Resident #53. The findings included: 1. For Resident #53, the facility staff failed to protect the resident from enduring physical and sexual abuse, which resulted in psychosocial harm for the resident. On 09/26/2023, during a clinical record review of Resident #53's clinical chart the following was noted: a. Resident #53 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. b. A progress note dated 08/10/2023 at 5:06 p.m., stated, Patient sent to Saint Mary's for evaluation r/t [related to] alleged assault, MD [medical doctor] made aware. Patient verbalized understanding the reason for transfer. c. Another progress note dated 08/10/2023 at 5:15 p.m., read, Patient made a statement in regard to an assault that took place this morning, a statement was given from patient to myself dictated at 2:11 PM at the south unit nursing station. Phone call placed to nonemergency services so patient could give an official statement and press charges. On 09/27/2023, a review was conducted of the facility's investigation that had been performed. There was a written statement that was taken from Resident #53 that read as follows: Statement of [Resident #53's name redacted] patient stated that while he was asleep, he was awakened by a washcloth being placed on his face, he then heard a voice say, can you see me? Patient then says in return, I am not blind. Patient states the CNA [certified nursing assistant/CNA C] then pulled off his sheets and undid his brief and began flicking his penis back and forth. Patient states the CNA then stated he was going to shave his pubic hairs. Patient stated he began to yell out for help, which caused the CNA to abruptly stop, then pick the patient up and throw him in the chair. Patient then restated all of the above details to the speech therapist. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 09/27/2023 at 11:26 a.m., an interview was conducted with the facility Director of Nursing (DON), with the Administrator and survey team present. The DON was asked about the incident involving Resident #53 and CNA C. The DON reported, On 8/10 when I came in, the speech therapist (SLP) came and talked with me 8:30 a.m., and gave me a service concern and said she saw Resident #53 and he reported that a CNA had touched him inappropriately. I went and talked with him [Resident #53] and he said when he did foley care it was discomfort. Then at noon he said the CNA had put a washcloth over his face and he was flicking his penis back and forth. He could not give a name or describe the person, we had one male CNA working that day, she identified as [CNA C's name redacted]. I asked him [Resident #53] if he wanted to be sent out, he said yes. The DON stated that she had CNA C sent home prior to her arrival at the facility early that morning due to performance issues, prior to her knowledge of the allegation involving Resident #53. On 09/27/2023 at 12:10 p.m., an interview was conducted with Employee M, the Speech Language Pathologist (SLP). The SLP reported on 08/10/2023, she arrived to work at 7:50 a.m., and as she walked down the hall, Resident #53 got her attention and reported, the aide [CNA C] had put a washcloth on his face and he had touched his penis. I told the nurse. The SLP also stated that at about 9:30 a.m., she saw Resident #53 in the dining room being fed by the CNA who had allegedly abused Resident #53 earlier that morning. The SLP said, I saw his [Resident #53] mouth was stuffed full of food, and I saw that was way too much and he [CNA C] was getting ready to put more in his mouth. I had the resident spit it out and said that's why too much and it was the wrong diet texture, he [CNA C] said that's what they sent. I had to take over feeding the resident. The SLP reported that she reported this incident to nursing leadership and her immediate supervisor. Later that day she saw CNA C still in the facility/in passing in the hall. She was not sure of the time. The SLP said she reported the events to the Director of Nursing (DON) and wrote a statement regarding the events involving Resident #53 and CNA C. Surveyors D and F attempted to interview Resident #53 the same day, but the resident was not available for interview. On 09/28/2023 at 3:00 p.m., Surveyors D and F visited Resident #53 in his room. Resident #53 gave the same accounting of events that were in the written statement referenced earlier. There was no change in his report. The resident became very tearful and stated he was so afraid and that CNA C laid me flat in the chair on my back and was trying to silence me and say I choked on food. Resident #53 said, [Employee M's name redacted] took a picture. The resident stated that following this incident he was afraid to sleep, kept looking around, and had to be prescribed Trazadone so he could sleep. When asked how all of this made him feel, Resident #53 said, Like I wanted to leave here, I was scared, I can't move, I was afraid I was going to choke, he was trying to silence me so he could say I choked. I watched all the time. This was harm. An additional review of the clinical record revealed that Resident #53 was ordered Trazodone 50 mg tablet to be given at bedtime for sleep aid on 08/23/2023. On the afternoon of 09/29/2023, an interview was conducted with the scheduler, who stated that on the afternoon of 08/10/2023, she was told by the Director of Nursing to send CNA C home, due to complaints and work performance. Review of payroll records revealed that CNA C did not clock out and leave the premises on 08/10/2023 until 1:17 p.m. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review was conducted of the facility's abuse policy titled, Abuse/Neglect/Misappropriation/Crime/Administrative Reference Guide. Excerpts from this policy read, 1. Physical abuse: b. physical contact intentionally or through recklessness that results in, or is likely to result in, death, physical injury, pain, or psychological harm to the patient. Indications of psychological harm include a noticeable level of fear, anxiety, agitation, or emotional distress in the patient. 3. Sexual Abuse: a. sexual harassment, inappropriate touching. The policy titled, Abuse/Neglect/Misappropriation/Crime/ Patient Protection, was reviewed. This policy read, There is a zero tolerance for mistreatment, abuse, neglect, misappropriation of property, or any crime against a patient of the Health and Rehabilitation Center. 1. Patients of the center have the legal right to be free from verbal, sexual, mental, and physical abuse, corporal punishment. 2. Any employee and/or covered agent of the Center, who willfully abuses or participates in any criminal activity against any patient of the center will be immediately subjected to corrective action. On 09/27/2023 and 09/28/2023, the facility Administrator and corporate staff were made aware of the above findings. On 09/27/2023, the corporate staff notified the survey team they would be re-opening the investigation into the events involving Resident #53 and CNA C. No further information was provided. 40026 2. For Resident #85, the facility staff failed to ensure the resident's right to be free from sexual abuse. On 09/26/2023, an interview was conducted with Resident #103, who stated she knew that on 08/10/2023 Resident #85 had been molested by a male CNA. She allowed the surveyors to listen to an audio recording of CNA E questioning Resident #85. According to the audio recording, CNA E could be heard saying, Why did you let that man shave you down there. Resident #85 stated that she did not let anyone shave her to which you can hear the CNA reply You are mighty bald down there. You got less hair than me and I was waxed. On 09/27/2023 at 1:00 p.m., an interview was conducted with CNA E who admitted that she had knowledge of the incident and that she made the nurse on duty and the DON aware of the incident. On 09/27/2023 an interview was conducted with the DON who stated she did not view it as abuse and stated. Coming from [Resident #103] she was not inclined to believe her. When asked what she was supposed to do with allegations of abuse, she stated she should investigate them. When asked what she should do first, she repeated Investigate them. The DON was advised that facilities are to report first and complete the investigation is second. The DON was also advised to review the facility's policy and the State Operations Manual (SOM) on abuse reporting. The incident was not reported nor investigated until 09/27/2023 (2 days after the survey began). The incident was reported to the Office of Licensure and Certification, Adult Protective Services, the Department of Health Professions, and the Police by the Regional Director of Clinical Services. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the concerns. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	No further information was provided.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to implement their abuse policy affecting 2 residents (#53 and #85), resulting in harm for Resident #53. Immediate Jeopardy (IJ) was identified on 09/27/2023 at 5:25 p.m., at which time the facility Administrator and Director of Nursing were made aware. Following verification of the removal of immediacy, the facility abated IJ on 10/04/2023 at 10:45 a.m. The scope and severity was lowered to a level 3, pattern. The findings included: 1. The facility staff failed to implement their abuse policy by permitting facility staff to work when their criminal background status was unknown. On 09/27/2023, a review was conducted of a sample of employee files which revealed the following: a. Staff #4 was hired 03/17/2022 and terminated employment on 10/01/2022. Staff #4's employee record had no evidence that a criminal background check had been obtained. Therefore, from 03/17/2022 - 10/01/2022, facility staff were unaware of Staff #4's criminal background status, and the staff member provided direct resident care during this time. b. Staff #10 was hired on 10/31/2022 and terminated employment on 01/10/2023. There was no evidence provided to indicate that Staff #3 had a criminal background check performed. Therefore, from 10/31/2022 - 01/10/2023, facility staff were unaware of Staff #10's criminal background status and was permitted to provide direct care to residents. c. Staff #13 was hired 07/5/2022 and terminated employment on 10/08/2022. Staff #13's employee record had no evidence of a criminal background check on file. Therefore, from 07/05/2022 - 10/08/2022, facility staff were unaware of Staff #13's criminal background status and was permitted to provide direct care to residents. d. Staff #24 was hired 03/08/2023. Staff #24's criminal background check was requested on 03/07/2023 and noted to read, Transaction is being processed and the final report was not on file. Therefore, from 03/08/2023 until the time of survey, the facility staff were unaware of Staff #24's criminal background status and the employee was permitted to continue to work without knowing if the employee was guilty of a barrier crime. On 09/27/2023 at approximately 1:00 p.m., an interview was conducted with the Human Resources Director (HRD) who stated, We get criminal background checks on every applicant. For the Virginia State Police, we wait 30 days, and they can work with another employee while we wait for it. The HRD verified that Staff #4, #10, #13, and #24 did not have a criminal background report within 30 days of their respective hire dates. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the facility's policy entitled, Abuse/Neglect/Misappropriation/Crime Prevention/Screening/Training, dated 01/23/2020, subtitle, Procedure, item 1 read, Criminal background and reference checks are performed on all employees. Prior to conclusion of the survey, the facility staff provided the survey team with a facility policy entitled, Onboarding/Virginia, with an effective date of 10/01/2023, which was reviewed. This policy read, The company will comply with all local and state regulations and guidelines as required for all employees who are employed in the Commonwealth of Virginia. 1. A complete and accurate personnel file, as outlined in Policy #207 and in accordance with 12VAC5-371-140-E of the Administrative Code of Virginia, will be created for each new employee which contains the basic demographic and indicative data needed for employment, as well as: a. A criminal history check of the Central Criminal Records Exchange conducted via Virginia State Police Non-Criminal Justice Interface (NCJI) in accordance with 32.1-126.01 of the Code of Virginia . 2. For Resident #53, the facility staff failed to prevent the resident from being abused by a staff member. After being made aware of the allegation, the facility staff failed to take measures to protect the Resident #53 from their alleged perpetrator, which permitted the staff member to abuse the resident again. On 09/26/2023, during a clinical record review of Resident #53's clinical chart, the following was noted: a. Resident #53 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. b. A progress note dated 08/10/2023 at 5:06 p.m. stated, Patient sent to Saint Mary's for evaluation r/t [related to] alleged assault, MD [medical doctor] made aware. Patient verbalized understanding the reason for transfer. c. Another progress note dated 08/10/2023 at 5:15 p.m. read, Patient made a statement in regard to an assault that took place this morning, a statement was given from patient to myself dictated at 2:11 PM at the south unit nursing station. Phone call placed to nonemergency services so patient could give an official statement and press charges. On 09/27/2023, a review was conducted of the facility's documentation regarding the events involving Resident #53. There was a written statement taken from Resident #53 that read, Statement of [Resident #53's name redacted] patient stated that while he was asleep, he was awakened by a washcloth being placed on his face, he then heard a voice say, can you see me? Patient then says in return, I am not blind. Patient states the CNA [certified nursing assistant/CNA C] then pulled off his sheets and undid his brief and began flicking his penis back and forth. Patient states the CNA then stated he was going to shave his pubic hairs. Patient stated he began to yell out for help, which caused the CNA to abruptly stop, then pick the patient up and throw him in the chair. Patient then restated all of the above details to the speech therapist. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/27/2023 at 11:26 a.m., an interview was conducted with the facility Director of Nursing (DON), with the Administrator and survey team present. The DON was asked about the incident involving Resident #53 and CNA C. The DON reported, On 8/10 when I came in the speech therapist (SLP) came and talked with me 8:30 a.m., and gave me a service concern and said she saw Resident #53 and he reported that a CNA had touched him inappropriately. I went and talked with him [Resident #53] and he said when he did foley care it was discomfort. Then at noon he said the CNA had put a washcloth over his face and he was flicking his penis back and forth. He could not give a name or describe the person, we had one male CNA working that day, she identified as [CNA C's name redacted]. I asked him [Resident #53] if he wanted to be sent out, he said yes. The DON stated she had CNA C sent home prior to her arrival at the facility early that morning due to performance issues, prior to her knowledge of the allegation involving Resident #53. However, it was later determined that CNA C had not been removed from the premises until over 5 hours following the initial incident. On 09/27/2023 at 12:10 p.m., an interview was conducted with Employee M, the Speech Language Pathologist (SLP). The SLP reported on 08/10/2023, she arrived to work at 7:50 a.m., and as she walked down the hall, Resident #53 got her attention and reported, the aide [CNA C] had put a washcloth on his face and he had touched his penis. I told the nurse. The SLP stated at about 9:30 a.m. in the dining room, she saw Resident #53 being fed by the CNA who had allegedly abused the resident earlier that morning. The SLP said, I saw his [Resident #53] mouth was stuffed full of food, and I saw that was way too much and he [CNA C] was getting ready to put more in his mouth. I had the Resident spit it out and said that's why too much and it was the wrong diet texture, he [CNA C] said that's what they sent. I had to take over feeding the Resident. The SLP reported that she reported this incident to nursing leadership and her immediate supervisor. Later that day, she saw CNA C still in the facility/in passing in the hall. She was not sure of the time. The SLP said she reported the events to the Director of Nursing and wrote a statement regarding the events involving Resident #53 and CNA C. On 9/27/23, Surveyors D and F attempted to interview Resident #53, but the resident was not available for interview. On 09/28/2023 at 3:00 p.m., Surveyors D and F visited Resident #53 in his room. Resident #53 gave the same accounting of events that were in the written statement referenced earlier. There was no change in his report. The resident became very tearful and stated he was so afraid and that CNA C laid me flat in the chair on my back and was trying to silence me and say I choked on food. Resident #53 said, [Employee M's name redacted] took a picture. The resident stated that following this incident he was afraid to sleep, kept looking around, and had to be prescribed Trazadone so he could sleep. When asked how all of this made him feel, Resident #53 said, Like I wanted to leave here, I was scared, I can't move, I was afraid I was going to choke, he was trying to silence me so he could say I choked. I watched all the time. This was harm. An additional review of the clinical record revealed that Resident #53 was ordered Trazodone 50 mg tablet to be given at bedtime for sleep aid on 08/23/2023. On the afternoon of 09/29/2023, an interview was conducted with the scheduler, who stated on the afternoon of 08/10/2023, she was told by the Director of Nursing to send CNA C home, due to complaints and work performance. Review of payroll records revealed that CNA C did not clock out and leave the premises on 08/10/2023 until 1:17 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495193	A. Building B. Wing	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henrico Health & Rehabilitation Center	561 North Airport Drive Highland Springs, VA 23075

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review was conducted of the facility's abuse policy titled, Abuse/Neglect/Misappropriation/Crime/Administrative Reference Guide. Excerpts from this policy read, 1. Physical abuse: b. physical contact intentionally or through recklessness that results in, or is likely to result in, death, physical injury, pain, or psychological harm to the patient. Indications of psychological harm include a noticeable level of fear, anxiety, agitation, or emotional distress in the patient. 3. Sexual Abuse: a. sexual harassment, inappropriate touching. The policy titled, Abuse/Neglect/Misappropriation/Crime/ Patient Protection, was reviewed. This policy read, There is a zero tolerance for mistreatment, abuse, neglect, misappropriation of property, or any crime against a patient of the Health and Rehabilitation Center. 1. Patients of the center have the legal right to be free from verbal, sexual, mental, and physical abuse, corporal punishment. 2. Any employee and/or covered agent of the Center, who willfully abuses . or participates in any criminal activity against any patient of the center will be immediately subjected to corrective action. 3. For Resident #53, the facility staff failed to report and investigate allegations of abuse. On 09/27/2023, a review was conducted of the facility's documentation of the allegation and actions taken regarding Resident #53 and the incidents with CNA C. There was a written statement taken from Resident #53. There was also a written statement from Employee M, the Speech Language Pathologist (SLP). Lastly there was evidence the state survey agency/Office of Licensure and Certification (OLC) and Adult Protective Services (APS) were faxed a report of the incident on 08/10/2023 at 7:10 p.m. There was no evidence that an investigation into the allegations was conducted. The report submitted to the OLC and APS lacked significant information regarding Resident #53's allegations involving CNA C. The details of being awakened by a washcloth being put across his face, saying he was going to shave the resident's pubic hair, and the details of the aggressive feeding were all omitted from the report. On 09/27/2023 at 11:26 a.m., an interview was conducted with the facility's Director of Nursing (DON), with the Administrator and survey team present. The DON was asked about the incident involving Resident #53 and CNA C. The DON reported, On 8/10 when I came in the speech therapist (SLP) came and talked with me 8:30 a.m. and gave me a service concern and said she saw Resident #53 and he reported that a CNA had touched him inappropriately. I went and talked with him [Resident #53] and he said when he did foley care it was discomfort. Then at noon he said the CNA had put a washcloth over his face and he was flicking his penis back and forth. He could not give a name or describe the person, we had one male CNA working that day, which she identified as [CNA C's name redacted]. I asked him [Resident #53] if he wanted to be sent out, he said yes. The DON stated that she had CNA C sent home prior to her arrival at the facility early that morning due to performance issues, prior to her knowledge of the allegation involving Resident #53. During the above interview, the DON was asked to explain what steps were taken to investigate the allegation and if she had any additional documentation regarding an investigation. The DON stated she had interviewed other residents and reviewed the hospital records of Resident #53. Because there was no forensic evidence, she unsubstantiated the allegation. The DON was asked to provide evidence of the resident interviews she conducted, and she said she had nothing to provide. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	When asked if staff, including but not limited to CNA C, were interviewed, the DON indicated none of the staff were interviewed. The facility had no evidence of any investigation being conducted. A review was conducted of the facility's abuse policy titled, Abuse/Neglect/Misappropriation/Crime/Reporting Requirements/Investigations. Excerpts from this policy read, 2. The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigation protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations. Immediate Jeopardy (IJ) was identified on 09/27/2023 at 5:25 p.m., at which time the facility's Administrator and Director of Nursing were made aware. On 10/02/2023 at 3:30 p.m., the facility submitted an accepted IJ removal plan and on 10/04/2023, submitted a revised plan which read as follows: 1. 9/27/23: Resident #103 reported an allegation of abuse on 8/10/2023 and FRI submitted regarding resident #85. 2. 9/27/23: FRI submitted for an allegation of abuse on 8/10/2023 involving resident #53 and #85. Physician, responsible party, and police notified, and case assigned to detective [NAME]. 3. The identified CNA, [Name redacted], removed from schedule on 8/10/2023 and no longer permitted in the center. 4. 9/28/2023: [Name redacted] license (CNA) reported to the board of nursing. 5. 9/28/2023: Facility personnel educated on the abuse policy to identify, protect, report, and investigate allegations of abuse prior to working. 6. 9/27/2023: New hires educated on abuse policy prior to working. 7. 9/27/2023: Regional Director of Human Resources reviewed all personnel files to verify Virginia State Police (VSP) background checks. 8. 10/2/2023: Employees with pending VSP background check clearances removed from the schedule. 9. 9/27/2023: Regional Human Resources educated Administrator and managers on screening employees and VSP background checks clearance. 10. 9/27/2023: The facility educated all personnel on protecting, reporting, investigation, screening employees, and adhering to a mandated reporting procedure. 11. 9/27/2023: The facility interviewed residents to determine if there was any other allegation of abuse. 12. 9/27/2023: skin checks completed on residents who could not be interviewed to determine any signs of abuse. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	13. 9/27/2023: The facility completed a comprehensive audit of all FRIs and service concerns that occurred from January 2023 up to the present to ensure no other case of abuse existed. 14. 9/27/2023: The facility identified an allegation of abuse involving a receptionist, and resident #103. 15. Receptionist suspended pending an investigation. A FRI sent to the Office of Licensure and Certification on 9/26/2023. 16. The implementation deadline of this immediacy removal plan is October 2, 2023, by 3:20 PM. On 10/02/2023, the facility's administration submitted to the survey team credible evidence of the IJ immediacy removal plan. Included in the documents was documentation of Direct Supervision, which indicated that employees without a criminal background check clearance would be permitted to work under the direct supervision of a staff member with a criminal background clearance. The survey team notified the facility's administration that this was not permissible, and that each employee had to have a criminal background check clearance to work beyond 30 days of employment. On 10/03/2023, the survey team attempted again to verify the facility staff had implemented their approved IJ immediacy removal plan. Staff interviews were conducted with facility staff from various departments to ensure they were aware of what abuse is, how to respond and protect residents in the event of abuse, and that they were mandated reporters. The survey team obtained a resident census listing and cross checked to ensure that residents who could be interviewed had been interviewed, and residents who could not be interviewed had a head-to-toe assessment. There was one resident identified that had not been interviewed or assessed for signs of abuse. The survey team reviewed the employee audits and identified that the contracted dietary, housekeeping, and laundry staff had not been audited to ensure they had a criminal background check from the Virginia State Police that indicated they were free from any barrier crimes. On 10/03/23 at 4:40 p.m., the facility Administrator and corporate staff were made aware that the survey team had been unable to verify abatement. On 10/04/2023, the survey team returned to the facility for them to attempt to abate IJ. The facility staff provided the survey team with a head-to-toe assessment for the resident that had previously not been assessed for signs and symptoms of abuse. Additionally, the team reviewed the employee record audit and noted that the contracted staff were now listed. However, the audit indicated that Staff #24, who was a cook, was noted as having had a criminal background check. It had previously been noted as recently as 10/03/2023, Staff #24 did not have a criminal background check on-file at the facility and his status regarding barrier crimes and his criminal record remained unknown. In addition, 2 agency staff members were noted on the current working schedule for the day and there was not any evidence provided to indicate they had been screened for criminal records. On 10/04/2023 at approximately 10:00 a.m., the facility's Administrator was again made aware that they were unable to abate IJ. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/04/2023 at 10:40 a.m., the facility's Administrator returned with a revised audit which correctly reflected that Staff #24 did not have a criminal record on file. The audit verified that employees without a criminal background check had been removed from the schedule and were not currently working. The facility's administration also provided a criminal background that was free from barrier crimes for the 2 agency staff working. The survey team confirmed IJ was abated on 10/04/2023 at 10:45 a.m. 40026 4. For Resident #85, the facility staff failed to implement the abuse policy by reporting an allegation of sexual abuse. On or about 08/10/2023, an allegation that a CNA shaved the pubic hair of Resident #85, who is cognitively impaired and unable to be interviewed. The allegation was reported by the CNA who cares for her and the roommate of Resident #85. On 09/26/2023, an interview was conducted with Resident #103, who stated she knew that Resident #85 had been molested by a male CNA. She allowed the surveyors to listen to an audio recording of CNA E questioning Resident #85. According to the audio recording, CNA E could be heard saying, Why did you let that man shave you down there. Resident #85 has a Brief Interview of Mental Status (BIMS) score of 99, and stated she did not let anyone shave her to which you can hear the CNA reply, You are mighty bald down there. You got less hair than me and I was waxed. On 09/27/2023 at 1:00 p.m., an interview was conducted with CNA E who admitted that she had knowledge of the incident and that she made the nurse and the former DON aware of the incident; however, she did not report it as abuse at that time. On 09/26/2023, an interview was conducted with the DON, who was asked if she reported the allegation of sexual abuse, and she stated that she did not find it was abuse. She stated she heard about it from Resident #103, and she did not consider it abuse. The DON stated, Coming from (Resident #103 name redacted) I don't believe it. When asked again if she followed the abuse policy, and reported to the appropriate parties, she stated she did not think it was abuse so she did not report it. A review of the Abuse Policy read: All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, 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. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the findings. No further information was provided.

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(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. 41449 Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility failed to report allegations of abuse by a staff member involving 2 residents (Residents #53 and #85) in a survey sample of 48 residents. The findings included: 1. For Resident #53, the facility staff failed to complete a timely and accurate report of an allegation of physical and sexual abuse by CNA C to the state survey agency, adult protective services, and law enforcement. On 09/26/2023, during a clinical record review of Resident #53's clinical chart, the following were noted: a. A progress note dated 08/10/2023 at 5:06 p.m. read, Patient sent to saint Mary's for evaluation r/t [related to] alleged assault, MD [medical doctor] made aware. Patient verbalized understanding the reason for transfer. b. Another progress note dated 08/10/2023 at 5:15 p.m., stated, Patient made a statement in regard to an assault that took place this morning, a statement was given from patient to myself dictated at 2:11 PM at the south unit nursing station. Phone call placed to nonemergency services so patient could give an official statement and press charges. On 09/27/2023, a review was conducted of the facility's documentation of the allegation and actions taken. There was a written statement that was taken from Resident #53 that read as follows: Statement of [Resident #53's name redacted] patient stated that while he was asleep, he was awakened by a washcloth being placed on his face, he then heard a voice say, can you see me? Patient then says in return, I am not blind. Patient states the CNA [certified nursing assistant/CNA C] then pulled off his sheets and undid his brief and began flicking his penis back and forth. Patient states the CNA then stated he was going to shave his pubic hairs. Patient stated he began to yell out for help, which caused the CNA to abruptly stop, then pick the patient up and throw him in the chair. Patient then restated all of the above details to the speech therapist. There was evidence the state survey agency/Office of Licensure and Certification (OLC) and Adult Protective Services (APS) were faxed a report of the incident on 08/10/2023 at 7:10 p.m., almost 12 hours after facility management were made aware of the initial abuse allegation. Additionally, the report submitted grossly misrepresented the allegation(s) made. The report read, It was reported to Speech therapist and floor nurse by [Resident #53's name redacted], BIMS [brief interview for mental status score] 14, that the aide who took care of him touched him inappropriately, cannot give date but states not today or yesterday but the same one that worked this morning. Aide immediately sent home upon knowledge pending investigation. During Surveyor F's investigation of this incident, payroll records revealed CNA C did not leave the facility on the day of the allegations until 1:17 p.m. (continued on next page)

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(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	On 09/27/2023 at 11:26 a.m., an interview was conducted with the facility's Director of Nursing (DON), with the Administrator and survey team present. The DON was asked about the incident involving Resident #53 and CNA C. The DON reported, On 8/10 when I came in the speech therapist (SLP) came and talked with me 8:30 a.m. and gave me a service concern. She said she saw Resident #53 and he reported that a CNA had touched him inappropriately. I went and talked with him [Resident #53] and he said when he did foley care it was discomfort. Then at noon he said the CNA had put a washcloth over his face and he was flicking his penis back and forth. He could not give a name or describe the person, we had one male CNA working that day, she identified as [CNA C's name redacted] I asked him [Resident #53] if he wanted to be sent out, he said yes. The DON stated she had CNA C sent home prior to her arrival at the facility early that morning due to performance issues, prior to her knowledge of the allegation involving Resident #53. During the above interview, the DON was asked about the reporting of the incident. The DON was able to verbalize that reports regarding allegations of abuse are to be reported within 2 hours. When questioned about the timing of the report involving Resident #53, she did not respond as to why it was delayed. The DON was asked about the lack of details regarding Resident #53's allegations involving CNA C, in the report submitted. The details of being awakened by a washcloth being put across his face, saying he was going to shave the resident's pubic hair and the details of the aggressive feeding were all omitted from the report. Again, the DON did not give an answer as to why those details were omitted. When asked if the allegations against CNA C were reported to the Board of Nursing, which is the agency that certified CNA C to practice as a nursing assistant, the DON said yes, but was unable to provide any credible evidence it was reported. On 09/27/2023 at 12:10 p.m., an interview was conducted with Employee M, the speech language pathologist (SLP). The SLP confirmed Resident #53's report of abuse was reported to her on 08/10/2023, when she arrived to work at 7:50 a.m. She also stated she immediately reported the allegation to her departmental supervisor, the nursing unit manager, and then to the Director of Nursing. On 09/27/2023, Surveyors D and F attempted to interview Resident #53, but the resident was not available for interview. On 09/28/2023 at 3:00 p.m., Surveyors D and F visited Resident #53 in his room. Resident #53 gave the same accounting of events that were in the written statement referenced earlier. There was no change in his report. Resident #53 became very tearful, said he was so afraid, and that CNA C laid me flat in the chair on my back and was trying to silence me and say I choked on food. Resident #53 said, [Employee M's name redacted] took a picture. The resident stated following this incident he was afraid to sleep, kept looking around, and had to be prescribed Trazadone so he could sleep. When asked how all of this made him feel, Resident #53 said, Like I wanted to leave here, I was scared, I can't move, I was afraid I was going to choke, he was trying to silence me so he could say I choked. I watched all the time. (continued on next page)

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(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	A review was conducted of the facility's abuse policy titled, Abuse/Neglect/Misappropriation/Crime/Reporting Requirements/Investigations. Excerpts from this policy read, 1. Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury. b. Notify the Adult Protective Services Agency, the local Ombudsman, and the appropriate local law enforcement authorities (police, sheriff's office, and/or medical examiner as deemed appropriate) for any incident of patient abuse, mistreatment, neglect, or misappropriation of personal property or other reasonable suspicion of a crime. c. Notify within 24 hours the Department of Health Professions (DHP) for incidences involving nurse aides, RNs, LPNs, Physicians, or others licensed or certified by DHP. On 09/27/2023 and 09/28/2023, the facility's Administrator and corporate staff were made aware of the above findings. On 09/27/2023, the corporate staff notified the survey team they would be re-opening the investigation into the events involving Resident #53 and CNA C and had made an accurate report of the allegations to the required agencies/authorities. No further information was provided. 40026 2. For Resident #85, the facility staff failed to ensure allegations of abuse are reported within 24 hours for allegations that do not result in serious bodily injury. On or about 08/10/2023, an allegation that a CNA shaved the pubic hair of Resident #85 who is cognitively impaired and unable to be interviewed. The allegation was reported by the CNA who cares for her and the roommate of the resident. On 09/26/2023, an interview was conducted with Resident #103 who stated she knew that Resident #85 had been molested by a male CNA. She allowed the surveyors to listen to an audio recording of CNA E questioning Resident #85, Why did you let that man shave you down there. Resident #85 has a Brief Interview of Mental Status (BIMS) score of 99 and stated that she did not let anyone shave her, to which you can hear the CNA reply You are mighty bald down there. You got less hair than me and I was waxed. On 09/27/2023 at 1:00 p.m., an interview was conducted with CNA E who admitted that she had knowledge of the incident and that she made the nurse aware of the incident and the former DON was also made aware, however she did not report it as abuse at that time. On 09/26/2023, an interview was conducted with the DON who was asked if she reported the allegation of sexual abuse and she stated that she did not find it was abuse. She stated she heard about it from Resident #103, and she did not consider it abuse. The DON stated, Coming from (Resident #103 name redacted) I don't believe it. When asked again if she followed the Abuse Policy and reported the incident to the appropriate parties, she stated she did not think it was abuse, so she did not report it. A review of the Abuse Policy read: (continued on next page)

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(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	All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, 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. The incident was not reported nor investigated until 09/27/2023 2 days after the survey began. The incident was reported to the Office of Licensure and Certification, Adult Protective Services, the Dept of Health Professions, and the Police by the Regional Director of Clinical Services on 09/27/2023. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the findings. No further information was provided.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 41449 Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility failed to conduct investigations of allegations of abuse by a staff member involving 2 residents (Residents #53 and #85) in a survey sample of 48 residents. The findings included: 1. For Resident #53, who reported an allegation of physical and sexual abuse by CNA C, the facility staff failed to conduct an investigation and take measures to prevent further abuse while an investigation was conducted. On 08/10/2023, Resident #53 reported an allegation of abuse to facility staff. On 09/26/2023, during a clinical record review of Resident #53's clinical chart the following was noted: a. A progress note dated 08/10/2023 at 5:06 p.m., read, Patient sent to saint Mary's for evaluation r/t [related to] alleged assault, MD [medical doctor] made aware. Patient verbalized understanding the reason for transfer. b. Another progress note dated 08/10/2023 at 5:15 p.m., stated, Patient made a statement in regard to an assault that took place this morning, a statement was given from patient to myself dictated at 2:11 PM at the south unit nursing station. Phone call placed to nonemergency services so patient could give an official statement and press charges. On 09/27/2023, a review was conducted of the facility's documentation of the allegation and actions taken. There was a written statement that was taken from Resident #53 that read as follows: Statement of [Resident #53's name redacted] patient stated that while he was asleep, he was awakened by a washcloth being placed on his face, he then heard a voice say, can you see me? Patient then says in return, I am not blind. Patient states the CNA [certified nursing assistant/CNA C] then pulled off his sheets and undid his brief and began flicking his penis back and forth. Patient states the CNA then stated he was going to shave his pubic hairs. Patient stated he began to yell out for help, which caused the CNA to abruptly stop, then pick the patient up and throw him in the chair. Patient then restated all of the above details to the speech therapist. There was also a written statement from Employee M, the Speech Language Pathologist (SLP). Lastly, there was evidence the state survey agency, Office of Licensure and Certification (OLC), and Adult Protective Services (APS) were faxed a report of the incident on 08/10/2023 at 7:10 p.m. There was no evidence an investigation into the allegations was conducted. During Surveyor F's investigation of this incident, payroll records revealed CNA C did not leave the facility on the day of the allegations until 1:17 p.m., despite the initial report being made at approximately 7:50 a.m. Following that initial incident of physical and sexual abuse, CNA C then continued to provide care for Resident #53 and at 9:30 a.m., was seen aggressively feeding the resident, to the point the SLP had to intervene for the resident's safety and welfare. (continued on next page)

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Henrico Health & Rehabilitation Center	561 North Airport Drive Highland Springs, VA 23075

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/27/2023 at 11:26 a.m., an interview was conducted with the facility's Director of Nursing (DON), with the Administrator and survey team present. The DON was asked about the incident involving Resident #53 and CNA C. The DON reported, On 8/10 when I came in the speech therapist (SLP) came and talked with me 8:30 AM and gave me a service concern and said she saw Resident #53 and he reported that a CNA had touched him inappropriately. I went and talked with him [Resident #53] and he said when he did foley care it was discomfort. Then at noon he said the CNA had put a washcloth over his face and he was flicking his penis back and forth. He could not give a name or describe the person, we had one male CNA working that day, which she identified as [CNA C's name redacted]. I asked him [Resident #53] if he wanted to be sent out, he said yes. The DON stated she had CNA C sent home prior to her arrival at the facility early that morning due to performance issues, prior to her knowledge of the allegation involving Resident #53. During the above interview, the DON was asked to explain what steps were taken to investigate the allegation and if she had any additional documentation regarding the investigation. The DON stated she had interviewed other residents and reviewed the hospital records of Resident #53, and because there was no forensic evidence, she unsubstantiated the allegation. The DON was asked to provide evidence of the residents' interviews she conducted, and she said she had nothing to provide. When asked if staff, including but not limited to CNA C, were interviewed, the DON indicated no. The facility had no evidence of any investigation being conducted. On 09/27/2023 at 12:10 p.m., an interview was conducted with Employee M, the speech language pathologist (SLP). The SLP confirmed Resident #53's report of abuse reported to her on 08/10/2023, when she arrived to work at 7:50 a.m. She also stated she immediately reported the allegation to her departmental supervisor, the nursing unit manager, and then to the Director of Nursing. On 09/27/2023, Surveyors D and F attempted to interview Resident #53, but the resident was not available for interview. On 09/28/2023 at 3:00 p.m., Surveyors D and F visited Resident #53 in his room. Resident #53 gave the same accounting of events that were in the written statement referenced earlier. There was no change in his report. Resident #53 became very tearful, said he was so afraid, and that CNA C laid me flat in the chair on my back and was trying to silence me and say I choked on food. Resident #53 said, [Employee M's name redacted] took a picture. The resident also stated that following this incident, he was afraid to sleep, kept looking around, and had to be prescribed Trazadone so he could sleep. When asked how all of this made him feel, Resident #53 said, Like I wanted to leave here, I was scared, I can't move, I was afraid I was going to choke, he was trying to silence me so he could say I choked. I watched all the time. A review was conducted of the facility's abuse policy titled, Abuse/Neglect/Misappropriation/Crime/Reporting Requirements/Investigations. Excerpts from this policy read, 2. The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigation protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations. On 09/27/2023 and 09/28/2023, the facility Administrator and corporate staff were made aware of the above findings. The corporate staff notified the survey team they would be re-opening the investigation into the events involving Resident #53 and CNA C. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided. 40026 2. For Resident #85, the facility staff failed to thoroughly investigate an allegation of sexual abuse at the time it occurred. On or about 08/10/2023, an allegation that a CNA shaved the pubic hair of Resident #85 who is cognitively impaired and unable to be interviewed. The allegation was reported by the CNA who cares for her and the roommate of the resident. On 09/26/2023, an interview was conducted with Resident #103 who stated she knew that Resident #85 had been molested by a male CNA. She allowed the surveyors to listen to an audio recording of CNA E questioning Resident #85. According to the audio recording, CNA E stated, Why did you let that man shave you down there? Resident #85 has a Brief Interview of Mental Status (BIMS) score of 99, and stated that she did not let anyone shave her to which you can hear the CNA reply, You are mighty bald down there. You got less hair than me and I was waxed. On 09/27/2023 at 1:00 p.m., an interview was conducted with CNA E who admitted she had knowledge of the incident and that she made the nurse and the former DON aware of the incident; however, she did not report it as abuse at that time. On 09/26/2023, an interview was conducted with the DON who was asked if she reported the allegation of sexual abuse and she stated that she did not find it was abuse. She stated she heard about it from Resident #103, and she did not consider it abuse. The DON stated, Coming from (Resident #103 name redacted) I don't believe it. When asked again if she followed the abuse policy and reported it to the appropriate parties, she stated she did not think it was abuse, so she did not report it. A review of the Abuse Policy read: All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, 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. The incident was not reported nor investigated until 09/27/2023, 2 days after the survey began. The incident was reported to the Office of Licensure and Certification, Adult Protective Services, the Department of Health Professions, and the Police by the Regional Director of Clinical Services on 09/27/2023. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the findings. No further information was provided.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interview and clinical record review, the facility staff failed to complete a comprehensive assessment after significant change in a timely manner for one resident (Resident #19) in a survey sample of 48 residents. For Resident #19, the facility staff failed to perform a significant change in status assessment after 2 areas of decline in pressure ulcer formation after hospitalization , and significant weight loss prior to and after hospitalization within 14 days of knowing about the 2 declines. The findings included: For Resident #19, the facility staff did not intervene during the significant weight loss of a resident with known dysphagia following a stroke, insulin dependent Diabetes Mellitus, and 3 wounds. Resident #19 was admitted to the facility on [DATE], and most recently readmitted after hospitalization on [DATE] with diagnoses including; encephalopathy, urinary tract infection, oral cadidiasis, and COVID-19. Resident #19 had a medical history including, stroke, diabetes, and acute gastrointestinal bleeding with resulting acute post hemorrhagic anemia and weakness from the 12/26/2022 admission. Resident #19's most recent quarterly Minimum Data Set (MDS) assessment was dated with an assessment reference date of 06/21/2023, and coded the resident as moderately cognitively impaired, required extensive assistance with feeding, coded no wounds nor skin problems, at risk for malnutrition, weight 148.0 lbs (pounds), and no swallowing issues. The assessment was in error as the resident had 2 ongoing long standing foot wounds from an original admission known for years. It is notable to add that no significant change to the MDS assessment was completed from Resident #19's readmission from the hospital on 09/19/2023 through the time of survey ending 10/04/2023 (15 days after readmission). Resident #19 had a known significant weight loss before hospitalization , and a new pressure sore on Resident #19's right buttock found on the day of readmission at unstageable due to slough in the wound bed. These issues would require further nutritional support for wound healing and significant weight loss. According to the regulation, a significant change assessment should be conducted within 14 days of a known decline in 2 or more areas such as unplanned weight loss and a new unstageable pressure wound. On 01/02/2023, the Registered Dietician (RD) evaluated Resident #19, and documented Nutrition Assessment (A) Diagnoses .regular diet level 4 pureed texture, regular liquids consistency. Po (oral) intake 25-75% of most meals, supplement none, .pressure wound, medications named .Nutrition Prescription/interventions (1) add multivitamin with minerals to aid in wound healing (2) Add ensure compact 4 ounces by mouth due to variable oral intake, increased needs for wound healing, malnutrition prevention, advanced age Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/20/2023, the last RD evaluation document was completed in the clinical record and stated, Nutrition Assessment (A) quarterly ARD 6-21-23 .Diagnoses .regular diet regular texture, thin liquids consistency. Po (oral) intake 50-100% of most meals, supplement med plus 2.0 at 120 milliliters by mouth with (hs) bedtime labs, medications named .continue current interventions Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol. weight 148.3 lbs (pounds). On 09/07/2023 and 09/14/2023, dietary notes indicated significant weight loss was identified; however, no new interventions nor orders were added. The facility inspection/survey began 09/25/2023 and ended on 10/04/2023. Resident #19's weight document was reviewed and revealed the following: 1. 07/03/2023 - 145.0 pounds 2. 08/07/2023 - 140.2 pounds (5 pound weight loss in one month begins) 3. 09/06/2023 - 131.6 pounds (now a 14 pound (10 %) weight loss in 2 months) 4. 09/11/2023 - 129.0 pounds (now a 16 pound weight loss 9 weeks) Resident #19 went out to the hospital on 09/16/2023, and returned on 09/19/2023. 5. 09/19/2023 - 135.0 (a 6 pound weight gain during hospitalization) 6. 09/25/2023 - 126.0 pounds (a 9 pound weight loss begins again) 7. 09/27/2023 - 119.4 pounds (now almost 20% weight loss in less than 4 months) and weight loss continues. Physician and RD orders were reviewed, and revealed that from 01/03/2023, multivitamin was ordered and discontinued on 06/30/2023, the regular diet was discontinued on 06/30/2023, and the Ensure Compact supplement was discontinued on 06/01/2023. The Med Plus 2.0 supplement was started on 06/01/2023, and discontinued on 06/30/2023. There were no orders for supplements after the 06/30/2023 discontinuance until 09/19/2023, after a significant weight loss had occurred and been ongoing for months. The multivitamin, and Med Plus 2.0 were restarted on 09/19/2023; however, the Med Plus 2.0 supplement was discontinued nine days later on 09/28/2023 by a physician's order. Weekly weights were obtained beginning 09/06/2023, indicating knowledge of the significant weight loss (10 days) before hospitalization on [DATE] for Resident #19; however, no interventions were added for the weight loss. The medication administration record (MAR) documented that the Med plus 2.0 was given daily after 09/28/2023, even after being discontinued, and on 09/28/2023, the diet was changed to mechanically altered which dietary staff indicated meant chopped. Resident #19 did not receive supplements from 06/30/2023 through 09/19/2023 during a significant weight loss, and the RD did not evaluate nor intervene during a significant weight loss. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #19's nutrition care plan, completed and initiated on 01/02/2023, was canceled on 09/18/2023 by the RD. No new nutrition care plan nor any other care plan had been completed at the time of survey on 09/25/2023, nor through 09/27/2023 (9 days after readmission) when documents were obtained. The new readmission care plan was in development according to staff nurses when asked to review the care plan in the electronic clinical record. Resident #19 did not have a dehydration care plan even though the resident had experienced dehydration in the facility and received Clysis fluid resuscitation instilled subcutaneously on several occasions. Resident #19 did not receive diuretic medications which assists with removing fluid from the body. Activities of Daily Living records (ADLs) were reviewed and revealed Resident #19 needed to be assisted and received extensive assistance. The resident consumed varying amounts of meals from 0% to 75%. Family interviews to include the resident's daughter, and granddaughter, who stated she was a Licensed Practical Nurse (LPN), revealed that Resident #19 had to be fed and will, at times, accept things in her hands to eat, such as sandwiches. However, she must be cued to eat them. The family was very involved with the resident's care and were in the facility almost daily. The family stated they had not received a baseline care plan nor had they been invited to a care plan meeting since Resident #19 was readmitted on [DATE], and they were concerned about the resident's weight loss. Staff interviews revealed that Resident #19 had to be fed, and that she would stop eating if not fed. Observations conducted on 09/29/2023 at 12:00 p.m., revealed Resident #19 in the communal dining room on the nursing unit. The resident was sitting at a table with 3 other residents with meal trays in front of them, and they were being assisted by one staff member to set-up, and feed the residents at the table. Resident #19's tray was observed to have 1/2 inch cubed turkey meat, 1/2 inch chopped cubes of cabbage, mashed potatoes and gravy. The resident was not eating and Certified Nursing Assistant (CNA) D, who was sitting with the residents, stated she would be feeding Resident #19. Observations were continued and only one teaspoonful of potatoes was placed up to the mouth of Resident #19, of which, the resident took half into her mouth and swallowed. At 1:00 p.m., all trays were loaded onto the cart to return to the kitchen. Resident #19's tray was observed to have 1/2 spoonful of mashed potatoes consumed and the other half of the spoonful was still on the spoon, indicating no other food was fed to the resident. At 1:15 p.m., CNA D was interviewed and asked why she had not fed Resident #19. CNA D stated, She (Resident#19) was very sleepy, so I told the nurse (LPN D) and didn't offer her any more food. LPN (Licensed Practical Nurse) D was interviewed and stated, the speech therapist was changing the resident's diet and the resident would receive another tray, but the resident has thrush so she probably won't eat anyway. The surveyor told LPN D that CNA D stated she was sleepy and that is why she was not eating. LPN D stated she didn't tell me that. Resident #19 was observed for the rest of the shift, and never received another tray. It is notable to mention that the resident's finger stick blood sugar (FSBS) testing that morning indicated 78, which was low for the resident. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/29/2023 at the end of day debriefing, the Administrator and Regional Director of Operations were notified of the findings for Resident #19. On 10/04/2023 at approximately 2:00 p.m., the Administrator, Corporate Nurse Consultant, and Regional Director of Operations were again notified of the findings, and they stated they had nothing further to provide.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on observation, family interview, staff interview, facility document review, and clinical record review, the facility staff failed to complete a 48-hour baseline care plan for one resident (Resident #19) in a survey sample of 48 residents. For Resident #19, the facility staff failed to develop and operationalize a 48-hour base line care plan after readmission and discontinuance of the resident's former care plan, which was canceled. The findings included: For Resident #19, the facility staff did not intervene during the significant weight loss of a resident with known dysphagia following a stroke, insulin dependent Diabetes Mellitus, and 3 wounds. Resident #19 was admitted to the facility on [DATE], and most recently readmitted after hospitalization on [DATE] with diagnoses including, encephalopathy, urinary tract infection, oral cadidiasis, and COVID-19. The resident had a medical history including, stroke, diabetes, and acute gastrointestinal bleeding with resulting acute post hemorrhagic anemia and weakness from the 12/26/2022 admission. Resident #19's most recent quarterly Minimum Data Set (MDS) assessment was dated with an assessment reference date of 06/21/023, and coded the resident as moderately cognitively impaired, required extensive assistance with feeding, coded no wounds nor skin problems, at risk for malnutrition, weight 148.0 lbs (pounds), and no swallowing issues. The assessment was in error as Resident #19 had 2 ongoing long standing foot wounds from an original admission known for years. It is notable to add that no significant change MDS assessment was completed from Resident #19's readmission from the hospital on 09/19/2023 through the time of survey ending on 10/04/2023 (15 days after readmission). Resident #19 had a known significant weight loss before hospitalization , and a new pressure sore on the resident's right buttock was found on the day of readmission at unstageable due to slough in the wound bed. These issues would require further nutritional support for wound healing and significant weight loss. According to the regulations, a significant change assessment should be conducted within 14 days of a known decline in 2 or more areas such as unplanned weight loss and a new unstageable pressure wound. On 01/02/2023, the Registered Dietician (RD) evaluated Resident #19 and documented Nutrition Assessment (A) Diagnoses .regular diet level 4 pureed texture, regular liquids consistency. Po (oral) intake 25-75% of most meals, supplement none, .pressure wound, medications named .Nutrition Prescription/interventions (1) add multivitamin with minerals to aid in wound healing (2) Add ensure compact 4 ounces by mouth due to variable oral intake, increased needs for wound healing, malnutrition prevention, advanced age Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/20/2023, the last RD evaluation document was completed in the clinical record and stated; Nutrition Assessment (A) quarterly ARD 6-21-23 Diagnoses .regular diet regular texture, thin liquids consistency. Po (oral) intake 50-100% of most meals, supplement med plus 2.0 at 120 milliliters by mouth with (hs) bedtime labs, medications named , continue current interventions Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol. Weight 148.3 lbs (pounds). On 09/27/2023 and 09/14/2023, dietary notes indicated significant weight loss was identified; however, no new interventions nor orders were added. The facility inspection/survey began 09/25/2023 and ended 10/04/2023. Resident #19's weight document was reviewed and revealed the following: 1. 07/03/2023 - 145.0 pounds 2. 08/07/2023 - 140.2 pounds (5 pound weight loss in one month begins) 3. 09/06/2023 - 131.6 pounds (now a 14 pound (10 %) weight loss in 2 months) 4. 09/11/2023 - 129.0 pounds (now a 16 pound weight loss 9 weeks) Resident #19 went out to the hospital on 09/16/2023 and returned on 09/19/2023. 5. 09/19/2023 - 135.0 (a 6 pound weight gain during hospitalization) 6. 09/25/2023 - 126.0 pounds (a 9 pound weight loss begins again) 7. 09/27/2023 - 119.4 pounds (now almost 20% weight loss in less than 4 months) and weight loss continues. Physician and RD orders were reviewed and revealed that from 01/03/2023, multivitamin was ordered and discontinued on 06/30/2023, the regular diet was discontinued on 06/30/2023, and the Ensure Compact supplement was discontinued on 06/01/2023. The Med Plus 2.0 supplement was started on 06/01/2023 and discontinued on 06/30/2023. There were no orders for supplements after the 06/30/2023 discontinuance until 09/19/2023 after a significant weight loss had occurred and been ongoing for months. The multivitamin and Med Plus 2.0 were restarted on 09/19/2023; however, the Med Plus 2.0 supplement was discontinued nine days later on 09/28/2023 by a physician's order. Weekly weights were obtained beginning 09/06/2023, indicating knowledge of the significant weight loss (10 days) before hospitalization on [DATE] for Resident #19; however, no interventions were added for the weight loss. The medication administration record (MAR) documented that the Med plus 2.0 was given daily after 09/28/2023, even after being discontinued, and on 09/28/2023, the diet was changed to mechanically altered which dietary staff indicated meant chopped. Resident #19 did not receive supplements from 06/30/2023 through 09/19/2023 during a significant weight loss, and the RD did not evaluate nor intervene during a significant weight loss. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #19's nutrition care plan, completed and initiated on 01/02/2023, was canceled on 09/18/2023 by the RD. No new nutrition care plan nor any other care plan had been completed at the time of survey on 09/25/2023 nor through 09/27/2023 (9 days after readmission) when documents were obtained. The new readmission care plan was in development according to staff nurses when asked to review the care plan in the electronic clinical record. Resident #19 did not have a dehydration care plan even though the resident had experienced dehydration in the facility and received Clysis fluid resuscitation instilled subcutaneously on several occasions. Resident #19 did not receive diuretic medications which remove fluid from the body. Activities of Daily Living records (ADLs) were reviewed and revealed that Resident #19 needed to be assisted and received extensive assistance. The resident consumed varying amounts of meals from 0% to 75%. Family interviews to include the resident's daughter and granddaughter, who stated she was an Licensed Practical Nurse (LPN), revealed that the resident had to be fed and will at times accept things in her hands to eat, such as sandwiches; however, she must be cued to eat them. The family was very involved with the resident's care and were there in the facility almost daily. The family stated they had not received a baseline care plan nor had they been invited to a care plan meeting since Resident #19 was readmitted on [DATE], and they were concerned about the resident's weight loss. Staff interviews revealed that Resident #19 had to be fed, and that she would stop eating if not fed. Observations conducted on 09/29/2023 at 12:00 p.m., revealed Resident #19 in the communal dining room on the nursing unit. The resident was sitting at a table with 3 other residents with meal trays in front of them, and they were being assisted by one staff member to set up, and feed the residents at the table. Resident #19's tray was observed to have 1/2 inch cubed turkey meat, 1/2 inch chopped cubes of cabbage, mashed potatoes and gravy. Resident #19 was not eating and CNA (Certified Nursing Assistant) D, who was sitting with the residents, stated she would be feeding Resident #19. Observations were continued and only one teaspoonful of potatoes was placed up to the mouth of Resident #19, of which, the resident took half into her mouth and swallowed. At 1:00 p.m., all trays were loaded onto the cart to return to the kitchen. Resident #19's tray was observed to have 1/2 spoonful of mashed potatoes consumed and the other half of the spoonful was still on the spoon, indicating no other food was fed to Resident #19. At 1:15 p.m., CNA D was interviewed and asked why she had not fed Resident #19. CNA D stated, She (Resident#19) was very sleepy so I told the nurse (LPN D) and didn't offer her any more food. LPN (Licensed Practical Nurse) D was interviewed and stated, the speech therapist was changing the resident's diet and Resident #19 would receive another tray, but the resident has thrush so she probably won't eat anyway. The surveyor told LPN D that CNA D stated she was sleepy and that is why she was not eating. LPN D stated, she didn't tell me that. The resident was observed for the rest of the shift, and never received another tray. It is notable to mention that Resident #19's finger stick blood sugar (FSBS) testing that morning indicated 78, which was low for the resident. On 09/29/2023 at the end of day debriefing, the Administrator and Regional Director of Operations were notified of findings for Resident #19. (continued on next page)

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Henrico Health & Rehabilitation Center	561 North Airport Drive Highland Springs, VA 23075

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/04/2023 at approximately 2:00 p.m., the Administrator, Regional RN consultant, and Corporate Director of Operations were made aware of findings, and they stated they had nothing further to provide.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41450 Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide care and services in accordance with professional standards for 1 resident, Resident #362, in a survey sample of 48 residents. The findings included: For Resident #362, facility staff failed to administer medications as ordered by the physician on 07/17/2023 and 07/18/2023. On 09/28/2023, Resident #362's clinical record was reviewed and revealed physician orders and medication administration times as follows: *Aspirin EC-low dose tablet delayed release, 81mg, give 1 tablet by mouth one time a day--ordered on 7/18/23, documented as given on 7/19/23 *Ferrous Sulfate tablet 325 (65 Fe)mg, give 1 tablet by mouth one time a day--ordered on 7/18/23, documented as given on 7/19/23 *Finasteride tablet 5mg, give 1 tablet by mouth one time a day--ordered on 7/18/23, documented as given on 7/19/23 *Gabapentin Oral Capsule 300mg, give 1 capsule by mouth at bedtime--ordered on 7/17/23, documented as given on 7/18/23 *Multiple Vitamin Tablet, give 1 tablet by mouth one time a day--ordered on 7/18/23, documented as given on 7/19/23 *Nifedipine ER Oral Tablet Extended Release 24 Hour 90mg, give 120mg by mouth one time a day--ordered on 7/18/23, documented as given on 7/19/23 *Carvedilol Oral Tablet 6.25mg, give 6.25mg by mouth two times a day--ordered on 7/17/23, documented as given on 7/18/23 *Eliquis Oral Tablet 2.5mg, give 2.5mg by mouth two times a day--ordered on 7/17/23, documented as given on 7/18/23 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/2023 at approximately 2:00 p.m., an interview was conducted with the Clinical Nurse Consultant (CNC) who confirmed the findings and stated that medications are expected to be given as ordered by the physician. She verified Resident #362 was actually admitted on [DATE] and stated, It appears that most of his [Resident #362's] med orders weren't entered into the system on the day of his admission as they should have been, it is my expectation that upon any resident's arrival to our facility, the admitting nurse will enter all admitting orders which includes all medications, if there is a question about medications then the nurse should contact the doctor for clarification and document it in a note, this nurse failed to follow our admissions process. The admitting nurse was unavailable to interview. The CNC stated the facility's professional nursing standards reference was [NAME]. A facility policy on medication administration was requested and received. Review of the facility policy entitled, General Guidelines for Medication Administration, revised 08-2020, heading Policy read, Medications are administered as prescribed in accordance with good nursing principles and practices . According to [NAME] Nursing Procedures, Seventh Edition, 2016, section entitled, Oral Drug Administration, steps in the implementation of medication administration included but were not limited to: Verify the medication is being administered at the proper time .to reduce the risk of medication errors. On 10/02/2023 at the end of day meeting, the facility Administrator was updated on the findings. No further information was provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide Activities of Daily Living (ADL) assistance to residents residing on 1 of 2 nursing units. The findings included: 1. For Resident #19, who was dependent upon facility staff for eating, the facility staff failed to provide assistance with the meal to ensure the resident was fed a meal. Observations conducted on 09/29/2023 at 12:00 p.m., revealed Resident #19 in the communal dining room on the nursing unit. The resident was sitting at a table with 3 other residents with meal trays in front of them, and they were being assisted by one staff member to set up, and feed the residents at the table. Resident #19's tray was observed to have 1/2 inch cubed turkey meat, 1/2 inch chopped cubes of cabbage, mashed potatoes and gravy. The resident was not eating and CNA (Certified Nursing Assistant) D who was sitting with the residents stated she would be feeding Resident #19. Observations were continued and only one teaspoonful of potatoes was placed up to the mouth of Resident #19, of which, the resident took half into her mouth and swallowed. At 1:00 p.m., all trays were loaded onto the cart to return to the kitchen. Resident #19's tray was observed to have 1/2 spoonful of mashed potatoes consumed and the other half of the spoonful was still on the spoon, indicating no other food was fed to the resident. At 1:15 p.m., CNA D was interviewed and asked why she had not fed the resident. CNA D stated She (Resident#19) was very sleepy so I told the nurse (LPN D) and didn't offer her any more food. LPN (Licensed Practical Nurse) D was interviewed and stated that the speech therapist was changing the resident's diet and that the resident would receive another tray, but the resident has thrush so she probably won't eat anyway. The surveyor told LPN D that CNA D stated she was sleepy and that is why she was not eating. LPN D stated she didn't tell me that. Resident #19 was observed for the rest of the shift, and never received another tray. It is notable to mention that the resident's finger stick blood sugar (FSBS) testing that morning indicated 78, which was low for the resident. Activities of Daily Living (ADL) records were reviewed and revealed that Resident #19 needed to be assisted and received extensive assistance. The resident consumed varying amounts of meals from 0% to 75%. Family interviews to include the resident's daughter, and granddaughter, who stated she was an Licensed Practical Nurse (LPN), revealed that the resident had to be fed and will at times accept things in her hands to eat, such as sandwiches; however, she must be cued to eat them. The family was very involved with the resident's care and were there in the facility almost every day. The family stated they had not received a baseline care plan nor had they been invited to a care plan meeting since the resident was readmitted on [DATE], and they were concerned about the resident's weight loss. Staff interviews revealed that Resident #19 had to be fed, and that she would stop eating if not fed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident Council expressed ongoing concerns over the lack of incontinence care, with no resolution. On 09/26/2023 at 1:00 p.m., a group meeting was held with 6 residents who were members of the Resident Council. During this meeting with the Surveyor, residents verbalized ongoing concerns over the lack of call bell response time and ADL assistance for residents who are incontinent. The residents stated, residents who cannot ambulate and have dementia are left in the day room area on the South Hall all day without being changed. Six of the six residents in attendance at the Resident Council meeting stated, that the room is supposed to be used for activities; however, the staff park residents in there and they cannot do activities. They stated the room always smells of urine and feces because they do not change the residents they park in there. A review of the Resident Council minutes for the past 6 months revealed that residents are complaining about call bell answer times and improper incontinent care repeatedly. Review of the grievances revealed the same, ongoing concerns about incontinence care and assistance with ADLs. On 10/03/2023 during an end of day meeting, the facility Administrator was made aware of the above findings. No further information was provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40026 Based on observation, interview, facility documentation, and clinical record review, the facility staff failed to ensure the resident environment remains free of accident hazards for 1 of 2 units. The findings included: For the residents using the showers on the South Hall the facility, staff failed to ensure the shower room tiles were in good repair. On 09/26/2023 at 2:00 p.m. during the Resident Council meeting, it was brought up that the shower rooms were dirty, and Resident #42 added that the shower room has bugs and is dirty. Residents #68 and #18 added that in the shower cubical, the tiles are loose and coming up out of floor. When asked how long this was going on 6 of 6 residents in attendance agreed that it has been a few months (more than 2). When asked were staff aware of the issue, Resident #42 stated and the group agreed The staff have to be aware they are giving showers to residents in that room. On 09/26/2023 at 4:00 p.m., this surveyor accompanied the Maintenance Director to the shower rooms to observe the condition of the shower room. Upon entering the shower room, the first stall had black and white tiles that were pulled up and several were missing. An interview was conducted with the maintenance director who was asked if that presents a safety issue. The maintenance director stated that it does present a potential safety issue as tiles may be sharp and a resident could possibly cut their feet on the tile. The maintenance director stated he was not aware of the tiles being broken. On the afternoon of 09/26/2023, an interview was conducted with CNA D who stated she was aware of the broken tiles and had complained about it to the nurse. She stated that they had reported the broken tiles a month or so ago. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the concern. No further information was provided.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to ensure residents maintain acceptable parameters of nutritional status for 3 residents (Residents #22, #53 and #19) in a survey sample of 48 residents. The findings included. 1. For Resident #22, the facility staff failed to ensure the resident did not sustain a significant weight loss. On 09/25/2023 at approximately 2:00 p.m., Resident #22 was interviewed and stated, The food is horrible, and they never give what is actually on the ticket. They don't care if I eat or not, I have lost weight being in here. A review of the clinical record revealed that on admission to the facility on [DATE], Resident #22 weighed 175 lbs. 3 months later on 08/09/2023, Resident # 22 weighed 154 lbs., which is a 12% weight loss (21 lbs.) in 3 months' time. A review of the care plan revealed the following: FOCUS: Resident is at risk for weight fluctuations related to recent hospitalization , BMI, pressure ulcers, Incomplete Lesion of L1 Lumbar Spinal Cord, Paraplegia, Hereditary and Idiopathic Neuropathy, Necrotizing Fasciitis, Colostomy, Psychoactive Substance Abuse, Anemia, malnutrition. date initiated: 5/3/23 Revision on 9/29/23 [Note revision Resident #22 was interviewed] GOAL: The resident will have optimal nutrition and hydration status thru review period Date Initiated: 05/03/2023 Revision 9/26/23. INTERVENTIONS: Diet as ordered Date Initiated: 09/26/2023 Created on: 09/26/2023. Encourage to eat Date Initiated: 05/09/2023 Created on: 05/09/2023. Meds as ordered Date Initiated: 09/26/2023 Created on: 09/26/2023. RD consult as needed Date Initiated: 05/03/2023 Created on: 05/03/2023. Record meal % intake Date Initiated: 05/03/2023 Created on: 05/03/2023. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review dietary preferences with the resident as needed Date Initiated: 06/07/2023 Created on: 06/07/23. Supplements as ordered Date Initiated: 09/28/2023 Created on: 09/28/2023. Weights as ordered Date Initiated: 05/09/2023. A review of the clinical record revealed the following excerpts from the Registered Dietician Admission note dated 05/03/2023: Height: 70 inches, IBW (ideal body weight) =166.0# Weight: 5/3/2023=175.0# (Hosp wt. 175#) BMI: 25.1 Nutrition risk potential for weight fluctuations r/t recent hospitalization , Incomplete Lesion of L1 Lumbar Spinal Cord, Paraplegia, Hereditary and Idiopathic Neuropathy, Sepsis, Necrotizing Fasciitis, Colostomy, Psychoactive Substance Abuse, Anemia in CKD Nutrition Prescription / Interventions (I): Add MVI with Minerals to aid in wound healing Monitor / Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol. The following excerpt is from the Registered Dietician's quarterly note dated 06/06/2023: Diet: Regular diet, Regular texture, Thin Liquids consistency - Po intake: 76-100% of most meals Supplement: none Skin: pressure area to Sacrum per 5/30/2023 Skin Observation Tool Labs: none Pertinent Meds: Morphine Sulfate, Famotidine, Ondansetron HCl, Gabapentin, MVI with Minerals, Oxycodone HCl Height: 70 inches, IBW (Ideal Body Weight) =166.0# Weight: 5/3/2023=175.0# (Hosp wt. 175#) BMI: 25.1 Continue current interventions Monitor / Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol. The following Registered Dietician note was entered during the survey: 9/29/2023 6:33 AM -Nutrition/Dietary Note: Note Text: Spoke with resident 9/27/2023, requested supplement change from Med Plus to Mighty Shake q day at 2pm. Residents goal weight is ~160.#. Weights now appear stable at goal, resident refused monthly weight. Continues consuming current diet well. Monitor /Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol. On 09/29/2023 at approximately 3:00 p.m., an interview was conducted with Resident #22. He was asked if he was trying to lose weight, and he stated he was not and now they are giving him mighty shakes to gain back what he lost. On 10/4/23 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided. 2. For Resident #53, the facility staff failed to ensure the resident did not sustain a significant weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #53 was admitted to the facility on [DATE] weighing 130 lbs. On 09/25/2023, Resident #53 weighed 119 lbs. this is a weight loss of 8.4% (11lbs) in little over a month. A review of the care plan read as follows: FOCUS: Resident is at risk for weight loss or malnutrition related to recent hospitalization , mechanically altered diet, Encephalopathy, HIV, Opioid Dependence, Cerebral Infarction, Dysphagia, Chronic Hepatitis Date Initiated: 08/07/2023 Created on: 08/07/2023. GOAL: The resident will have optimal nutrition and hydration status thru review period Date Initiated: 08/07/2023 Created on: 08/07/2023. INTERVENTIONS: Assist with meals as needed and observe for any difficulty eating/swallowing Date Initiated: 08/10/2023 Created on: 08/10/2023. Diet/fluids as ordered Date Initiated: 08/10/2023 Created on: 08/10/2023. Encourage to eat Date Initiated: 08/07/2023 Created on: 08/07/2023. RD consult as needed Date Initiated: 08/07/2023. Record meal % intake Date Initiated: 08/07/2023 Created on: 08/07/2023. Review dietary preferences with the resident as needed Date Initiated: 08/10/2023 Created on: 08/10/2023. Supplements as ordered Date Initiated: 08/07/2023 Created on: 08/07/2023. Weights as ordered Date Initiated: 08/07/2023 Created on: 08/07/2023. A review of the clinical record revealed that Resident #53 had only been seen by the Registered Dietician on one occasion, 08/07/2023. Excerpts are as follows: 8/7/2023 09:54 Nutrition/Dietary Note: Note Text: Nutrition Assessment (A) Brief Patient Description: [AGE] year-old male, admitted [DATE] Medical Dx: Encephalopathy, HTN, Asymptomatic HIV, Cardiac Arrhythmia, Rhabdomyolysis, Opioid Dependence, Cerebral Infarction, Dysphagia, Chronic Hepatitis Diet: Regular diet, Dysphagia Mechanically Altered texture, Nectar Thick Liquid consistency Po intake: 50-100% of most meals - Supplement: Ensure Nutrition Shake BID. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Height: 67 inches, IBW [Ideal Body Weight] =148.0# Weight: 8/1/2023=130.0# BMI: 20.4 Estimated nutritional needs: 59 kg = 1700-1900 kcal (28-32 kcal/kg), 59-70 gms protein (1.0-1.2 gms/kg), 1700-1900 mL fluid (1 mL/kcal) Nutrition risk potential for weight fluctuations or malnutrition r/t recent hospitalization , mechanically altered diet, Encephalopathy, Asymptomatic HIV, Opioid Dependence, Cerebral Infarction, Dysphagia, Chronic Hepatitis Nutrition Prescription / Interventions (I): Change Ensure Nutrition Shake to Med Plus 2.0 @ 120 mL po BID between meals to allow for increased po intake at meals, mechanically altered diet, malnutrition prevention Monitor / Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol. Diet orders for Resident #53 read as follows: Regular diet, Dysphagia Advanced texture, Thin Liquids consistency Aspiration Precautions; [NAME] Tuck Diet Active 8/23/2023 8:05 am. On 09/28/2023 at approximately 12:00 p.m., an interview was conducted with Resident #53 who stated he did not like the food at the facility. When asked if anyone had asked him for his preferences or his likes and dislikes he stated, They might have but that is not what I get. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the findings. No further information was provided 31199 3. For Resident #19, the facility staff did not intervene during the significant weight loss of a resident with known dysphagia following a stroke, insulin dependent Diabetes Mellitus, and 3 wounds. Resident #19 was admitted to the facility on [DATE], and most recently readmitted after hospitalization on [DATE] with diagnoses including, encephalopathy, urinary tract infection, oral cadidiasis, and COVID-19. Resident #19 had a medical history including, stroke, diabetes, and acute gastrointestinal bleeding with resulting acute post hemorrhagic anemia and weakness from the 12/26/2022 admission. The resident's most recent quarterly Minimum Data Set (MDS) assessment was dated with an assessment reference date of 06/21/2023, and coded Resident #19 as moderately cognitively impaired, required extensive assistance with feeding, coded no wounds nor skin problems, at risk for malnutrition, weight 148.0 lbs (pounds), and no swallowing issues. The assessment was in error as Resident #19 had 2 ongoing long standing foot wounds from an original admission known for years. It is notable to add that no significant change MDS assessment was completed from Resident #19's readmission from the hospital on 09/19/2023 through the time of survey ending 10/04/2023 (15 days after readmission). Resident #19 had a known significant weight loss before hospitalization , and a new pressure sore on the resident's right buttock was found on the day of readmission at unstageable due to slough in the wound bed. These issues would require further nutritional support for wound healing and significant weight loss. According to the regulation, a significant change assessment should be conducted within 14 days of a known decline in 2 or more areas such as unplanned weight loss and a new unstageable pressure wound. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/02/2023, the Registered Dietician (RD) evaluated the resident and documented: Nutrition Assessment (A) .Diagnoses regular diet level 4 pureed texture, regular liquids consistency. Po (oral) intake 25-75% of most meals, supplement none, .pressure wound, medications named , Nutrition Prescription/interventions (1) add multivitamin with minerals to aid in wound healing (2) Add ensure compact 4 ounces by mouth due to variable oral intake, increased needs for wound healing, malnutrition prevention, advanced age Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol. On 06/20/2023, the last RD evaluation document was completed in the clinical record and stated, Nutrition Assessment (A) quarterly ARD 6-21-23 Diagnoses .regular diet regular texture, thin liquids consistency. Po (oral) intake 50-100% of most meals, supplement med plus 2.0 at 120 milliliters by mouth with (hs) bedtime labs, medications named , continue current interventions Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol. weight 148.3 lbs (pounds). On 09/07/2023 and 09/14/2023, dietary notes indicated significant weight loss was identified; however, no new interventions nor orders were added. The facility inspection/survey began on 09/25/2023 and ended on 10/04/2023. Resident #19's weight document was reviewed and revealed the following: 1. 07/03/2023 - 145.0 pounds 2. 08/07/2023 - 140.2 pounds (5 pound weight loss in one month begins) 3. 09/06/2023 - 131.6 pounds (now a 14 pound (10 %) weight loss in 2 months) 4. 09/11/2023 - 129.0 pounds (now a 16 pound weight loss 9 weeks) Resident #19 went out to the hospital on 09/16/2023 and returned on 09/19/2023. 5. 09/19/2023 - 135.0 (a 6 pound weight gain during hospitalization) 6. 09/25/2023 - 126.0 pounds (a 9 pound weight loss begins again) 7. 09/27/2023 - 119.4 pounds (now almost 20% weight loss in less than 4 months) and weight loss continues. Physician and RD orders were reviewed and revealed that from 01/03/2023, multivitamin was ordered and discontinued on 06/30/2023, the regular diet was discontinued on 06/30/2023, and the Ensure Compact supplement was discontinued on 06/01/2023. The Med Plus 2.0 supplement was started on 06/01/2023, and discontinued on 06/30/2023. There were no orders for supplements after the 06/30/2023 discontinuance until 09/19/2023 after a significant weight loss had occurred and been ongoing for months. The multivitamin, and Med Plus 2.0 were restarted on 09/19/2023; however, the Med Plus 2.0 supplement was discontinued nine days later on 09/28/2023 by a physician's order. Weekly weights were obtained beginning 09/06/2023, indicating knowledge of the significant weight loss (10 days) before hospitalization on [DATE] for Resident #19; however, no interventions were added for the weight loss. (continued on next page)

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	495193	A. Building B. Wing	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henrico Health & Rehabilitation Center	561 North Airport Drive Highland Springs, VA 23075

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The medication administration record (MAR) documented that the Med plus 2.0 was given daily after 09/228/2023, even after being discontinued, and on 09/28/2023, the diet was changed to mechanically altered, which dietary staff indicated meant chopped. Resident #19 did not receive supplements from 06/30/2023 until 09/19/2023 during a significant weight loss, and the RD did not evaluate nor intervene during a significant weight loss. Resident #19's nutrition care plan, completed and initiated on 01/02/2023, was canceled on 09/18/2023 by the RD. No new nutrition care plan nor any other care plan had been completed at the time of survey on 09/25/2023, nor through 09/27/2023 (9 days after readmission) when documents were obtained. The new readmission care plan was in development according to staff nurses when asked to review the care plan in the electronic clinical record. Resident #19 did not have a dehydration care plan even though the resident had experienced dehydration in the facility and received Clysis fluid resuscitation instilled subcutaneously on several occasions. Resident #19 did not receive diuretic medications, which remove fluid from the body. Activities of Daily Living (ADL) records were reviewed and revealed that the Resident needed to be assisted and received extensive assistance. The Resident consumed varying amounts of meals from 0% to 75%. Family interviews to include the Resident's daughter, and granddaughter, who stated she was an Licensed Practical Nurse (LPN), revealed that Resident #19 had to be fed and will at times accept things in her hands to eat, such as sandwiches; however, she must be cued to eat them. The family was very involved with the resident's care and were there in the facility almost every day. The family stated they had not received a baseline care plan nor had they been invited to a care plan meeting since the resident was readmitted on [DATE], and they were concerned about the resident's weight loss. Staff interviews revealed that Resident #19 had to be fed, and that she would stop eating if not fed. Observations conducted on 09/29/2023 at 12:00 p.m., revealed Resident #19 in the communal dining room on the nursing unit. The resident was sitting at a table with 3 other residents with meal trays in front of them, and they were being assisted by one staff member to set up and feed the residents at the table. Resident #19's tray was observed to have 1/2 inch cubed turkey meat, 1/2 inch chopped cubes of cabbage, mashed potatoes and gravy. The resident was not eating and CNA (Certified Nursing Assistant) D who was sitting with the residents stated she would be feeding Resident #19. Observations were continued and only one teaspoonful of potatoes was placed up to Resident #19's mouth, of which, the resident took half into her mouth and swallowed. At 1:00 p.m., all trays were loaded onto the cart to return to the kitchen. Resident #19's tray was observed to have 1/2 spoonful of mashed potatoes consumed and the other half of the spoonful was still on the spoon, indicating no other food was fed to the resident. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 1:15 p.m., CNA D was interviewed and asked why she had not fed Resident #19. CNA D stated She (Resident#19) was very sleepy so I told the nurse (LPN D) and didn't offer her any more food. LPN (Licensed Practical Nurse) D was interviewed and stated, the speech therapist was changing the resident's diet and Resident #19 would receive another tray, but the resident has thrush so she probably won't eat anyway. The surveyor told LPN D that CNA D stated she was sleepy and that is why she was not eating. LPN D stated she didn't tell me that. The resident was observed for the rest of the shift, and never received another tray. It is notable to mention Resident 19's finger stick blood sugar (FSBS) testing that morning indicated 78, which was low for the resident. On 09/29/2023 at approximately 1:15 p.m., Resident #19's room was entered with CNA D, in the search for Resident #19's dentures which were missing. The resident had 3 plastic denture cups; however, all three were empty. One cup was in the floor behind the headboard of the resident's bed, one was in the large lower door of the bedside cabinet, and the third was in the upper drawer of the bedside cabinet. When the cabinet door and drawer were opened cockroaches ran out (approximately 5-10 insects) and all over the sides and top of the bedside cabinet. CNA D stated she would have maintenance come immediately and spray the area with insecticide. The dentures were not found in the room nor in the medication cart. On 09/29/2023 at the end of day debriefing, conducted with the Administrator and Regional Director of Operations, they were notified of findings for Resident #19. On 10/04/2023 at approximately 2:00 p.m., the Administrator, Corporate Nurse Consultant, and Regional Director of Operations were again notified of findings, and they stated they had nothing further to provide.

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F 0699 Level of Harm - Actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to ensure that residents who are trauma survivors receive trauma-informed care to mitigate triggers for 2 residents (Residents #22 and #53) in a survey sample of 48 residents. The findings included: 1. For Resident #53, the facility staff failed to provide trauma-informed care for a resident who has experienced sexual assault by CNA C at the facility. Resident #53 was admitted to the facility on [DATE] with diagnoses that include but are not limited to schizoaffective disorder, hemiplegia after CVA (Cerebrovascular Accident or stroke) right sided, HIV (Human Immunodeficiency Virus), Hepatitis C, and Hypertension. A review of the clinical record revealed the following: 8/10/2023 5:06 pm Transfer to Hospital Summary Note Text: Patient sent to [Hospital Name redacted] for evaluation r/t alleged assault, MD made aware. Patient verbalized understanding the reason for transfer. 8/10/2023 - 5:15 pm Health Status Note Text: Patient made a statement in regard to an assault that took place this morning, a statement was given from patient to myself dictated at 2:11 pm at the south unit nursing station. Phone call placed to nonemergent services so patient could give an official statement and press charges. 8/12/2023 4:51 - Alert Note Text: Due to safety concerns r/t behavioral issues; constant yelling and threatening staff to throw himself out of the bed when in room/bed. Administration made aware to possibly consider moving room closer to nurses' station. 8/15/2023 2:41 pm COMMUNICATION - with Resident Note Text: [name redacted] and [name redacted] spoke with [Resident #53] about his feelings today 8/15/23. Therapy reported that [Resident #53] wants to harm self, to which [Resident #53] admitted . [Resident #53] says that he can come up with a plan to harm himself [name redacted] made Dr. [name redacted] (psych) aware. 8/17/2023- 5:50 AM - Health Status Note-Note Text: Per reports, resident was suicidal during the day shift. Hourly checks done on resident throughout the shift, resident stated he had no plan or intention to commit suicide. During multiple encounter, resident was noted to be impatient, combative towards staff such as throwing water at care staff or yelling for not providing him with his needs as soon as he asked for them. Nurse provided education that he needs to give staff time to respond, also he needs to communicate with his words rather than violently/physically attempting to hit staff. Incontinent care provided every 2 hours and as needed, fall precautions followed and maintained, he is stable and resting in bed at this time. (continued on next page)

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F 0699 Level of Harm - Actual harm Residents Affected - Few	On 09/27/2023 and interview was conducted with the DON who was asked if they have psych services in the building and she stated that they did. When asked if she thought it would be beneficial for Resident #53 to have seen psych services after such an incident, she stated that she thought he did and would supply the notes from psych services. A review of the clinical record revealed that Resident #53 had an order dated 08/01/2023 that read, Psych Consult as needed however, was not seen by psych services until 08/23/2023. The visit on 08/23/2023 was not prompted by the sexual assault. A review of the psych notes revealed the following: Resident was referred today for stabilization in depressed mood. Per nurses' notes and report, resident is reported to be verbally abusive to staff, and refusing care sometimes, Resident was met in his room, in bed, calm, alert, speech clear and engaged. Resident reported in on multiple psychotropic medications to include Lithium, Haldol, Risperidone, Diazepam, Ativan, Methadone, Seroquel, Hydroxyzine and Trazadone. Reported he has not been sleeping well a night. I stay awake the whole night; I cannot sleep. Resident also reported he feels sad and depressed. On 08/23/2023 after the psych visit, the order was given for Trazadone 50mg for insomnia. On 09/28/2023 at 11:00 a.m., an interview was conducted with the Staff Development Coordinator who was asked about training for PTSD, she stated they do not tell me to train on that subject. When asked if she trained on trauma-informed care, she stated that she did not. When asked if she trained on behavioral healthcare needs related to substance abuse, she stated that she did not. When asked does your staff care for residents in this facility with any or all those issues and she stated that they do. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided. 2. For Resident #22, the facility staff failed to provide trauma-informed care for a resident diagnosed with Post Traumatic Stress Disorder (PTSD). Resident #22 was admitted to the facility on [DATE] with diagnoses that include but are not limited to incomplete paraplegia, PTSD, peripheral neuropathy, anxiety, history of substance abuse and smoking. On 09/25/2023 at approximately 1:00 p.m., an interview was conducted with Resident #22 who stated the facility Does not know how to deal with us, I have PTSD and they don't know how to talk to me. When asked to elaborate, he stated the facility staff are loud and rude and that triggers him to become aggressive. When asked if he has told anyone about this, he stated he has spoken to the DON and the Administrator about it, but nothing is done. Resident #22 also stated he had a substance abuse problem prior to coming to the facility and that the facility staff use that information against me. When asked what he meant by that, he stated the facility staff downplay his pain because he had a substance abuse issue prior to coming to the facility. He stated the staff have labeled him as drug seeking. (continued on next page)

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F 0699 Level of Harm - Actual harm Residents Affected - Few	On 09/28/2023 at 11:00 a.m., an interview was conducted with the Staff Development Coordinator who was asked about training for PTSD, she stated they do not tell me to train on that subject. When asked if she trained on trauma-informed care, she stated that she did not. When asked if she trained on behavioral healthcare needs related to substance abuse, she stated that she did not. When asked does your staff care for Residents in this facility with any or all those issues and she stated that they do. On 10/04/2023 during the end of the day debriefing, the Administrator was made aware of the concerns. No further information was provided.

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 34894 Based on resident interview, staff interview, and facility documentation review, the facility failed to ensure 5 of 5 nursing staff members (Staff #6, Staff #21, Staff #22, Certified Nursing Assistant [CNA]-H and CNA-K) in the sample were competent to provide care to the facility's resident population, resulting in psychological harm for Resident #22. Findings included: The facility staff failed to ensure nursing staff had the competencies including knowledge, skills, and abilities, necessary to meet the resident's needs when diagnosed with trauma/Post-traumatic Stress Disorder (PTSD) in accordance with the facility assessment, resulting in expression of psychological harm for Resident #22. During the initial tour of the facility on 09/25/2023 at 11:50 a.m., Resident #22 approached the surveyors (Surveyor C and Surveyor D) and stated he had PTSD, and the facility staff did not know how to take care of people diagnosed with PTSD. Resident #22 stated he was upset about it. He stated he really was diagnosed with PTSD. They (facility staff) act like they don't know how to handle it (PTSD). Resident #22 stated the staff treated him as if he was pretending. Resident #22 stated this is serious. The resident stated he did not feel understood by the staff. Resident #22 discussed his feelings more in depth with Surveyor D during the survey. On 09/26/2023 at 9:05 a.m., an interview was conducted with Licensed Practical Nurse B who stated there were residents in the facility who had diagnoses of PTSD and other behavioral health conditions. LPN-B stated she had not received specialized training on caring for residents with trauma/PTSD. On 09/27/2023 at 12:55 p.m., an interview was conducted with Certified Nursing Assistant-L who stated she had not received any special training on caring for residents with trauma/PTSD. Review of the Facility Assessment revealed a review date of 08/31/2023. The facility assessment, Part 2. Services and Care Offered Based on Resident Needs (on page 1 of 2) Section 2.1 General Care and Specific Care or Practices listed the general care area of Mental Health and Behavior and under Specific Care or Practices was written, Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with .trauma/PTSD, other psychiatric diagnoses . (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	On 09/27/2023 at 2:15 p.m., an interview was conducted with the Staff Development Coordinator who stated she provided in-service education and training to the facility staff members. The Staff Development Coordinator stated staff members also complete computer-based training on required subjects. She stated she was aware the facility accepted residents for admission who were diagnosed with behavioral health issues to include but not limited to mental, psychosocial, or substance use disorder, a history of trauma and/or post-traumatic stress disorder, or other behavioral health condition and dementia according to the facility assessment. The Staff Development Coordinator stated the facility assessment was utilized to ensure residents could receive the care and services necessary for their well-being. The Staff Development Coordinator stated she was not told to include trauma/PTSD in the training topics but would immediately begin to train on that topic. Review of the 5 sampled employee training records revealed no documentation of training on trauma/PTSD. All 5 staff members were hired in 2022 or 2023 (Staff #6 LPN hired in 2023, Staff #21 hired in 2022, Staff #22 hired in 2022, CNA-H hired in 2023 and CNA-K hired in 2022). During the end of day debriefing on 09/27/2023, the facility Administrator, Director of Nursing, and Corporate Nurse Consultant were informed of the findings of no behavioral health training on trauma/PTSD. They were informed that none of its staff members had received any training/education or met competencies regarding the provision of care to residents diagnosed with trauma/PTSD. The residents' needs were not being met in order for them to reach their highest potential. On 09/28/2023, the Staff Development Coordinator provided a copy of the training curriculum including topics covered during orientation and training sessions. Review of the curriculum revealed there was no documentation of the topic of trauma/PTSD (Post-traumatic Stress Disorder. During the end of day debriefing on 10/03/2023, the facility Administrator, Director of Nursing, Corporate Nurse Consultant, and [NAME] President of Operations were informed of the findings. They were informed by Surveyor D that one resident expressed feelings of psychosocial harm. No further information was provided.

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to ensure residents who display or are diagnosed with mental disorder, or history of Post-traumatic Stress Disorder (PTSD) receives appropriate treatment and services to attain the highest practical mental and psychosocial well-being for 1 resident (Resident #53) in a survey sample of 48 residents. The findings included: For Resident #53, the facility staff failed to ensure the resident received appropriate services post sexual assault by a staff member at the facility. Resident #53 was admitted to the facility on [DATE] with diagnoses that include but are not limited to schizoaffective disorder, hemiplegia after CVA (Cerebrovascular Accident or stroke) right sided, HIV (Human Immunodeficiency Virus), Hepatitis C, and Hypertension. A review of the clinical record revealed the following: 8/10/2023 5:06 pm Transfer to Hospital Summary Note Text: Patient sent to [hospital Name redacted] for evaluation r/t alleged assault, MD made aware. Patient verbalized understanding the reason for transfer. 8/10/2023 - 5:15 pm Health Status Note Text: Patient made a statement in regard to an assault that took place this morning, a statement was given from patient to myself dictated at 2:11 pm at the south unit nursing station. Phone call placed to nonemergent services so patient could give an official statement and press charges. 8/12/2023 4:51 -Alert Note Text: Due to safety concerns r/t behavioral issues; constant yelling and threatening staff to throw himself out of the bed when in room/bed. Administration made aware to possibly consider moving room closer to nurses' station. 8/15/2023 2:41 pm COMMUNICATION - with Resident Note Text: [name redacted] and [name redacted] spoke with [Resident #53] about his feelings today 8/15/23. Therapy reported that [Resident #53] wants to harm self, to which [Resident #53] admitted . [Resident #53] says that he can come up with a plan to harm himself [name redacted] made Dr. [name redacted] (psych) aware. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	8/17/2023- 5:50 AM -Health Status Note-Note Text: Per reports, resident was suicidal during the day shift. Hourly checks done on resident throughout the shift, resident stated he had no plan or intention to commit suicide. During multiple encounter, resident was noted to be impatient, combative towards staff such as throwing water at care staff or yelling for not providing him with his needs as soon as he asked for them. Nurse provided education that he needs to give staff time to respond, also he needs to communicate with his words rather than violently/physically attempting to hit staff. Incontinent care provided every 2 hours and as needed, fall precautions followed and maintained, he is stable and resting in bed at this time. On 09/27/2023, an interview was conducted with the DON who was asked if they have psych services in the building and she stated they did. When asked if she thought it would be beneficial for Resident #53 to have seen psych services after such an incident, she stated she thought he did and would supply the notes from psych services. A review of the clinical record revealed that Resident #53 had an order dated 08/01/2023 that read Psych Consult as needed; however, the resident was not seen by psych services until 08/23/2023. The visit on 08/23/2023 was not prompted by the sexual assault. A review of the psych notes revealed the following: Resident was referred today for stabilization in depressed mood. Per nurses' notes and report, resident is reported to be verbally abusive to staff, and refusing care sometimes, Resident was met in his room, in bed, calm, alert, speech clear and engaged. Resident reported in on multiple psychotropic medications to include Lithium, Haldol, Risperidone, Diazepam, Ativan, Methadone, Seroquel, Hydroxyzine and Trazadone. Reported he has not been sleeping well a night. I stay awake the whole night; I cannot sleep. Resident also reported he feels sad and depressed. On 08/23/2023 after the psych visit, the order was given for Trazadone 50mg for insomnia. On 09/28/2023 at approximately 3:00 p.m., Resident #53 was interviewed about the incident on 08/10/2023 involving the sexual assault by CNA C. Resident #53 stated that he was afraid to have male staff anymore. He stated he was unable to sleep at all after the incident and was prescribed Trazadone as a result. Resident #53 was in tears when explaining how the incident made him feel helpless and fearful because he has contractures that prevent him from defending himself. Resident #53 stated he was aware the CNA would no longer be in the building but still did not want any male CNA staff to work with him. When asked if he was provided with emotional support or psych services immediately following the incident, he stated that he did not. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40026 Based on interview, clinical record review, and facility documentation, the facility staff failed to ensure medications were available for 1 resident (Resident #103) in a survey sample of 48 residents. The findings included: For Resident #103, the facility staff failed to ensure the resident had an adequate supply of Morphine 15mg for her pain control due to a wound. On 09/25/2023 at approximately 4:30 p.m., an interview was conducted with Resident #103 who stated the facility keeps running out of her pain medicine (Morphine 15 mg). When asked if she knew why this was happening, she stated she did not know but It happened again this morning. She stated the nurse got her an order for Tramadol, but she still has to wait to get that. A review of the clinical record read: 9/25/2023-4:13 pm Health Status - Note Text: Spoke with Resident this AM due to complaints that medication MS every four pm was not available. Spoke with nurse and pharmacy and medication requiring prior authorization. Physician will be in tomorrow to sign PA, in the meantime new order for Tramadol 50 mg every six hours ordered. A review of the Medication Administration Record (MAR) revealed that Resident #103 did have a valid order for Morphine 15mg every 4 hours for pain. This medication was unavailable. Resident #103 did not receive morphine from 2:51 p.m. on 09/21/2023 until 09/26/2023 at 7:30 a.m. 9/26/2023 05:35 - Orders - Administration Note-Note Text: Tramadol 50mg every six hours routine every 6 hours related to SUBACUTE OSTEOMYELITIS, LEFT ANKLE AND FOOT Medication in route per pharmacy, unable to pull from omnicel at this time, MD aware that medication required script. On the afternoon of 09/26/2023, an interview was conducted with the DON who stated the process for reordering medications is that the staff notify the pharmacy for refills and if it requires a hard script, they contact the physician to get it. The DON was asked if they use a back-up pharmacy, she indicated they did have one but if they do not have a physician hard script they cannot get it from the back-up pharmacy either. When asked who is responsible for ensuring a new script is obtained, she stated the nurses are. On the morning of 09/27/2023, an interview was conducted with LPN B who stated that Resident #103's morphine is not scheduled, it is PRN, so the resident would have to ask for the medication to receive it. When asked if it was available in the cart on 09/25/2023, she stated it was not. When asked if it was in the Omnicell (stat box), she stated it was not. When asked if the Tramadol was available for use, she stated it was in the Omnicell, but needed a script at the time it was ordered because they only had a verbal order. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henrico Health & Rehabilitation Center	561 North Airport Drive Highland Springs, VA 23075

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Medication Administration Record (MAR) for Sept. 2023 revealed that although nurses notes document the Tramadol was unavailable, yet it is signed off as given on 09/25/2023 at 6:00 p.m., and on 09/26/2023 at 6:00 a.m. It was left blank, but at 12:00 noon it was signed off as being given. Resident #103 reports not receiving any ordered Tramadol pain medication until 09/26/2023 at 6:00 p.m. A review of the Resident Council minutes revealed that during the months of March through August, residents complained about medications not being on time and the facility running out of residents' medications. On the morning of 09/27/2023, an interview was conducted with LPN B who stated Resident #103's morphine is not scheduled, it is PRN. The resident would have to ask for the medication to receive it. When asked if it was available on the cart on 09/25/2023, she stated it was not. When asked if it was in the Omnicell (stat box), she stated it was not. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41449 Based on observation, resident interviews, staff interview, and facility documentation review, the facility staff failed to prepare the meal in accordance with the menu, which affected the residents residing on 2 of 2 nursing units. The findings included: On 09/25/2023 and 09/26/2023 during the initial tour, a significant number of residents, residing on both nursing units, expressed concern regarding the food to all surveyors. On 09/27/2023 during the morning, Surveyor F made observations of several residents' breakfast trays. The findings were as follows: For Resident #17, the meal ticket indicated she was to get scrambled eggs, slivered green onions, biscuit, grits, and sausage gravy. There was a notation at the bottom that the resident requested Hb Egg [hardboiled egg]. The meal tray consisted of 2 hardboiled eggs, 2 pieces of toast, and a bowl of oatmeal. During the above observation of Resident #17's meal tray, the resident said, I don't eat grits, but we never get what is on the ticket. Additional observations were made, which included but were not limited to Resident #65 and Resident #49. Both residents' meal ticket indicated they were to have scrambled eggs, slivered green onions, biscuit, grits, and sausage gravy. Neither of them had any slivered onions, biscuits, grits, or sausage gravy. Both had scrambled eggs, toast, and oatmeal. Resident #49 said, While you are here and make recommendations, next week it will go back to the same thing, there is no consistency. We never get salt, the toast is burnt on the ends, and we never have sausage gravy. On 09/27/2023, Surveyor F reviewed the menu, which indicated it was Day 18 and the menu was supposed to be, Scrambled eggs, slivered green onions, biscuit, grits, and sausage gravy. On 09/27/2023 at 9:20 a.m., Surveyor F conducted an interview with the cook, Employee J. When asked what he had prepared for the meal, Employee J said, eggs, oatmeal, toast, hard boiled eggs, and sausage. When asked what is the purpose of the meal ticket, the cook stated, It tell you what they are eating and their diet. The cook was asked to let the surveyor see the menu for the day. The cook pulled out a binder with the menu which listed the biscuits and sausage gravy and oatmeal. When questioned why these items were not prepared, the cook said, The biscuits didn't come on the truck, we don't do sausage gravy, when you see that on the menu, we do sausage and grits. We changed because they complained they didn't like it anymore. The dietary manager joined Surveyor F and Employee J during the above interview. The dietary manager was asked to allow Surveyor F to see the menu substitution log. The dietary manager was unable to locate the log and indicated she would have to call the evening cook. At the end of the day, the dietary manager confirmed she had never been able to locate the menu substitution log. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/27/2023 at 10:08 a.m., the dietary manager (DM), Employee K, and the registered dietician (RD), Employee N, were in the conference room with the survey team. The DM and RD were asked about the process with regarding the residents' meals. The DM said they, at the least, discuss it during Resident Council meetings. The survey team shared the abundance of concerns that residents had shared regarding the food. Surveyor F made the RD aware of the observations from breakfast and asked if she had approved such changes to the menu. The RD said she had just been made aware prior to them coming into the conference room and the menu had not formally been changed. It was also pointed out that their current menu had been in use since January 5, 2022, and that residents have complained about always getting the same thing. The RD and DM both stated they are working to update menus now. On 09/28/2023 during the breakfast meal observations, it was again noted that the residents were not receiving the meal items that were listed on their meal tickets. On 09/28/2023 during mid-morning, the Administrator was made aware of the above findings and observations regarding the menus not being followed and residents' concerns with the meals. On 09/29/2023 during the mid-day/lunch meal, observations were made of residents' meal trays. Again, it was noted that the items listed on the menu were not being served. Squash casserole was supposed to be served according to the menu, the meal tickets had that item crossed out and broccoli hand-written in, but the residents were served cabbage. On 09/29/2023, the dietary manager presented Surveyor F with a Dietary Menu Substitution Record that indicated for the lunch meal, cabbage was added and squash was omitted. The reason for the change was noted as, Residents choice. There was no indication in any other records reviewed that the residents had requested this change or were previously made aware of the change. Review of the Resident Council meeting minutes revealed the following: 1. During the August 16, 2023, meeting, Residents expressed, What is on meal tickets are not served . Wrong diets served. The department's response was, Dietary staff will alert pt [patient] when there are menu changes. 2. During the meeting held July 21, 2023, residents expressed, Quality of the food has not improved. 3. In May's meeting, the residents expressed, Alternate meals and sandwiches are not offered. In the resolution section it was noted, Reminder, [contracted dietary company name redacted] is only responsible for posted menu items only per Dietary Manager. There was no evidence that the Resident Council had expressed any concerns regarding the sausage gravy, grits, or biscuits. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, Menus was conducted. This policy read, It is the center policy that menus are planned in advance, and to meet the nutritional needs of the residents/patients, will be developed utilizing an established national guideline. 6. Menus are served as written, unless changed in response to preference, unavailability of an items, or a special meal. 7. A menu substitution log will be maintained on file. On 09/28/2023, at the end of the survey day, the facility Administrator was made aware of the above findings. No further information was provided.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41449 Based on observation, resident interview, staff interview, and facility documentation review, the facility staff failed to serve food that was palatable and hot to residents on 2 of 2 nursing units. Findings include: For residents residing on both nursing units, the facility staff failed to serve food in a manner to ensure the food was at a preferred temperature when it reached the residents. On 09/25/2023 - 09/26/2023 during the initial tour process, an abundance of residents on both nursing units expressed concerns about the food not being hot. On 09/28/2023, observation of breakfast tray distribution was conducted. For residents residing on the North wing, breakfast trays were not served until 10:00 a.m. It was noted that each cart of meal trays held approximately 25-30 meal trays. One entire cart, which served residents in rooms 1-12, were all served in Styrofoam containers, like a restaurant carryout container. Another cart, which served residents in rooms 13-24, approximately half of the trays were on regular dinnerware plates and the other half were in the same Styrofoam containers. On 09/28/2023 at approximately 10:05 a.m., while breakfast trays were being distributed to residents, interviews were conducted with CNA B and CNA G. When asked about the Styrofoam, their responses were, They must have run out of plates and Sometimes they are all served on Styrofoam. Resident interviews were conducted, and numerous residents complained that the food was not hot. Resident #65 commented that she did not mind the Styrofoam so much as it did not keep the food warm. On 09/28/2023 at approximately 10:25 a.m., Surveyor F went to the kitchen to interview the cook. The cook was asked about the timing of meal trays, and he indicated the last cart had just left the kitchen about 10-15 minutes ago. When asked if this was normal or if something impacted the meals being late this morning, the cook said, No, everything went smooth, we had no problems. The cook was asked about residents being served on Styrofoam, and he said that they did not have enough clean plates. During the above interview, the dietary manager joined the conversation. The dietary manager stated, When late trays don't come back to the kitchen timely at night, we can't wash them, and they aren't available in the morning. The dietary manager also stated the food is hot when it leaves the kitchen, but it sits on the floors/halls and when staff do not pass/distribute them timely, the food gets cold. Additionally, she stated that one of the carts has a broken door and will not latch for the South wing, so it allows the heat to escape and that maintenance is going to work on the cart. On 09/29/2023, meal trays for lunch were observed on the South wing and multiple residents again complained that the food was not hot. Review of the Resident Council minutes was conducted. This review revealed a Service Concern Report was submitted in April following the Resident Council meeting for food being cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's dietary policies provided to the survey team were reviewed. The policies did not address the palatability and food temperature at the time of meal delivery. On 09/29/2023, the facility Administrator was made aware of the above findings. No additional information was provided.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 31199 Based on observation, staff interview, resident interview, clinical record review, and facility documentation review, the facility staff failed to measure the success and track performance in their Quality Assurance and Process Improvement (QAPI) program for their abuse protocols resulting in Immediate Jeopardy involving abuse policy implementation for 2 residents (Residents #12 and #13) on 01/20/2023, and again on 09/27/2023 for 3 residents (Residents #53, #85, and #103) 8 months later. Immediate Jeopardy was found during a standard survey of the facility commencing on 09/25/2023 and conducted through 10/04/2023 when an abatement of the Immediate Jeopardy finding was achieved for the three new residents (Resident #53, #85, and #103), and the facility at large. The findings included; On 01/20/2023, Immediate Jeopardy (IJ) was identified at 3:55 p.m., at which time the facility Administrator and Director of Nursing were made aware. Following verification of the removal of immediacy, the facility abated IJ on 01/26/2023 at 4:07 p.m. The scope and severity was lowered to a level 2, pattern. At that time, the facility failed to implement their abuse policy for 2 residents (Resident #13 and #12) in a survey sample of 9 residents by permitting a known perpetrator of abuse (CNA B) to work in the facility having direct contact with residents on 1 of 2 nursing units. As part of the facility plan of correction, the QAPI committee was tasked with monitoring, measuring, tracking data, and sustaining compliance performance in their abuse prevention programming. On 09/27/2023, IJ was again invoked by the state survey agency for failure to implement their abuse program. The facility staff failed to implement measures to protect residents from abuse as evidenced by their failure to screen employees, failure to take measures to protect residents from alleged perpetrators, failed to report allegations of abuse, failed to conduct investigations of allegations of abuse, and failed to provide education to staff on abuse and mandated reporting. On 08/10/2023, Resident #53 reported an allegation of sexual abuse by a CNA C, stating that the CNA C, Covered his face with a washcloth, flicked his penis back and forth, and said he was going to shave his pubic hair, causing the resident to yell out for help, which caused CNA C to abruptly stop. Resident #53 reported the allegations to the Speech Therapist (ST) at 7:50 a.m. The therapist then reported the allegations immediately to nursing administration. CNA C was permitted to continue to provide care to Resident #53 as evidenced by being seen at 9:30 a.m. aggressively feeding Resident #53 the wrong diet including excessive amounts of food being fed quickly. The Speech Therapist had to intervene as she felt it was not safe. The facility staff failed to conduct an investigation into the allegations and protect the resident by removing the alleged perpetrator immediately. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/10/2023 at approximately mid-day, Resident #103 reported an allegation of abuse on behalf of her roommate, Resident #85. Resident #103 stated the same CNA, (CNA C), had shaved Resident #85's pubic area. On 08/10/2023 at 11:57 a.m., a CNA was heard questioning Resident #85 about why she had been shaved down there. The facility staff failed to report and failed to conduct an investigation into the allegation of abuse involving Resident #85. The facility staff failed to remove the alleged perpetrator, CNA C, until 5 hours after learning of the allegation(s). Facility staff were unable to verbalize what a mandated reporter is. On 09/27/2023 during a review of employee record reviews, it was noted that the facility currently has 2 sampled employees that are actively working, and the facility is unaware of their criminal background status because a criminal background check was not obtained. The facility staff had failed to take measures to implement their abuse policy to identify, protect, report, and investigate allegations of abuse. The facility staff had also failed to screen employees prior to their employment. The facility staff were required to take immediate action to protect residents from failure by the facility to protect, report, investigate, and screen employees, thus adhering to a federally mandated abuse protocol. Failure to do this would place all residents at risk for further abuse, which could result in physical, sexual, mental, and/or psychosocial harm. The facility was made aware of all findings and proceeded during the course of survey to abate the immediacy, and IJ on 10/04/2023. No further information was provided after abatement; however, the facility was tasked at the end of the inspection with producing a plan of correction in the survey report issued by the state survey agency. The plan of correction will require QAPI involvement, and correction, to the QAPI failed practice in regard to their abuse program.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to maintain an effective pest control program so that the facility is free of pests involving 2 of 2 units in the facility. The findings included: For 2 of 2 units in the facility, roaches and/or bedbugs have been reported. On 09/29/2023 at approximately 1:15 p.m., Surveyor E entered Resident #19's room with CNA D, in the search for Resident #19's dentures which were missing. When the cabinet door and drawer were opened, cockroaches ran out (approximately 5-10 insects) all over the sides and top of the bedside cabinet. A review of the pest control log revealed that on 08/04/2023 rooms #32, #37 and #54 were treated for bed bugs; however, no follow-up treatment was done to ensure any eggs that have hatched were treated for, which is standard practice for bedbug treatment. On 09/28/2023, the resident in room [ROOM NUMBER] was complaining of itching and stated he had bed bugs. The facility did treat that room on 09/29/2023. On 10/04/2023 during the end of day meeting, the Administrator was made aware of the findings. No further information was provided.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 40026 Based on interview, clinical record review, and facility documentation, the facility staff failed to provide behavioral health training for all staff caring for the residents identified as having behavioral healthcare needs for 5 of 5 nursing staff members (Staff #6, Staff #21, Staff #22, Certified Nursing Assistant [CNA]-H and CNA-K) in the sample. The findings included: 1. For all residents identified as having behavioral healthcare needs, the facility failed to provide training to staff to care for such residents. A review of the facility assessment and CMS form 672 - Census and Condition Form revealed that there are 46 residents identified with behavioral healthcare needs. A review of the document entitled Facility Assessment, the facility is equipped to care for residents with behavioral healthcare needs, PTSD (Post-traumatic Stress Disorder), and substance abuse issues. On 09/25/2023 at approximately 1:00 p.m., an interview was conducted with Resident #22 who stated the facility, Does not know how to deal with us. I have PTSD and they don't know how to talk to me. When asked to elaborate, he stated the facility staff are loud and rude and that triggers him to become aggressive. When asked if he has told anyone about this, he stated he has spoken to the DON and the Administrator about it, but nothing is done. He also stated he had a substance abuse problem prior to coming to the facility and that the facility staff use that information against me. When asked what he meant by that, he stated the facility staff downplay his pain because he had a substance abuse issue prior to coming to the facility. He stated the staff have labeled him as drug seeking. On 09/26/2023 at approximately 3:00 p.m., an interview was conducted with Resident #103 who stated she had a substance abuse problem that she was addressing with the methadone clinic. She stated she also had a diagnosis of PTSD due to past trauma. She indicated the staff at the facility did not understand how to care for her. She stated, They don't know how to talk to me. They don't understand what triggers me and how to handle folks like me. She stated they say she is a drug seeker. She stated she had a PRN morphine order that she sometimes only took 1 time a day. She said, If I was drug seeking, I would be asking for it every 4 hours. On 09/28/2023 at 11:00 a.m., an interview was conducted with the Staff Development Coordinator who was asked about training for PTSD. She stated, They don't tell me to train on that subject. When asked if she trained on trauma-informed care, she stated she did not. When asked if she trained on behavioral healthcare needs related to substance abuse, she stated she did not. When asked does your staff care for residents in this facility with any or all those issues, and she stated they do. On 09/28/2023 at approximately 3:00 p.m., an interview was conducted with the Administrator who was asked if the facility accepts residents with PTSD, substance abuse, or other behavioral healthcare issues, and she stated they did. When asked if she expected the staff to be equipped with the training to care for those residents, she stated she did. When asked if she was aware that the Staff Development Coordinator was not conducting training on those areas, she stated that she was not. (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/04/2023 during the end of day debriefing, the Administrator was made aware of the concerns. No further information was provided. 34894 2. The facility failed to provide behavioral health education/training and competencies to include trauma and Post-traumatic Stress Disorder (PTSD) for its staff members. On 09/25/2023 at 11:50 a.m. during the initial tour of the facility, Resident #22 approached the surveyors and stated he had PTSD and the facility staff, Did not know how to take care of people diagnosed with PTSD. Resident #22 stated he was upset about it. He stated he really was diagnosed with PTSD. They (facility staff) act like they don't know how to handle it (PTSD). Resident #22 also stated the staff treated him as if he was pretending. Resident #22 stated this is serious. The resident stated he did not feel understood by the staff. On 09/26/2023 at 9:05 a.m., an interview was conducted with Licensed Practical Nurse B (LPN B) who stated there were residents in the facility who had diagnoses of PTSD and other behavioral health conditions. LPN-B stated she had not received specialized training on caring for residents with trauma/PTSD. On 09/27/2023 at 12:55 p.m., an interview was conducted with Certified Nursing Assistant who stated she had not received any special training on caring for residents with trauma/PTSD. Review of the Facility Assessment revealed a review date of 08/31/2023. The Facility Assessment, Part 2. Services and Care Offered Based on Resident Needs (on page 1 of 2) Section 2.1 General care and Specific Care or Practices listed the general care area of Mental health and behavior and under Specific Care or Practices was written, Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with trauma/PTSD, other psychiatric diagnoses. On 09/27/2023 at 2:15 p.m., an interview was conducted with the Staff Development Coordinator who stated she provided in-service education and training to the facility staff members. The Staff Development Coordinator stated staff members also complete computer-based training on required subjects. She stated she was aware the facility accepted residents for admission who were diagnosed with behavioral health issues to include but not limited to mental, psychosocial, or substance use disorder, a history of trauma and/or post-traumatic stress disorder, or other behavioral health condition and dementia according to the facility assessment. The Staff Development Coordinator stated the facility assessment was utilized to ensure residents could receive the care and services necessary for their well-being. The Staff Development Coordinator stated she was not told to include trauma/PTSD in the training topics, but would immediately begin to train on that topic. Review of the 5 sampled employee training records revealed no documentation of training on trauma/PTSD. On 09/27/2023 during the end of day debriefing, the facility Administrator, Director of Nursing, and Corporate Nurse Consultant were informed of the findings of no behavioral health training on trauma/PTSD. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495193	A. Building B. Wing	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henrico Health & Rehabilitation Center	561 North Airport Drive Highland Springs, VA 23075

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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/28/2023, the Staff Development Coordinator provided a copy of the training curriculum including topics covered during orientation and training sessions. Review of the curriculum revealed there was no documentation of the topic of trauma/PTSD. During the end of day debriefing on 10/3/2023, the facility Administrator, Director of Nursing, Corporate Nurse Consultant, and [NAME] President of Operations were informed of the findings. No further information was provided.