STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495141	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alleghany Health and Rehab	1725 Main Street Clifton Forge, VA 24422

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, resident interview, facility staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure residents were free from abuse and neglect having the potential to affect numerous residents on 2 of 3 nursing units. The abuse and neglect resulted in psychosocial harm for two residents (Resident #8- R8 and Resident #17-R17), which resulted in the identification of Immediate Jeopardy and Substandard Quality of Care. The findings included: 1. The facility staff failed to protect residents and implement safeguards for all residents residing on the A and B wings who shared the common areas, from being subjected to a hostile environment where verbal threats of physical harm and death, and sexual comments by Resident #16-R16 were ongoing. R16's behaviors resulted in psychosocial harm for R8 and R18. On 1/22/24 at approximately 9:30 a.m., during an interview with resident #8 (R8), the resident verbalized to the surveyor and facility Administrator that Resident #16 (R16) had told R8 to Suck my di*k. R8 went on to state that she had been molested three times in the past and just can't handle this. The current administrator was observed taking notes during this interview. On 1/22/25 -1/23/25, a clinical record review was conducted of R8 clinical record. R8's diagnosis included, but were not limited to major depressive disorder, insomnia, generalized anxiety disorder, borderline personality disorder, bipolar disorder, and schizoaffective disorder. According to R8's most recent minimum data set (MDS) (an assessment tool) with an assessment reference date of 12/28/24, R8 scored a 13 out of 15 on the brief interview for mental status, which indicated she was cognitively intact. According to a Trauma Informed Care Screen dated 4/21/24 and another dated 5/22/24, R8 reported having been a victim of physical abuse, verbal abuse, emotional neglect, having a family member who was an alcoholic/addict, and a victim of sexual violence. The most recent trauma screen noted that R8 answered yes to the following questions: Have you had a nightmare about event(s) or thought about the event (s) when you did not want to? Have you tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? Have you been constantly on guard, watchful, or easily startled? Have you ever felt numb or detached from people, activities, or your surroundings? According to the screening form R8 was asked, What if any mental health treatment have you had in the past? R8's response was recorded as, I see a doctor. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER: Alleghany Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 1725 Main Street, Clifton Forge, VA 24422	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	According to the nursing progress notes, the following entries were noted: A note dated 6/25/23, read in part, Resident came to nursing station requesting pain medication at 1520. Resident [R16's medical record number redacted] was also sitting near the nursing station. Resident [R8] said she would be in her room and walked back to her room with the assistance of her rolling walker. When this nurse entered resident's room, she began crying out in pain and was holding her right foot. This nurse asked what was going on with her foot and the resident stated resident [R16's medical record number redacted] ran over her foot with his wheelchair. She also stated that resident [R16's medical record number redacted] threatened her life and she did not feel safe RN [registered nurse] supervisor was called and made aware of what resident was reporting. RN Supervisor came into the facility to access this situation. Will continue to observe resident On 1/21/25, a note was entered that read, During this time SSD (social services director) spoke with [R8's name redacted] after hearing her yell at another Resident [R16's medical record number redacted] to shut up across the hallway from her room. SSD let [R8's name redacted] know that she needed to be respectful of other Residents. The issue resolved following discussion. According to facility documentation, a facility investigation was initiated on 1/16/25, regarding R8 reporting that R16 had made inappropriate comments to her. There was a prior documentation dated 3/13/24, where R8 reported that R16 touched her leg and said, it made her uncomfortable . On 1/22/25 at 10:09 a.m., an interview was conducted with the facility's social worker (SW). During the interview with the SW, she was asked if she had any knowledge about R8 being a victim of sexual abuse. The SW said, I do recall her mentioning she had an ex-significant other that she had issues with. On 1/23/25, during a follow-up interview, R8 reported being afraid of R16 and gets another resident, identified as Resident #2, to accompany her because .she watches out for me. During this interview, R8 was observed breaking eye contact, tucking her head downwards while speaking, with hands slightly trembling. He said, 'Come on Baby, suck my d-ck!' He would say we need to go to bed in his room . I told him No! and he said, Ok, B-tch, I will just f-ck the hell out of you then! Sometimes I'm afraid to go to sleep. I've gotten so afraid at night, that he is gonna come in here. On 1/23/25, an interview was conducted with Resident #2 (R2), who reported that she has witnessed R16 threaten to hit R8, This can happen daily, [R8] cries and gets upset about it. I have to calm her down. [R8] is scared of him. At times, he says hateful things to her, sometimes he approaches her and intimidates her, and her hands start shaking. She said he makes her very nervous. I try to help and break it up. He says, Suck my d-ck b-tch, I will blow this place up. R2 went on to report that R8 would wake her to go with her to the dining/activity room. R2 reported she is not personally afraid of R16, and that he used to say that stuff to her, .but R8 gets so upset her hands shake. On 1/22/25-1/23/25, a clinical record review was conducted of R16's chart. This review revealed the following notes with regards to behaviors, in addition to almost daily refusals of treatment and medications: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/16/23, a behavioral charting note read, Describe Behavior/Mood: agitated, angry, hostile, combative. What was the resident doing prior to or at the time of behavior/mood: Resident was sitting in the dining room, staff offered resident another tea and resident started to make obscene sexual comments toward the staff member. Other residents began to get upset about the comments this resident was making towards the staff and other residents. Interventions attempted: Staff attempted to redirect sexual comments with other topics. Resident offered to have lunch delivered to his room. Staff attempted to ask resident what was wrong. Effectiveness of the Interventions: Resident continued to make sexual remarks. Resident attempted to throw hot coffee at staff. When asked what was wrong, resident continued to make obscene sexual comments to staff. Resident threatened to hurt staff and continued to ask for sexual favors. A progress note by the medical provider on 4/17/23, read in part, .Patient also noted to have more behaviors and is talking about bugs in his room that are not there. Patient has noted to have this in the past when he cycles. Patient has history of bipolar, anxiety, depression . On 4/25/23 a note titled, SSD [social services director] annual note read in part, . Relationships: Resident maintains a mostly positive relationship with all staff. Resident sometimes has trouble interacting appropriately with peers . Behavioral: Resident has behaviors of sometimes making sexual comments and can be verbally aggressive with staff and peers . On 5/6/23, the note read in part, Resident angry, cursing at staff in presence of other residents On 5/10/23, the note read, Resident had several episodes of behaviors this shift. Cussing and making threats but did not do any harm to others or himself On 5/14/23, a nursing entry read, Resident had behaviors in dining room during lunch. Resident used vulgar language and was making threats. Resident did not act on any of the threats . On 5/19/23, the note read, Resident had behaviors in dining room this shift and was taken to the front office to sit with BOM [business office manager] . On 6/8/23, a note read in part, Resident continues with behaviors. Resident cussing and yelling at other resident's and making threats. Resident re-directed several times throughout the shift . On 6/9/23, the entry read in part, Resident has had 2 outbursts of cussing and threatening others this shift. Resident was re-directed successfully both times On 6/10/23, the entry read, .Resident began displaying belligerent behavior, stating 'I/m going to burn this (expletive) down, people are dying in here'. Another entry the same day read, Patient became agitated in the dining room and began yelling that he was going to get gas and burn the building . He continued to curse and use sexual language as he left the dining room . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/10/23 at 8:20 p.m., an entry was noted that read, Resident being belligerent this shift towards staff and residents. Threatening to blow up the building, kill us all. On Call physician called . Family came to visit, and behaviors continued to get worse. Resident was taken to whirlpool room by family and CNA to get a bath, and he seen female resident [Resident #8's medical record number redacted] walk by and yelled I'm going to kill you b-tch while getting up from his wheelchair to grab her. This nurse, CNA, and resident's sister was able to stop him and get him back into his wheelchair. Resident continued with threatening behaviors and began to threaten his family . Squad was called, and resident was sent to ER [emergency room]. On 6/11/23, the nursing note read, Went to answer residents call light and noticed water in the hallway of adjoining room. When this RN opened the door clean water began flowing in the hall and the room floor was covered with water, including the adjoining bathroom. This RN went to open the door of this resident and water began seeping into the hall. The Resident's floor was also covered with water and his commode stuffed with toilet paper and overflowing. He stated he was going to flood the place . Another entry on 6/11/23 read in part, Resident continued with behaviors this shift but was able to be redirected after a few minutes. Family in to see resident again this shift. Resident was found this evening standing up without his O2 on taking apart the light above his bed. Fluorescent light bulb and light cover were laying across his bed. This nurse took the light and hardware from the patients' room and RN contacted maintenance supervisor to come and repair the light. Light was repaired . On 6/12/23, the note read, Resident stayed in room all night but became upset that his television would not work. Resident stated that he was gonna blow this place up. and cursed at staff. This morning it was found that resident had stuffed unknown items into toilet in his restroom On 6/17/23, the entry read, . Resident had an outburst this shift after another resident interfered with his conversation in the dining room. This nurse was able to re-direct resident, and he calmed down . On 6/22/23, the note read, Rsd [resident]. has had some behaviors of yelling/cursing rsd. redirected well thus far . On 6/23/23, the note read, Rsd. continues with behaviors. Rsd. woke up and came in the hall. Rsd. has had episodes of cursing staff and other rsd. Rsd. has thus far been redirected without issue . On 6/25/23, R16 was aggressive towards R8 as noted in the progress note entry that read, Resident kicked resident [R8's medical record number redacted] rolling walker in the dining room after [R8's medical record number redacted] did not move it out of his way. Resident was also threatening to kill everyone and blow up the building when asked to leave the dining room. Resident was brought back to A Wing. Resident eventually calmed down. RN supervisor was called in to help with the situation between the two residents. Will continue to observe resident. On 6/26/23, the entry read, Resident had belligerent behaviors this shift. Resident upset over not having money in his account and accusing the office of keeping his $13. Resident threatened to blow up the build and kill all of us. Eventually staff was able to redirect resident and calm him down. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/29/23, the late entry note read, This RN was assisting residents with breakfast in the dining room when [R16's name redacted] who had finished his breakfast, and two cups of coffee held his coffee cup up in the air and yelled out asking for a refill He put the cup down and began cursing. As I put the tray of food on the table he threw his cup toward me. The cup hit a table and fell to the floor. I ignored his behavior because any response to it yields more behaviors. Less than 5 minutes later he had confronted the resident next to him telling her he was going to kill her for looking at him. He began cursing, ranting about his sister, saying he was being held hostage. Several other staff members entered the dining room to talk with him and to try to calm him down and assist him back to his room or another area since he had finished his meal, eating 100 percent. He wanted to see the Administrator, [prior administrator's name redacted], and the Administrator took him to his office and made a behavioral contract with him. 1100 I was asked to check on resident and found him in the hallway on his wing The nursing assistant told him she would give him a whirlpool with the bubbles he liked and a few minutes later he was screaming, I will blow this MF place up. He continued screaming until Physical Therapy talked to him about coming to therapy. The PT assistant was taking him toward therapy when he met a female resident in the hallway outside the dining room and he began ranting again. His states were as follows: I will get gas and set this MF place on fire and burn all of you GD old people up. I will get a gun and shoot everyone in this building. I have scissors in my pocket, and I'll cut your mf eyes out I hate my GD MF sister, and I will kill her too. He then pulled his Oxygen out of his nose and began walking toward one of the nursing assistants telling her he had a pitcher of tea, and he would throw it all over her. I took the tea from his hand and assisted him back to the wheelchair and replaced the oxygen. The Administrator once again tried to talk with him remind him of the contract. He again became angry, aggressive, screamed threats and scared the residents who were gathering for lunch. He got up from his wheelchair the second time after jerking his oxygen off and began walking toward another staff member while screaming he would kill her. Resident continued for a period of more than an hour with aggressive behavior, racial slurs, cursing, threatening other residents and screaming as loud as he could scream. Staff reports the screaming and threats to blow everyone up, etc. has become an everyday event along with accusations of people stealing from him. Patient assisted to the courtyard while waiting ECO and stated he comes out to the courtyard to feed differed colored animals that come out from under a large flowerpot every day. Also says that there are bugs imbedded in his skin that he has to pick out. I told him he would be going to the hospital to see if he could have medications adjusted or to see if he could be helped. This behavior, per staff, began in April and has continued to escalate Progress notes entries in R16's chart continued to document ongoing behaviors being displayed on the following dates: 7/22/23, 7/23/23, 7/27/23, 7/28/23, and 9/5/23. On 9/29/23, the entry read in part, Resident was sitting at nurses' station when resident [resident number redacted] said something that upset this resident. This resident then began to yell out that no one was going to talk to him that way . and he will hurt someone for talking to him that way When social worker came to speak with resident, he became more upset and was very belligerent towards social worker. Other LPN [licensed practical nurse] came to speak with resident to try and calm resident down. Once social worker walked away other LPN was able to deescalate resident. Administrator also came and spoke with resident and took him to get coffee. Another entry on 9/29/23 spoke of an incident during lunch in the dining room that noted, .Resident started yelling and cursing at everything/everyone around him because he could not get to the seat, he wanted in the dining room . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Additional behavior instances were documented on 9/30/23, 10/2/23, and 10/11/23. On 10/22/23, a nursing entry in R16's chart read, Resident had a behavior outburst during morning devotions. Resident threw coffee on resident [R8's medical record number redacted]. Staff was able deescalate the situation. The on-call nurse was notified, and the administrator was notified or the incident. On 10/23/23, 11/3/23, 11/6/23, and 11/8/23, R16 had documented behaviors. Then on 12/2/23, R16 was noted to be .cursing at other residents in dining room, hit another resident with shoe [other resident not identified]. On 12/6/23, the note indicates Resident [R16] does exhibit behaviors and aggression daily. A note dated 1/5/24, read in part, Resident occasionally becomes agitated by other residents' interactions with him. At other times the resident will refuse his medications and/or supplemental oxygen, stating I don't need that stuff, it doesn't help anyway. Resident will sometimes throw objects during these outbursts. Resident ambulates pushing w/c or uses w/c to move about the unit and the facility, resident enjoys eating meals in the dining room . On 2/3/24, a note by the medical provider noted, .Nursing staff requested that this patient be seen again today due to continued episodes of intermittent irritability as well as having occasional outbursts . According to a nursing progress note entry dated 3/22/24, scissors were removed from R16's possession following him being observed scraping dry skin off BLE [bilateral lower extremities] with a pair of scissors. On 3/24/24, R16 was noted to have been . agitated with resident in room adjacent to his, he stated, 'I'm a tough man, I'll mess him up .'. Then on 6/8/24, the note read, .Very angry. Yelling and cursing in the hallway while families at facility with their loved ones. What was the resident doing prior to or at the time of behavior/mood: Rsd just finished lunch; coming out of the dining room Interventions attempted: CNA tried to change out O2 tank This nurse tried to change out O2 tank Effectiveness of the interventions: Rsd refused for this nurse along with staff to touch him. Rsd stated I don't want that sh*t. It does nothing for me. As this nurse tried to give rsd oxygen tank; rsd stopped this nurse stating F@@k that G@d D@$N tank. It does nothing to help. I am going to blow this F@&king place up. Yall can suck my d&@k and go to hell. F&@k all of yall. I still have bugs all over my room and nobody gives a F&@k. Rsd then went into his room and shut his door . An entry dated 7/6/24, read in part, . resident exhibits occasional verbal outbursts when angry or frustrated . On 10/2/24, a note entry read, Agitated, verbally aggressive. Verbally expressing anger at staff members and various other residents. On 11/9/24, a nurse note documented in part, Resident was sitting at nurse's station making foul comments such as I'll blow this whole place up .You can suck my d-ck g-d d-mn for not giving me what I want . you can't give me what I want, then it's time to kill ya a** (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/25/24, the nursing entry recorded .Resident then proceeded to make the comment 'I will go find me a woman to have sex with, I haven't had sex in a long time,' and asked this nurse if I would make love to him. educated resident that, that is a very inappropriate thing to say. Resident stated, I don't give a damn, I'll blown this damn place up. On 12/7/24, during R16's most recent hospitalization , behaviors were displayed that warranted a psychiatric consult. The note dated 12/7/24, read in part, . was cooperative with care until this morning prior to discharge, he became upset and threatened to blow up the building with people in it. Psychiatry was consulted for concern of this behavior . He states that he has to tell people he is going to kill them so he can go to sleep, but he would never harm anybody . He does state that he was 'cursing and stuff' he apologizes for this . there was concern that reduction in psychotropic medications may have contributed to his decompensation. Nursing staff was able to call and speak with patient's regular nurse at [this nursing facility's name redacted]. She reports that this behavior is typical for him. He will have an outburst like this wanted to time a week [sic] [one to two times a week] . This has quite consistent with behavior witnessed this morning . Patient has a long psychiatric history. He was admitted here in July of 2023 for threatening behaviors and outbursts . On 12/9/24, a progress note documented that Resident threw his oxygen tank and knocked over his dresser in his room. 'I'm going to kill everyone and blow this building up.' Resident stated that his neighbor beside him was coming into his room and moving his belongings. Resident takes his wheelchair and [NAME] his neighbor's door. Resident is saying explicit words and other residents are complaining. On 12/15/24, the medical provider noted, .Please order a psych consult . On 12/26/24, a nursing note documented that resident was saying, I'm gonna blow this damn place up. I am a bad motherf-cker, yall can suck my d-ck ya'll got five minutes to get me my pain pills or I am gonna start killing people. On 12/27/24, a provider note indicated, .The patient has been experiencing increased behavioral outbursts, as noted by the staff. He was previously receiving Seroquel 250 mg PO BID prior to a hospital admission on 12/4/2024. Upon return from the hospital, his Seroquel dosage was adjusted to 50 mg TID. Staff reported a significant behavioral incident on 12/26/2024, during which the patient accused nurses of withholding his medications and giving his pain pills to other residents. He refused PRN pain medication and made threats of violence, stating he would blow the damn place up and start killing people if not given his pain pills On 1/15/25, a nursing progress note, which read in part, .resident cursing at another resident [identified as R8] in dining room. he returned to his room. currently q15 minute checks. his mood at this time is pleasant and cooperative. As of the survey being conducted 1/21/25, R16 had not seen a psychiatrist since hospitalization in early December 2024. Prior to that, the last psych visit onsite had been documented on 10/14/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	According to R16's care plan, listed behaviors that included I can be physically abusive to others. I have a HX [history] of assaultive behavior towards staff and throwing items (cups, etc.) at other residents, I can be verbally abusive to others. When I feel provoked, I can began [sic] to swear/cuss, I am to have my coffee placed in a thermal blue mug with a tight fitting lid. I have a history of tossing my coffee at others when I become agitated. This care plan was initiated on 10/23/23 and last revised on 5/15/24. According to the hospital discharge summary and psychiatry consultation dated 12/7/24, both documents noted that R16's Seroquel dose was to return to the prior dosage of 250 mg twice daily. According to R16's physician orders and medication administration records, upon readmission to the nursing facility R16 was receiving 50 mg three times daily 12/8/24-12/27/24. On 12/27/24, the dose was increased to 100 mg three times daily. On 1/23/25 at approximately 11:30 a.m., during an interview with certified nursing assistant #15 (CNA #15) and CNA #16, it was reported that R16 took the oxygen tank out to throw at us, we ran up the hall. CNA #15 reported they got the administrator to intervene, and that they had been scared that day R16, but neither CNA #15 & CNA #16 could recall specifically what date the incident had occurred. On 1/24/25 at 2:30 p.m., an interview was conducted with the nurse practitioner (NP). The NP was asked about R16's behaviors and Seroquel dosing. The NP stated that she was not aware of the order/recommendation from the hospital for R16's Seroquel to return to the dose of 250 mg twice daily and stated had she seen the addendum with that recommendation she would have followed it because, I do follow what is on the hospital discharge summary. The NP also stated she was aware of R16 having some behaviors, but it had been reported to her that it was related to his pain management and had just increased his Gabapentin (pain medication). The NP said, We have not had an on-site psych provider since I started in December. We have only had 1 telehealth psych visit; from what I am told we now have a psych provider starting. The NP went on to state that she was not aware of R16 making abusive sexual comments to other residents or the instances of R16 attempting to throw his oxygen cylinder. According to interviews conducted by the survey team, the facility social worker, five CNA's, three nurses, the activities director, and the maintenance director had all been aware of and verbalized that R16 has long standing behaviors of saying he is going to blow this place up and shouting, Suck my d*ck. All 11 of the staff interviewed expressed being aware of R16 making targeted sexual comments to R8 repeatedly. When asked about interventions implemented to address these inappropriate behaviors, staff stated that 15 min checks were done, but mostly offering snacks works, and that sometimes R16's escalating behaviors required the removal of the other residents from the dining room, which is where he likes to sit the most. According to the facility social worker, who also serves as the grievance coordinator, another resident, identified as R18, had also verbalized being upset about R16's ongoing verbally aggressive and sexually inappropriate comments in the dining/activity room. When questioned about R16's behaviors, the facility social worker stated that R16 is easily agitated, yells, curses, but stated that she doesn't know how to stop the cursing and allow him freedom of expression. When asked if these concerns had been reported, the social worker responded that the previous administrator had stated that grievances were not abuse allegations. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/23/25, R18 was interviewed and reported that R16 was often yelling and cursing, mostly at [R8] and that it upsets her. R18 said, I try to stay away from him . I don't like those words and wasn't raised like that. He was loud and kinda upset me .We were taught to turn our backs and walk away . I said a prayer. According to nursing staff working the unit where R16 resides, R16 was placed on 15-minute checks on 1/15/24, following the recent incident which targeted R8. According to the facility documentation the checks were performed 1/15/25 from 4:45 p.m., until they were discontinued on 1/17/25 at 6:45 p.m. Each day of survey, R16 was observed to ambulate independently throughout the facility on two of three nursing units, as well as in the dining room, without any direct supervision, which provided unrestricted access to R8 as well as other residents. On 1/23/25 at approximately 6 p.m., the survey team met with the facility administrator, director of nursing, and corporate level staff. When questioned about facility actions regarding R16's abusive behaviors, the administrator, DON, regional vice-president of operations, and the regional clinical director all stated that they had not been aware that the behaviors had been to the level of severity as shared by the survey team and indicated that he [R16] would be put on 1:1 supervision immediately. On 1/23/25 at approximately 6:15 p.m., Resident #16 was being escorted out of the dining room due to him becoming verbally aggressive. The survey team was exiting the conference room with the facility administration and corporate staff, while R16 was yelling, using racial slurs, and fussing about a caucasian being seated at his table. 2. For R17, who reported an allegation of abuse and neglect by certified nursing assistant #1 (CNA #1), which resulted in psychosocial harm, the facility staff failed to take measures to protect the resident and did not identify the incident as an allegation of abuse and neglect. On 1/22/25, during a review of facility documentation, it was noted that on 1/19/25, R17 reported an allegation of verbal abuse and neglect by CNA #1 to the nurse, who completed a grievance form. Within the grievance documentation it read, CNA [CNA #1's name redacted] became very smart and rude with resident when she asked to have her shower. Resident shower days are designated to Monday and Thursday. However, resident wanted one due to feeling unsanitary. Resident was very upset and even called her husband wanting to go home . resident became very emotional . Resident became hesitant on using her call light as well, because she didn't want any more attitude. According to a document dated 1/20/25, where the social worker interviewed R17, it was noted, Resident reports that when the aide came in and spoke to her about getting a shower Saturday the aide was very rude and told her 'Absolutely not tonight' and continued to state that 'Saturday was not her day' for a scheduled shower. [R17's name redacted] also reported that later that night she had an accident and needed to be changed she said that the other aide came in and told her that she was passing snacks and would have to come back after doing that to assist her. I don't want her in here if she's going to talk to me like that. Resident is concerned other people are being talked to that way. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alleghany Health and Rehab	1725 Main Street Clifton Forge, VA 24422

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/23/25 at 8:45 a.m., an interview was conducted with R17. R17 was very complimentary of the care she has received at the facility. When asked about the incident involving CNA #1, R17 said, I was told when I came that Wednesday and Saturdays were my shower days. I was so excited and told my husband I was going to get a shower. It was about 8:15 p.m., I rang to see when I would get the shower. She [CNA #1] came in and said, 'absolutely not, no ma'am, I'm not giving you a shower tonight. Tuesday and Fridays was your shower day and tomorrow, Sunday is the make up day. I called my husband crying and told him to come get me. Thank God they had me medicated. This girl needs to know if I have to deal with her I will slap her. If she talks to me like this, how is she talking to other residents. The next day my husband called and said I had 2 choices; I could tell them or he would be down here Monday morning. The next morning [nurse's name redacted, identified as registered nurse #2- RN #2] came in and knew something was wrong. I burst out crying. Sunday when [certified nursing assistant #4's name redacted] got her stuff done, she gave me a shower. On 1/23/25, the facility social worker (SW) said during an interview that she felt the allegation rose to the level of abuse and neglect. The SW stated when this happens, she takes the grievance to the administrator and in this case took R17's grievance to the administrator, who was the abuse coordinator. However, the facility administrator failed to respond to the incident as an allegation of abuse and treated it as a grievance. When asked about R17's abuse allegations, the facility administrator reported that he considered it a poor customer service issue, indicating that he had not reported or investigated the allegations. The administrator said, I may be wrong, but I will have to live with that. A review of CNA#1's timecard revealed that she continued to work, without any suspension, and was not restricted

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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	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 The facility staff have failed to implement abuse policies and procedures to protect residents from alleged perpetrators and failed to report and investigate all allegations of abuse/neglect affecting multiple residents on 2 of 3 nursing units, resulting in psychosocial harm for two residents (Resident #8 and Resident #17). The facility staff have also failed to follow their abuse policy with regards to the prescreening of employees affecting 1 employee, in a sample of 13 employee records reviewed. This facility noncompliance led to the identification of Immediate Jeopardy and Substandard Quality of Care. The findings included: 1. The facility staff have failed to implement their abuse policies and procedures to protect residents from a perpetrator (Resident #16-R16) with known aggressive behaviors, failed to report instances of abuse, failed to conduct a thorough abuse investigation, and failed to implement appropriate safeguards to prevent further potential abuse. The abusive behaviors resulted in psychosocial harm for Resident #8. On 1/22/24, during an interview with resident #8 (R8), the resident verbalized to the surveyor and facility Administrator that Resident #16 (R16) had told R8 to Suck my di-k. R8 went on to state that she had been molested three times in the past and I just can't handle this. The current administrator was observed taking notes during this interview. Review of R16's clinical record revealed an entry dated 1/15/25 that read in part, .resident cursing at another resident in dining room. He returned to his room. currently q15 [every 15] minute checks. His mood at this time is pleasant and cooperative. According to R16's care plan, listed behaviors included I can be physically abusive to others. I have a HX [history] of assaultive behavior towards staff and throwing items (cups, etc.) at other residents, I can be verbally abusive to others. When I feel provoked, I can began [sic] to swear/cuss, I am to have my coffee placed in a thermal blue mug with a tight-fitting lid. I have a history of tossing my coffee at others when I become agitated. This care plan was initiated on 10/23/23 and last revised on 5/15/24. According to interviews conducted by the survey team, the facility social worker, five CNA's, three nurses, the activities director, and the maintenance director had all been aware of and verbalized that R16 has long standing behaviors of saying he is going to blow this place up and shouting, Suck my d-ck. All 11 of the staff interviewed expressed being aware of R16 repeatedly making targeted sexual comments to R8. When asked about interventions implemented to address these aggressive behaviors, staff stated that 15 min checks were done, but mostly offering snacks works, and that sometimes R16's escalating behaviors required the removal of the other residents from the dining room, which is where he likes to sit the most. According to the facility documentation, R16's 15-minute checks were only conducted from 4:45 p.m. on 1/15/25 until 1/17/25 at 6:45 p.m. The 15-minute checks were discontinued prior to the facility completing an investigation. On 1/23/25, during a meeting with the facility administrator and Regional [NAME] President of Operations, when asked why the 15-minute checks were discontinued, they reported, because he had no further behaviors. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	According to both R8's and R16's clinical records, multiple progress note entries indicated R16 had a propensity of displaying aggression towards R8. One note in R8's chart dated 6/25/23 read in part, Resident [R8] came to nursing station requesting pain medication at 1520. Resident [R16's medical record number redacted] was also sitting near the nursing station. Resident [R8] said she would be in her room and walked back to her room with the assistance of her rolling walker. When this nurse entered resident's room, she began crying out in pain and was holding her right foot. This nurse asked what was going on with her foot and the resident stated resident [R16's medical record number redacted] ran over her foot with his wheelchair. She also stated that resident [R16's medical record number redacted] threatened her life and she did not feel safe RN [registered nurse] supervisor was called and made aware of what resident was reporting. RN Supervisor came into the facility to access this situation. Will continue to observe resident R16's chart had an entry dated 6/25/23, which read, Resident kicked resident [R8's medical record number redacted] rolling walker in the dining room after [R8's medical record number redacted] did not move it out of his way. Resident was also threatening to kill everyone and blow up the building when asked to leave the dining room. On 10/22/23, a nursing entry in R16's chart read, Resident had a behavior outburst during morning devotions. Resident threw coffee on resident [R8's medical record number redacted]. Staff was able deescalate the situation. The on-call nurse was notified, and the administrator was notified or the incident. According to the facility social worker, who also serves as the grievance coordinator, another resident, identified as R18, had also verbalized being upset about R16's ongoing verbally aggressive and sexually inappropriate comments in the dining/activity room. When questioned about R16's behaviors, the facility social worker stated that R16 is easily agitated, yells, curses, but stated that she doesn't know how to stop the cursing and allow him freedom of expression. When asked if these concerns had been reported, the social worked responded that the previous administrator had stated that grievances were not abuse allegations. On 1/23/25, R18 was interviewed and reported that R16 was often yelling and cursing, mostly at [R8] and that it upsets her. R18 said, I try to stay away from him . I don't like those words and wasn't raised like that. He was loud and kinda upset me .We were taught to turn our backs and walk away . I said a prayer. Each day of survey, R16 was observed to ambulate independently throughout the facility on two of three nursing units, as well as in the dining room, without any direct supervision, which provided unrestricted access to R8 as well as other residents. On 1/23/25, during a follow-up interview, R8 reported being afraid of R16 and gets another resident, identified as Resident #2, to accompany her because she watches out for her. During this interview, R8 was observed breaking eye contact, tucking her head downwards while speaking, with hands slightly trembling. He said, Come on Baby, suck my d-ck! He would say we need to go to bed in his room. I told him, No, but he said, Ok, B-tch, I will just f-ck the hell out of you then! Sometimes I'm afraid to go to sleep. I've gotten so afraid at night, that he is gonna come in here. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/23/25, an interview was conducted with Resident #2 (R2), who reported that she has witnessed R16 threaten to hit R8, This can happen daily, [R8] cries and gets upset about it. I have to calm her down. [R8] is scared of him. At times, he says hateful things to her, sometimes he approaches her and intimidates her, and her hands start shaking. She said he makes her very nervous. I try to help and break it up. He says, Suck my d-ck, b-tch, I will blow this place up. R2 went on to report that R8 will wake her to go with her to the dining/activity room. R2 reported that she is not personally afraid of R16, that R16 has made those comments to her as well, but that R8 gets so upset, her hands shake. Additional entries in R16's clinical record revealed multiple and on-going instances of verbal aggression, threats, and physical violence towards other residents. Some of R16's charted documentation read as follows: On 4/16/23, a behavioral charting note read, Describe Behavior/Mood: agitated, angry, hostile, combative. What was the resident doing prior to or at the time of behavior/mood: Resident was sitting in the dining room, staff offered resident another tea and resident started to make obscene sexual comments toward the staff member. Other residents began to get upset about the comments this resident was making towards the staff and other residents. Interventions attempted: Staff attempted to redirect sexual comments with other topics. Resident offered to have lunch delivered to his room. Staff attempted to ask resident what was wrong. Effectiveness of the Interventions: Resident continued to make sexual remarks. Resident attempted to throw hot coffee at staff. When asked what was wrong, resident continued to make obscene sexual comments to staff. Resident threatened to hurt staff and continued to ask for sexual favors. On 4/25/23, a progress note titled SSD [social services director] annual note read in part, . Relationships: Resident maintains a mostly positive relationship with all staff. Resident sometimes has trouble interacting appropriately with peers . Behavioral: Resident has behaviors of sometimes making sexual comments and can be verbally aggressive with staff and peers . On 5/6/23, a progress note read in part, Resident angry, cursing at staff in presence of other residents On 5/10/23, a progress note read, Resident had several episodes of behaviors this shift. Cussing and making threats but did not do any harm to others or himself On 5/14/23, a nursing entry read, Resident had behaviors in dining room during lunch. Resident used vulgar language and was making threats. Resident did not act on any of the threats . On 5/19/23, a note partially read, Resident had behaviors in dining room this shift and was taken to the front office to sit with BOM [business office manager] . On 6/8/23, a note read in part, Resident continues with behaviors. Resident cussing and yelling at other resident's and making threats. Resident re-directed several times throughout the shift . On 6/9/23, the entry read in part, Resident has had 2 outbursts of cussing and threatening others this shift. Resident was re-directed successfully both times (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/10/23, the entry read, .Resident began displaying belligerent behavior, stating 'I/m going to burn this (expletive) down, people are dying in here'. Another entry the same day read, Patient became agitated in the dining room and began yelling that he was going to get gas and burn the building . He continued to curse and use sexual language as he left the dining room . According to a late entry progress note dated 6/10/23, it read in part, Resident being belligerent this shift towards staff and residents. Threatening to blow up the building, kill us all. On Call physician called and 2mg Ativan PO one time order given and 100 mg Seroquel given. Family came to visit and behaviors continued to get worse. Resident was taken to whirlpool room by family and CNA to get a bath, and he seen female resident [Resident #8's medical record number redacted] walk by and yelled I'm going to kill you bitch while getting up from his wheel chair to grab her. This nurse, CNA, and resident's sister was able to stop him and get him back into his wheelchair. Resident continued with threatening behaviors and began to threaten his family . Squad was called and resident was sent to ER. On 6/17/23, the entry read, . Resident had an outburst this shift after another resident interfered with his conversation in the dining room. This nurse was able to re-direct resident, and he calmed down . On 6/22/23, the note read, Rsd [resident] has had some behaviors of yelling/cursing rsd. redirected well thus far . On 6/23/23, the note read, Rsd. continues with behaviors. Rsd. woke up and came in the hall. Rsd. has had episodes of cursing staff and other rsd . On 6/29/23, the late entry note read, This RN was assisting residents with breakfast in the dining room when [R16's name redacted] who had finished his breakfast, including two cups of coffee, held his coffee cup up in the air and yelled out asking for a refill. I explained to him I would get it as soon as I had finished handing out a tray of food that I was carrying to someone who had not eaten. He put the cup down and began cursing. As I put the tray of food on the table he threw his cup toward me. The cup hit a table and fell to the floor. I ignored his behavior because any response to it yields more behaviors. Less than 5 minutes later he had confronted the resident next to him telling her he was going to kill her for looking at him. He began cursing, ranting about his sister, saying he was being held hostage. Several other staff members entered the dining room to talk with him and to try to calm him down and assist him back to his room or another area since he had finished his meal, eating 100 percent. He wanted to see the Administrator, [prior administrator's name redacted], and the Administrator took him to his office and made a behavioral contract with him . His states were as follows: I will get gas and set this MF place on fire and burn all of you GD old people up. I will get a gun and shoot everyone in this building. 'I have scissors in my pocket, and I'll cut your mf eyes out. I hate my GD MF sister, and I will kill her too' . It was noted that R16 was sent to the hospital under an emergency custody order, but upon return had no interventions implemented to protect other residents from on-going abuse by R16. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/29/23, the entry read, Resident was sitting at nurses' station when resident [resident number redacted] said something that upset this resident. This resident then began to yell out that no one was going to talk to him that way . and he will hurt someone for talking to him that way.When social worker came to speak with resident, he became more upset and was very belligerent towards social worker. Other LPN [licensed practical nurse] came to speak with resident to try and calm resident down. Once social worker walked away other LPN was able to deescalate resident. Administrator also came and spoke with resident and took him to get coffee. At this time resident is calm and no longer yelling. On 9/29/23, another entry documented an incident during lunch in the dining room that noted, .Resident started yelling and cursing at everything/everyone around him because he could not get to the seat, he wanted in the dining room . On 10/23/23, 11/3/23, 11/6/23, and 11/8/23, R16 also had documented behaviors. Then on 12/2/23, R16 was noted to be .cursing at other residents in dining room, hit another resident with shoe [other resident not identified]. On 12/6/23, the note indicates Resident does exhibit behaviors and aggression daily. On 1/5/24, a note read in part, Resident occasionally becomes agitated by other residents' interactions with him . Resident will sometimes throw objects during these outbursts. Resident ambulates pushing w/c [wheelchair] or uses w/c to move about the unit and the facility . On 3/22/24, a nursing progress note entry dated documented that scissors were removed from R16's possession following him being observed scraping dry skin off BLE [bilateral lower extremities] with a pair of scissors. On 3/24/24, R16 was noted to have been . agitated with resident in room adjacent to his, he stated, 'I'm a tough man, I'll mess him up .'. On 6/8/24, the note read, .Very angry. Yelling and cursing in the hallway while families at facility with their loved ones . On 10/2/24, a note entry read, Agitated, verbally aggressive. Verbally expressing anger at staff members and various other residents. On 11/9/24, a nurse note documented in part, Resident was sitting at nurse's station making foul comments such as . I'll blow this whole place up . you can suck my d-ck g-d d-mn for not giving me what I want. and you can't give me what I want, then it's time to kill ya a** On 11/25/24, the nursing entry recorded .Resident then proceeded to make the comment 'I will go find me a woman to have sex with, I haven't had sex in a long time,' and asked this nurse if I would make love to him. educated resident that, that is a very inappropriate thing to say. Resident stated, I don't give a damn, I'll blown this damn place up. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 12/7/24, during R16's most recent hospitalization , behaviors were displayed that warranted a psychiatric consult. The note dated 12/7/24, read in part, . was cooperative with care until this morning prior to discharge, he became upset and threatened to blow up the building with people in it. Psychiatry was consulted for concern of this behavior . He states that he has to tell people he is going to kill them so he can go to sleep, but he would never harm anybody . He does state that he was 'cursing and stuff' he apologizes for this . there was concern that reduction in psychotropic medications may have contributed to his decompensation. Nursing staff was able to call and speak with patient's regular nurse at [this nursing facility's name redacted]. She reports that this behavior is typical for him. He will have an outburst like this wanted to time a week [sic] [one to two times a week] . This has quite consistent with behavior witnessed this morning . Patient has a long psychiatric history. He was admitted here in July of 2023 for threatening behaviors and outbursts . On 12/9/24, a note recorded Resident threw his oxygen tank and knocked over his dresser in his room. I'm going to kill everyone and blow this building up Resident stated that his neighbor beside him was coming into his room and moving his belongings. Resident takes his wheelchair and [NAME] his neighbor's door. Resident is saying explicit words and other residents are complaining. On 12/15/24, the medical provider noted, .Please order a psych consult . On 12/26/24, a nursing note captured R16 as saying, I'm gonna blow this damn place up, I am a bad motherf-cker, y'all can suck my d-ck y'all got five minutes to get me my pain pills or I am gonna start killing people. On 12/27/24, provider note indicated, .The patient has been experiencing increased behavioral outbursts, as noted by the staff. He was previously receiving Seroquel 250 mg PO BID prior to a hospital admission on 12/4/2024. Upon return from the hospital, his Seroquel dosage was adjusted to 50 mg TID. Staff reported a significant behavioral incident on 12/26/2024, during which the patient accused nurses of withholding his medications and giving his pain pills to other residents. He refused PRN pain medication and made threats of violence, stating he would blow the damn place up and start killing people if not given his pain pills At the time of the survey being conducted in January 2025, there was no evidence that R16 had not seen a psychiatrist since hospitalization in early December 2024. According to the hospital discharge summary and psychiatry consultation dated 12/7/24, both documents directed that R16's Seroquel dose return to the prior dosage of 250 mg twice daily. According to R16's physician orders and medication administration records, upon readmission to the nursing facility R16 was receiving 50 mg three times daily from 12/8/24-12/27/24. On 12/27/24, the Seroquel dose was increased to 100 mg three times daily. When requested, the facility administration had no evidence that measures had been implemented to protect residents, or that the above allegations of abuse had been reported or investigated. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/24/25 at 2:30 p.m., an interview was conducted with the nurse practitioner (NP). The NP was asked about R16's behaviors and Seroquel dosing. The NP stated she was not aware of the order/recommendation from the hospital for R16's Seroquel to return to the dose of 250 mg twice daily and stated had she seen the addendum with that recommendation she would have followed it because, I do follow what is on the hospital discharge summary. The NP also stated she was aware of R16 having some behaviors, but it had been shared with her it surrounded his pain management and had just increased his Gabapentin. The NP said, We have not had an on-site psych provider since I started in December. We have only had 1 telehealth psych visit; from what I am told we now have a psych provider starting. The NP went on to state that she was not aware of R16 making abusive sexual comments to other residents or the instances of R16 attempting to throw his oxygen cylinder. On 1/23/25 at approximately 11:30 a.m., during an interview with certified nursing assistant #15 (CNA #15) and CNA #16, both reported R16 took the oxygen tank out to throw at us, we ran up the hall. CNA #15 stated they got the administrator to intervene, as they were both scared that R16 would throw the oxygen tank, but neither CNA #15 & CNA #16 could recall specifically when the incident occurred. On 1/23/25, the facility administrator provided the survey team with a copy of a facility incident summary and investigation initiated on 1/16/25, which was completed on 1/22/25. Review of this documentation revealed that during the investigation, the facility had not interviewed other residents to determine if they had been affected by R16's behaviors. The facility had also not interviewed facility staff or reviewed R16's chart to determine the severity of R16's behaviors. When questioned about facility actions regarding R16's aggressive behaviors, the administrator, DON, the regional vice-president of operations, and the regional clinical director all stated that they had not been aware that the behaviors had been to this severity and involved prior incidents with other residents, but indicated that R16 would be put on 1:1 supervision immediately. On 1/23/25 at approximately 6:15 p.m., Resident #16 was being escorted out of the dining room due to him becoming verbally aggressive. The survey team was exiting the conference room with the facility administration and corporate staff, when R16 was observed to be yelling racial slurs and fussing about a caucasian being sat at his table. 2. For Resident #17 (R17), the facility staff failed to take measures to protect residents from an alleged perpetrator, report the allegations of abuse/neglect, and failed to initiate an investigation, as required. On 1/22/25, during a review of facility documentation, it was noted that on 1/19/25, R17 reported an allegation of verbal abuse and neglect by CNA #1 to the nurse, who completed a grievance form. Within the grievance documentation it read, CNA [CNA #1's name redacted] became very smart and rude with resident when she asked to have her shower. Resident shower days are designated to Monday and Thursday. However, resident wanted one due to feeling unsanitary. Resident was very upset and even called her husband wanting to go home . resident became very emotional . Resident became hesitant on using her call light as well, because she didn't want any more attitude. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Alleghany Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 Main Street Clifton Forge, VA 24422	

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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	According to a document dated 1/20/25, where the social worker interviewed R17, it was noted, Resident reports that when the aide came in and spoke to her about getting a shower Saturday the aide was very rude and told her 'Absolutely not tonight' and continued to state that 'Saturday was not her day' for a scheduled shower. [R17's name redacted] also reported that later that night she had an accident and needed to be changed she said that the other aide came in and told her that she was passing snacks and would have to come back after doing that to assist her. I don't want her in here if she's going to talk to me like that. Resident is concerned other people are being talked to that way. On 1/23/25 at 8:45 a.m., an interview was conducted with R17. R17 was very complimentary of the care she has received at the facility. When asked about the incident involving CNA #1, R17 said, I was told when I came that Wednesday and Saturdays were my shower days. I was so excited and told my husband I was going to get a shower. It was about 8:15 p.m., I rang to see when I would get the shower. She [CNA #1] came in and said, 'absolutely not, no ma'am, I'm not giving you a shower tonight. Tuesday and Fridays was your shower day and tomorrow, Sunday is the make-up day. I called my husband crying and told him to come get me. Thank God they had me medicated. This girl needs to know if I have to deal with her, I will slap her. If she talks to me like this, how is she talking to other residents. The next day my husband called and said I had 2 choices; I could tell them, or he would be down here Monday morning. The next morning [nurse's name redacted, identified as registered nurse #2- RN #2] came in and knew something was wrong. I burst out crying. Sunday when [certified nursing assistant #4's name redacted] got her stuff done, she gave me a shower. On 1/23/25, the facility social worker said during an interview that she felt the allegation rose to the level of abuse and neglect. She said when this happens, she takes the grievance to the administrator and in this case took R17's grievance to the administrator, who was the abuse coordinator. However, the facility administrator failed to respond to the incident as an allegation of abuse and treated it as a grievance. When asked about R17's abuse allegations, the facility administrator reported that he considered it a poor customer service issue, indicating that he had not reported or investigated the allegations. The administrator said, I may be wrong, but I will have to live with that. A review of CNA#1's timecard revealed that she continued to work, without any suspension, and was not restricted from having access to R17 and other residents. The facility administrator failed to respond to the incident as an allegation of abuse and treated it as a grievance. When asked about R17's abuse allegations, the facility administrator reported that he considered it a poor customer service issue, indicating that he had not reported nor investigated the allegations. I may be wrong, but I will have to live with that. A review of CNA#1's timecard revealed that she continued to work, without any suspension, and was not restricted from having access to R17 and other residents. 3. For the facility's interim administrator, also serving as the abuse coordinator, the facility staff failed to obtain a criminal background check within 30 days of employment to ensure the employee was free from barrier crimes. On 1/27/25 at approximately 2:00 p.m. the surveyor requested 10 employee's files for the sufficient staffing and extended survey training review. The list of employees was given to the staff development coordinator, a registered nurse, RN#5 (RN5). The human resource director stated he had to get the administrators employee file from the corporate office. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/28/25 at 9:00 a.m., the employee files were obtained from R5 and reviewed. During the review of the administrator's employee file, the administrators file did not have a license verification or a criminal background check. The human resource director stated that he was requesting the documentation from the corporate office. On 1/28/25 at 10:25 a.m., an interview was conducted with the human resource director. The human resource director stated that in the hiring process a verbal job offer will be made but the candidate cannot start work until the background check had been received. The human resource director stated that all new hires and rehires had to have a background check completed prior to starting employment. On 1/28/25 at 11:20 a.m., an interview was conducted with the administrator. The administrator stated that he was calling corporate to see if he was able to get the copy of his background check and license verification sent to the facility. On 1/28/25 at 12:55 p.m., an interview was conducted with the regional vice president of operations (RVPO). The RVPO stated that the administrator had been on the phone trying to get the copy of his background check sent to the facility. She also stated that the corporate office had sent a copy of a background check and that it was not the correct one, it was not the administrators background check, it was a different employee with the same last name. The RVPO said, I will work on the background check because when they handed me the other one, I told them this is not right. On 1/28/25 at 1:27 p.m., the RVPO came to the surveyor and said, [the administrator, name redacted] doesn't have a background check, one wasn't run for him, so I am suspending him effective immediately until his background check is run. On 1/28/25 at approximately 1:30 p.m., a review of facility documentation was conducted. The facility document titled, Hiring Policy, read in part, .after a decision has been made to hire a particular candidate, an offer will be made to that individual contingent on satisfactory completion of reference checks, background checks and OIG checks. On 1/24/25 at 10:35 a.m., the survey team identified that the facility was in immediate jeopardy, as well as substandard quality of care as confirmed by the state agency. The survey team met with the administrator, director of nursing and corporate staff to make them aware Immediate Jeopardy had been identified for the failure to implement their abuse policy by not implementing interventions to protect the residents and not reporting and investigating instances of abuse. Specifically, Immediate Jeopardy was identified as having started on 6/10/23, when the facility failed to implement their abuse policies to protect R8 from R16's targeted abuse, as well as reporting and investigating the incident as required. On 1/24/25 at 6:15 p.m., the facility submitted an approved IJ removal plan that read as follows: The facility has taken immediate action to ensure all staff are knowledgeable and compliant with reporting obligations as covered individuals that: a) Abuse policies and procedures are implemented to report any allegations of abuse/neglect, regardless of source. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b) Ensure that a thorough investigation is conducted on all allegations of abuse/neglect, regardless of source. 1. Resident #16 was placed on 1:1 supervision to protect residents #2, #8, and #18. Resident #16 medications reviewed, and changes made to psychotropic dosing. 2. FRI submitted and investigation initiated based on Resident #17 allegation identified by surveyor. The alleged employee was immediately suspended protecting Resident #17 and investigation initiated. 3. Education will be completed with all current staff in the facility on the Abuse Policy which includes reporting and completing a thorough investigation. Staff not currently in the facility will not be able to work until education is completed. 4. NHA [nursing home administrator] conducting interviews with employees and residents and will be completed in the 5-day reporting timeframe related to resident #16 FRI. 5. Current residents on A wing and B wing will be interviewed by the Regional [NAME] President of Operations & Regional Clinical Director and other IDT [interdisciplinary team] members to determine if they had experienced any type of abuse, mental and/or sexually inappropriate, or lewd, aggressive, hostile or threatening comments that have been made toward them or others resulting in fear or feelings of being unsafe from either staff, residents or other visitors. Residents who are not interviewable will have a head-to-toe assessment. 6. Medical Director notified. 7. Completion 1/24/25 at 11:59 p.m. On 1/27/25, the survey team completed the following: Observations were made of R16 to ensure 1:1 supervision was being provided. A review of the logs from 1/24/25-1/27/24, were reviewed, which indicated R16 had been on continuous 1:1 supervision. R16's clinical record did reveal that R16's Seroquel dose had been increased on 1/24/25, to the prior to hospitalization dosage of 250 mg, BID [twice daily]. A facility reported incident was conducted with regards to R16 and R17, with an investigation being initiated. The staffing schedules were reviewed to ensure that the nursing assistant who was

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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. **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 policies and procedures for ensuring the reporting of reasonable suspicion of abuse violations, resulting in the failure to protect residents from further potential abuse by an alleged perpetrator, as required for three residents (Resident #8, Resident #16, and Resident #17), in a survey sample of 19 residents. The findings included: 1. For Resident #8 (R8) who was a target and victim of abuse by Resident #16 on multiple occurrences, the facility staff failed to protect R8 from further potential abuse and failed to report each of the alleged violations of abuse, as required. On 1/22/24 at approximately 9:30 a.m., during an interview with resident #8 (R8), the resident verbalized to the surveyor and facility Administrator that Resident #16 (R16) had told R8 to Suck my di*k. R8 went on to state that she had been molested three times in the past and I just can't handle this. The current administrator was observed taking notes during this interview. R8 reported being an ongoing victim of physical threats, verbal abuse, and unwanted sexual abuse by R16 on numerous occasions. On 1/22/25 -1/23/25, a clinical record review was conducted of R8's clinical record. R8's diagnosis included, but were not limited to major depressive disorder, insomnia, generalized anxiety disorder, borderline personality disorder, bipolar disorder, and schizoaffective disorder. According to R8's most recent minimum data set (MDS) (an assessment tool) with an assessment reference date of 12/28/24, R8 scored a 13 out of 15 on the brief interview for mental status, which indicated she was cognitively intact. According to the nursing progress notes within R8's and R16's clinical records, the following entries were noted: R16's chart contained a note dated 6/10/23 at 8:20 p.m., that read, Resident being belligerent this shift towards staff and residents. Threatening to blow up the building, kill us all. On Call physician called . Family came to visit, and behaviors continued to get worse. Resident was taken to whirlpool room by family and CNA to get a bath, and he seen female resident [Resident #8's medical record number redacted] walk by and yelled I'm going to kill you bitch while getting up from his wheelchair to grab her. This nurse, CNA, and resident's sister was able to stop him and get him back into his wheelchair. Resident continued with threatening behaviors and began to threaten his family . Squad was called, and resident was sent to ER [emergency room]. (continued on next page)

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

R16's progress note on 6/25/23, documented that R16 was aggressive towards R8. The entry read, Resident kicked resident [R8's medical record number redacted] rolling walker in the dining room after [R8's medical record number redacted] did not move it out of his way. Resident was also threatening to kill everyone and blow up the building when asked to leave the dining room. Resident was brought back to A Wing. Resident eventually calmed down. RN supervisor was called in to help with the situation between the two residents. Will continue to observe resident.

According to R8's chart, a nursing entry dated 6/25/23, read in part, Resident came to nursing station requesting pain medication at 1520. Resident [R16's medical record number redacted] was also sitting near the nursing station. Resident [R8] said she would be in her room and walked back to her room with the assistance of her rolling walker. When this nurse entered resident's room, she began crying out in pain and was holding her right foot. This nurse asked what was going on with her foot and the resident stated resident [R16's medical record number redacted] ran over her foot with his wheelchair. She also stated that resident [R16's medical record number redacted] threatened her life and she did not feel safe RN [registered nurse] supervisor was called and made aware of what resident was reporting. RN Supervisor came into the facility to access this situation. Will continue to observe resident

Review of the facility documentation revealed that neither of these instances had been reported to the state survey agency, adult protective services, or other agencies, as required.

2. Resident 16 (R16), who had on-going behavioral outbursts adversely affecting other residents, the facility staff failed to have evidence that alleged violations of abuse were reported to the state survey agency, adult protective services or other agencies, as required.

According to documentation within R16's clinical record, multiple occurrences of abusive behaviors affecting other residents was identified. They included:

On 4/16/23, a behavioral charting note read, Describe Behavior/Mood: agitated, angry, hostile, combative. What was the resident doing prior to or at the time of behavior/mood: Resident was sitting in the dining room, staff offered resident another tea and resident started to make obscene sexual comments toward the staff member. Other residents began to get upset about the comments this resident was making towards the staff and other residents. Interventions attempted: Staff attempted to redirect sexual comments with other topics. Resident offered to have lunch delivered to his room. Staff attempted to ask resident what was wrong. Effectiveness of the Interventions: Resident continued to make sexual remarks. Resident attempted to throw hot coffee at staff. When asked what was wrong, resident continued to make obscene sexual comments to staff. Resident threatened to hurt staff and continued to ask for sexual favors.

On 5/6/23, the note read in part, Resident angry, cursing at staff in presence of other residents

On 5/10/23, the note read, Resident had several episodes of behaviors this shift. Cussing and making threats but did not do any harm to others or himself

On 5/14/23, a nursing entry read, Resident had behaviors in dining room during lunch. Resident used vulgar language and was making threats

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/23, the note read, Resident had behaviors in dining room this shift and was taken to the front office to sit with BOM [business office manager] . On 6/8/23, a note read in part, Resident continues with behaviors. Resident cussing and yelling at other resident's and making threats. Resident re-directed several times throughout the shift . On 6/9/23, the entry read in part, Resident has had 2 outbursts of cussing and threatening others this shift . On 6/10/23, the entry read, .Resident began displaying belligerent behavior, stating 'I/m going to burn this (expletive) down, people are dying in here'. Another entry the same day read, Patient became agitated in the dining room and began yelling that he was going to get gas and burn the building . He continued to curse and use sexual language as he left the dining room . On 6/17/23, the entry read, . Resident had an outburst this shift after another resident interfered with his conversation in the dining room. The other resident involved in this incident, the victim, was not identified. On 6/23/23, the note read, Rsd. [resident] continues with behaviors. Rsd. woke up and came in the hall. Rsd. has had episodes of cursing staff and other rsd [residents] . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/29/23, the late entry note read, This RN was assisting residents with breakfast in the dining room when [R16's name redacted] who had finished his breakfast, including two cups of coffee, held his coffee cup up in the air and yelled out asking for a refill. He put the cup down and began cursing. As I put the tray of food on the table he threw his cup toward me. The cup hit a table and fell to the floor. I ignored his behavior because any response to it yields more behaviors. Less than 5 minutes later he had confronted the resident next to him telling her he was going to kill her for looking at him. He began cursing, ranting about his sister, saying he was being held hostage. Several other staff members entered the dining room to talk with him and to try to calm him down and assist him back to his room or another area since he had finished his meal, eating 100 percent. He wanted to see the Administrator, [prior administrator's name redacted], and the Administrator took him to his office and made a behavioral contract with him. 1100 I was asked to check on resident and found him in the hallway on his wing The nursing assistant told him she would give him a whirlpool with the bubbles he liked and a few minutes later he was screaming, I will blow this MF place up. He continued screaming until Physical Therapy talked to him about coming to therapy. The PT assistant was taking him toward therapy when he met a female resident in the hallway outside the dining room and he began ranting again. His states were as follows: I will get gas and set this MF place on fire and burn all of you GD old people up. I will get a gun and shoot everyone in this building. I have scissors in my pocket, and I'll cut your mf eyes out I hate my GD MF sister, and I will kill her too. He then pulled his Oxygen out of his nose and began walking toward one of the nursing assistants telling her he had a pitcher of tea, and he would throw it all over her. I took the tea from his hand and assisted him back to the wheelchair and replaced the oxygen. The Administrator once again tried to talk with him remind him of the contract. He again became angry, aggressive, screamed threats and scared the residents who were gathering for lunch. He got up from his wheelchair the second time after jerking his oxygen off and began walking toward another staff member while screaming he would kill her. Resident continued for a period of more than an hour with aggressive behavior, racial slurs, cursing, threatening other residents and screaming as loud as he could scream. Staff reports the screaming and threats to blow everyone up, etc. has become an everyday event along with accusations of people stealing from him This behavior, per staff, began in April and has continued to escalate On 9/29/23, the entry read, Resident was sitting at nurses' station when resident [resident number redacted] said something that upset this resident. This resident then began to yell out that no one was going to talk to him that way . and he will hurt someone for talking to him that way.When social worker came to speak with resident, he became more upset and was very belligerent towards social worker. Other LPN [licensed practical nurse] came to speak with resident to try and calm resident down. Once social worker walked away other LPN was able to deescalate resident. Administrator also came and spoke with resident and took him to get coffee. Another entry on 9/29/23 spoke of an incident during lunch in the dining room that noted, .Resident started yelling and cursing at everything/everyone around him because he could not get to the seat, he wanted in the dining room . On 12/2/23, R16 was noted to be .cursing at other residents in dining room, hit another resident with shoe . The resident who was the victim in this altecation was unidentified. On 10/2/24, a note entry read, Agitated, verbally aggressive. Verbally expressing anger at staff members and various other residents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/24, the note read, Resident threw his oxygen tank and knocked over his dresser in his room. I'm going to kill everyone and blow this building up Resident stated that his neighbor beside him was coming into his room and moving his belongings. Resident takes his wheelchair and [NAME] his neighbor's door. Resident is saying explicit words and other residents are complaining. Review of facility documentation revealed that none of the instances of targeted abuse towards other residents by R16 was reported to the state survey agency, adult protective services, or law enforcement agencies. On 1/22/25 at 3:25 p.m., during a meeting with the facility administrator, director of nursing, and Regional [NAME] President of Operations, they were asked to explain the protocol when an allegation of abuse is brought forward. The administrator explained that it goes on a facility reported incident form, We start an investigation and report the incident. On 1/23/25 at approximately 6 p.m., the survey team met with the facility administrator, director of nursing and corporate level staff. When questioned about facility actions regarding R16's abusive behaviors, the administrator, DON, regional vice-president of operations, and the regional clinical director all stated that they had not been aware that the behaviors had been to the level of severity as shared by the survey team and indicated that R16 would be put on 1:1 supervision immediately. On 1/23/25 at approximately 10 a.m., an interview was conducted with the facility Administrator and Regional [NAME] President of Operations (RVPO). The administrator was asked, can you tell me what abuse is? The administrator said, Not off the top of my head, I would like to refer to my policy. The administrator was asked the same question regarding neglect and gave the same response, wanting to refer to the policy. When asked the same questions, the RVPO defined abuse as willful intent causing harm and neglect as willful intent to not provide something. When asked if a resident had to suffer harm for it to be considered abuse, the RVPO stated no. On 1/28/25, the RVPO stated, in the review of R16's clinical chart, they had identified multiple instances of behaviors that rose to the level of being reported as abuse and would be preparing a report to cover each of the occurrences. 3. For R17, who reported an allegation of abuse and neglect by certified nursing assistant #1 (CNA #1), which resulted in psychosocial harm, the facility staff failed to take measures to protect the resident from the alleged perpetrator, did not identify the incident as an allegation of abuse and/ neglect, and failed to report the alleged violation as required. On 1/22/25, during a review of facility documentation, it was noted that on 1/19/25, R17 reported an allegation of verbal abuse and neglect by CNA #1 to the nurse, who completed a grievance form. Within the grievance documentation it read, CNA [CNA #1's name redacted] became very smart and rude with resident when she asked to have her shower. Resident shower days are designated to Monday and Thursday. However, resident wanted one due to feeling unsanitary. Resident was very upset and even called her husband wanting to go home . resident became very emotional . Resident became hesitant on using her call light as well, because she didn't want any more attitude. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a document dated 1/20/25, where the social worker interviewed R17, it was noted, Resident reports that when the aide came in and spoke to her about getting a shower Saturday the aide was very rude and told her 'Absolutely not tonight' and continued to state that 'Saturday was not her day' for a scheduled shower. [R17's name redacted] also reported that later that night she had an accident and needed to be changed she said that the other aide came in and told her that she was passing snacks and would have to come back after doing that to assist her. I don't want her in here if she's going to talk to me like that. Resident is concerned other people are being talked to that way. On 1/23/25 at 8:45 a.m., an interview was conducted with R17. R17 was very complimentary of the care she has received at the facility. When asked about the incident involving CNA #1, R17 said, I was told when I came that Wednesday and Saturdays were my shower days. I was so excited and told my husband I was going to get a shower. It was about 8:15 p.m., I rang to see when I would get the shower. She [CNA #1] came in and said, 'not, no ma'am, I'm not giving you a shower tonight. Tuesday and Fridays was your shower day and tomorrow, Sunday is the make-up day. I called my husband crying and told him to come get me. Thank God they had me medicated. This girl needs to know if I have to deal with her, I will slap her. If she talks to me like this, how is she talking to other residents. The next day my husband called and said I had 2 choices; I could tell them, or he would be down here Monday morning. The next morning [nurse's name redacted, identified as registered nurse #2- RN #2] came in and knew something was wrong. I burst out crying. Sunday when [certified nursing assistant #4's name redacted] got her stuff done, she gave me a shower. On 1/23/25, the facility social worker said during an interview that she felt the allegation rose to the level of abuse and neglect. She said when this happens, she takes the grievance to the administrator and in this case took R17's grievance to the administrator, who was the abuse coordinator. However, the facility administrator failed to respond to the incident as an allegation of abuse and treated it as a grievance. On 1/23/25, the administrator was asked why this report from R17 wasn't handled as an abuse and neglect allegation. The administrator said, I thought it was p*ss poor customer service, I didn't think it was an allegation of neglect based on the information I received. If I'm wrong, I will have to live with that, it was bad customer service. On 1/23/25, after notification by the survey team, the facility administration reported R17's allegation to the required agencies. According to the facility's abuse policy, it noted in section 2. Types of Abuse: . G. Mental Abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. H. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alleghany Health and Rehab	1725 Main Street Clifton Forge, VA 24422

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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	The facility's abuse policy went on to read in part, . G. Procedure for Reporting Abuse. i. All incidents of resident abuse are to be reported immediately to the licensed nurse in charge, Director of nursing, or the Administrator. Once reported to one of those three officials, the prescribed forms are to be completed and delivered to the Abuse Coordinator or his/her designee for an investigation. ii. The facility shall report to the state agency and one or more law enforcement entities any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. iii. And if the events that caused the suspicion resulted in serious bodily injury the facility must report within 2 hours after forming the suspicion. If the events that caused the suspicion did NOT result in serious bodily injury the facility shall report within 24 hours On 1/23/25 and again on 1/28/25, the above findings were reviewed with the facility administration. No additional information was provided.

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NAME OF PROVIDER OR SUPPLIER Alleghany Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 Main Street Clifton Forge, VA 24422	

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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 staff failed to conduct a thorough investigation into allegation of abuse and neglect involving two residents (Resident #8 and Resident #17) in a survey sample of 19 residents. The findings included: 1. For Resident #8 (R8), who reported an allegation of being abused by Resident #16 (R16), the facility administration failed to conduct a thorough investigation. On 1/22/24 at approximately 9:30 a.m., during an interview with resident #8 (R8), the resident verbalized to the surveyor and facility Administrator that Resident #16 (R16) had told R8 to Suck my di*k. R8 went on to state that she had been molested three times in the past and just can't handle this. The current administrator was observed taking notes during this interview. On 1/22/25 -1/23/25, a clinical record review was conducted of R8 clinical record. R8's diagnosis included, but were not limited to major depressive disorder, insomnia, generalized anxiety disorder, borderline personality disorder, bipolar disorder, and schizoaffective disorder. According to R8's most recent minimum data set (MDS) (an assessment tool) with an assessment reference date of 12/28/24, R8 scored a 13 out of 15 on the brief interview for mental status, which indicated she was cognitively intact. On 1/23/25, the facility administrator provided the survey team with the investigation documentation regarding R8's allegation. Within the investigation summary the question asked, Summary of interview(s) with other residents who may have had contact with the alleged perpetrator and the response was recorded as not applicable. The investigation summary also indicated that the incident had taken place in the dining room in the presence of other residents. Only R8, R16 and one other resident were interviewed. There was no evidence that facility staff were interviewed in the course of the investigation and the investigation findings were noted as inconclusive. In the course of the survey, the social worker identified another resident, Resident #18, who has expressed frustration over R16's behaviors and inappropriate sexual comments and verbal threats in the common areas. The facility administration failed to identify this information in the course of their investigation. 2. For Resident #17 (R17), who reported an allegation of abuse and neglect by which CNA #1 certified nursing assistant #1 (CNA #1), the facility staff failed to conduct an investigation into the allegation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25, during a review of facility documentation, it was noted that on 1/19/25, R17 reported an allegation of verbal abuse and neglect by CNA #1 that occurred on 1/18/25, to the nurse, who completed a grievance form. Within the grievance documentation it read, CNA [CNA #1's name redacted] became very smart and rude with resident when she asked to have her shower. Resident shower days are designated to Monday and Thursday. However, resident wanted one due to feeling unsanitary. Resident was very upset and even called her husband wanting to go home . resident became very emotional . Resident became hesitant on using her call light as well, because she didn't want any more attitude. According to a document dated 1/20/25, where the social worker interviewed R17, it was noted, Resident reports that when the aide came in and spoke to her about getting a shower Saturday the aide was very rude and told her 'Absolutely not tonight' and continued to state that 'Saturday was not her day' for a scheduled shower. [R17's name redacted] also reported that later that night she had an accident and needed to be changed she said that the other aide came in and told her that she was passing snacks and would have to come back after doing that to assist her. I don't want her in here if she's going to talk to me like that. Resident is concerned other people are being talked to that way. On 1/23/25 at 8:45 a.m., an interview was conducted with R17. R17 was very complimentary of the care she has received at the facility. When asked about the incident involving CNA #1, R17 said, I was told when I came that Wednesday and Saturdays were my shower days. I was so excited and told my husband I was going to get a shower. It was about 8:15 p.m., I rang to see when I would get the shower. She [CNA #1] came in and said, 'absolutely not, no ma'am, I'm not giving you a shower tonight. Tuesday and Fridays was your shower day and tomorrow, Sunday is the make-up day. I called my husband crying and told him to come get me. Thank God they had me medicated. This girl needs to know if I have to deal with her, I will slap her. If she talks to me like this, how is she talking to other residents. The next day my husband called and said I had 2 choices; I could tell them, or he would be down here Monday morning. The next morning [nurse's name redacted, identified as registered nurse #2- RN #2] came in and knew something was wrong. I burst out crying. Sunday when [certified nursing assistant #4's name redacted] got her stuff done, she gave me a shower. On 1/23/25, the facility social worker said during an interview that she felt the allegation rose to the level of abuse and neglect. She said when this happens, she takes the grievance to the administrator and in this case took R17's grievance to the administrator, who was the abuse coordinator. However, the facility administrator failed to respond to the incident as an allegation of abuse and treated it as a grievance. When asked about R17's abuse allegations, the facility administrator reported that he considered it a poor customer service issue, indicating that he had not reported or investigated the allegations. The administrator said, I may be wrong, but I will have to live with that. A review of CNA#1's timecard revealed that she continued to work, without any suspension, and was not restricted from having access to R17 and other residents. On 1/23/25 at approximately 11 a.m., an interview was conducted with the facility Administrator and Regional [NAME] President of Operations (RVPO). The surveyor read the grievance filed on behalf of R17 and asked how she would respond. The RVPO said, I would like to interview myself to get further details, it sounds like it would be neglect. The administrator was asked why this report from R17 wasn't handled as an abuse and neglect allegation and an investigation initiated. The administrator said, I thought it was p*ss poor customer service, I didn't think it was an allegation of neglect based on the information I received. If I'm wrong, I will have to live with that, it was bad customer service. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to R17's clinical record documentation for activities of daily living, CNA #1 signed off the on 1/18/25 and the following day, 1/19/25 as having provided care to R17, following the allegation being reported. According to CNA #1's timecard records, she continued to work as scheduled following facility staff being aware of the allegation of abuse and neglect. Review of the facility's abuse policy with a revision date of 1/2023, read in part in section 2.Types of Abuse: . G. Mental Abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. H. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability . 3. 8 Components of Abuse Prohibition . C. Prevention- the facility is committed to the prevention of abuse, neglect, or misappropriation of property . D. Identification. i. All reported events will be investigated by the Director of Nursing. Patterns or trends will be identified that might constitute abuse. This information will be forwarded to the Administrator, who will serve at the facility's abuse coordinator, and an abuse investigation will be conducted . The above findings were discussed with the facility administrator, director of nursing and corporate staff on 1/23/25. No additional information was provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41449 Based on observation, resident interviews, staff interviews, clinical record review, and facility documentation review, the facility staff failed to review and revise the care plan for two residents (Resident #8-R8 and Resident #16-R16), in a survey sample of 19 residents. The findings included: On 1/22/25 at approximately 9:30 a.m., R8 was interviewed in her room. During the conversation, R8 began making reports of being threatened by the prior administrator. The surveyor requested that the resident allow the surveyor to get someone from facility administration to be a part of the conversation to hear what she was reporting. The facility's interim administrator then accompanied the surveyor back to R8's room. R8 continued to report allegations with regards to the prior facility administrator and then identified resident #16 (R16) by name and reported, [R16's name redacted] says he is going to kill me or says suck my d**k. I don't like it because I wasn't raised like that. I have been molested three times and I just can't handle this! On 1/22/25 -1/23/25, a clinical record review was conducted of R8 and R16's clinical records. According to R8's most recent minimum data set (MDS) (an assessment tool) with an assessment reference date of 12/28/24, R8 scored a 13 out of 15 on the brief interview for mental status, which indicated she was cognitively intact. Review of R8's care plan revealed a focus area initiated 4/9/24, that read, I have stated that other residents' comments have made me uncomfortable. The interventions had not been revised since 5/20/24. Within the progress notes of R8 and R16's clinical records revealed documentation of multiple instances of on-going instances of R8 being a target of R16's behaviors that included threats of physical harm and violence, inappropriate sexual comments/requests, and physical aggression dating back to June 2023. According to facility documentation, an internal investigation was initiated on 1/16/25, regarding R8's having reported an allegation that [R16's name redacted] was verbally inappropriate in making a sexual statement to [R8's name redacted] while they were in the dining room. On 1/22/25-1/23/25, staff interviews included the facility social worker, five CNA's, three nurses, the activities director, and the maintenance director, who had all been aware of and verbalized that R16 has long standing behaviors of saying he is going to blow this place up and shouting, Suck my d*ck. All 11 of the staff interviewed expressed being aware of R16 repeatedly making targeted sexual comments to R8. On 1/23/25, during a follow-up interview, R8 reported being afraid of R16 and gets another resident, identified as Resident #2 to accompany her because she watches out for her. During this interview, R8 was observed breaking eye contact, tucking her head downwards while speaking, with hands slightly trembling. He said, Come on Baby, suck my d*ck! He would say we need to go to bed in his room. I told him, No, but he said, Ok, B*tch, I will just f-ck the hell out of you then! Sometimes I'm afraid to go to sleep. I've gotten so afraid at night, that he is gonna come in here. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25, an interview was conducted with Resident #2 (R2), who reports she has witnessed R16 threaten to hit R8, This can happen daily, [R8] cries and gets upset about it. I have to calm her down. [R8] is scared of him. At times, he says hateful things to her, sometimes he approaches her and intimidates her, and her hands start shaking. She said he makes her very nervous. I try to help and break it up. He says, Suck my d*ck b*tch, I will blow this place up. R2 went on to report that R8 will wake her to go with her to the dining/activity room. R2 reported she is not personally afraid of R16, that R16 has made those comments to her, but [R8] gets so upset, her hands shake. According to R8's care plan, no revisions were made to R8's care plan to include interventions regarding R16's targeted behaviors towards her. There were no interventions within R8's care plan with regards to being a target of R16's aggression and inappropriate sexual comments/abuse. According to R16's care plan, the care plan's most recent revision was 4/23/24, which identified behaviors that included, uses foul language, makes verbal threats to staff and residents. The care plan with the focus area that noted, can be physically abusive to others . was most recently revised on 4/23/24. Another care plan focus area in R16's care plan read, can be verbally abusive to others. When I feel provoked, I can began to swear/cuss. The most recent revision to that care plan focus area was dated 5/15/24. There was no evidence that R16's care plan was reviewed and/or revised following the reported aggression and sexual abuse targeted at R8. On 1/27/25 in the afternoon, an interview was conducted with registered nurse #4 (RN #4), who was the care plan coordinator. RN #4 said that the care plan is a plan of care for the resident and encompasses the entire picture. It serves as a guide to ensure they get the care they need. When asked about the review and revision of care plan(s) frequency, RN #4 said, They are reviewed quarterly and revised as needed because it is an on-going thing. When asked if she would have expected additional interventions to have been put in place following a resident to resident incident, RN #4 stated she would have expected new interventions to have been added to the care plan. When asked why neither of R8's or R16's care plans had been updated or revised, RN #4 stated that she didn't know why they were not reviewed and revised appropriately. According to the facility titled, Care Plan, with a revision date of 4/2024, it read in part, . 7. The comprehensive care plan is reviewed and updated at least every 90 days by the interdisciplinary team . 22. The IDT [interdisciplinary team] is to review the 24-hour report during morning meeting for significant changes or changes in resident's ADL [activities of daily living] status. The IDT will add minor changes in resident's status to the existing care plans . On 1/28/25 at 11:20 a.m., the survey team met with the facility Administrator, Director of Nursing and three corporate management staff to discuss the facility staff had had failed to review and revise the care plans for R8 and R16 to include implementation of interventions following aggressive behaviors and alleged violations of abuse. No additional information was provided.

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	495141	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alleghany Health and Rehab	1725 Main Street Clifton Forge, VA 24422

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 49456 Based on staff interviews, resident interviews, clinical record review, and facility documentation review, the facility staff failed to provide an ongoing activity program to meet the needs of numerous residents on one of three units. The findings included: The facility staff failed to provide daily activities for the 27 residents residing on the memory care unit. On 1/21/25 at 2:00 p.m., an interview was conducted with a license practical nurse, LPN#4 (LPN4). LPN4 was unable to find a January activity calendar on the memory care unit. LPN4 stated that the activity director came on the unit last week and had the activity of watercolors with the residents. LPN4 said, The activity director doesn't come over on this unit daily. The residents get bored and need more things to do, we are kind of the forgotten wing. LPN4 stated that the previous activity director was not on the memory care unit weekly, and activities were seldom conducted on the memory care unit. On 1/21/25 at 2:15 p.m., an interview was conducted with the activity director assistant, other staff #1 (OS1). OS1 stated that she puts up the monthly activity calendars at the beginning of the month on each unit. OS1 said, On memory care there is usually an activity calendar posted. OS1 stated that there is no activity scheduled for today and said, I do activities three to four times weekly, not daily, on memory care. On 1/22/25 at 10:15 a.m., an interview was conducted with Resident #4 (R4). R4 stated that activities were not .what I consider activities . Devotions was at 10 a.m. and no devotions were done. It's just not what it says it's to be. On 1/22/25 at 10:32 a.m., an interview was conducted with Resident #1 (R1). R1 said, Not enough activities going on, needed more activities. Some days we don't have any activities and they don't follow their calendar. Activities have fallen off. On 1/22/25 at 11:00 a.m., an interview was conducted with the administrator. The administrator stated that his expectation of activities on memory care was for activities to be happening daily and to have the residents engaged in the activity. On 1/22/25 at 11:10 a.m., an interview was conducted with the regional vice president of operations (RVPO). The RVPO said, The expectation is for activities to be provided daily, to keep the residents engaged, and that memory care staff should do activities throughout the day also. On 1/22/25 at approximately 4:00 p.m., a review of the memory care residents, Activity Participation Record, was conducted. During the review of 27 residents on the memory care unit's activity participation record, only two residents had three check marks for an activity for the month of January. The other 25 resident's activity participation record sheets were blank and only had the residents name, indicating they had not attended any activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/22/25 at approximately 4:15 p.m., a review of the activity calendar was conducted. The calendar for January only had 3-4 activities a week on the calendar scheduled for the memory care unit. There was three to four days weekly that no activity was scheduled for the memory care unit. The calendar for November and December had two activities for five days of the week for the memory care residents. The morning chatter and activity box were scheduled on the activity calendar for memory care, but the memory care staff stated these activities never took place on the unit. On 1/23/25 at approximately 10:00 a.m. a review of facility documentation was conducted. The grievance log was reviewed with several concerns about activities not being done, not following the calendar, and needing more activities for the residents. The policy titled, Activity Program, read in part, .ongoing program is designed to meet the spiritual, intellectual, emotional, psychosocial and physical needs of each resident. Activities are scheduled daily. Scheduled activities are posted in the facility. On 1/23/25 at 6:00 p.m., an end of day meeting was conducted with the administrator, the director of nursing, and the RVPO, who were made aware of the above concerns. No additional information was provided prior to exit conference.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 49456 Based on observation, staff interviews and facility documentation the facility staff failed to conduct annual performance reviews for one certified nursing assistant (CNA #14) in a sample of three certified nursing assistants reviewed. The findings included: The facility staff failed to complete an annual evaluation yearly on one certified nursing assistant, CNA#14 (CNA14). On 1/28/25 at 10:00 a.m. a review of employee records was conducted. During the review of the employee records CNA14 was hired on 6/12/22 and the first evaluation in her record was completed on 1/27/25, which was after the surveyor had requested the employee files. On 1/28/25 at 11:00 a.m. an interview was conducted with the director of nursing (DON). The surveyor informed the DON that the evaluation had not been completed yearly and that the one in the employee file was completed on 1/27/25 and most of the evaluations was given verbal consent by the employee. The DON stated that the purpose of the annual evaluations was to keep up with the employee's performance and to discuss the area's that may need improvement. On 1/28/25 at 12:30 p.m. a review of facility documentation was conducted. The facility document that was reviewed was a policy titled, Performance Evaluations, read in part, .performance evaluation provides a formal vehicle for the supervisor and the employee to discuss the employee's overall work performance and developmental areas as it relates to the employee's job description. On 1/28/25 at 1:00 p.m. an end of day meeting was held with the administrator, regional vice president of operations, and the director of nursing. They were made aware of the above concerns. No additional information was provided prior to exit conference.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 49456 Based on observation, staff interviews and facility documentation the facility staff failed to post daily staffing information, having the potential to affect residents on 3 of 3 nursing units. The findings included: The facility staff failed to post the daily staffing information for residents and visitors to be able to view. On 1/27/25 at 3:30 p.m. during a walkthrough of the nursing facility the surveyor observed that the daily staffing post were not up to date. The posting that was in the lobby was dated 1/24/25 and the posting at the time clock area was dated 1/22/25. On 1/27/25 at 3:50 p.m. an interview was conducted with the director of nursing (DON). The DON said, the purpose is so anyone can see how many nurses and license staff are in the building for the day. The DON then walked with the surveyor to the areas that she stated the posting were usually posted. The DON went to the B-wing and said, well there isn't one even posted here, and then she went to the time clock and said, that is the wrong date, and then she went to the lobby and said, that is the wrong date also. The DON said, the human resource director posts the staffing and would let him know. On 1/27/25 at 4:15 p.m. an end of day meeting was conducted with the administrator, regional vice president of operations, the director of nursing and other corporate members. During the meeting the above concerns were discussed and the regional vice president of clinical said, the system for the daily postings is messing up so I instructed [human resource director name redacted] to hand write the daily postings and to get those posted. No additional information was provided prior to exit conference.

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NAME OF PROVIDER OR SUPPLIER Alleghany Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 Main Street Clifton Forge, VA 24422	

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **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 provide behavioral health services to two residents (resident #8- R8 and resident #16-R16) in a survey sample of 19 residents. The findings included: 1. For R8, who had psychiatric conditions and was a trauma survivor, the facility failed to provide consistent behavioral health services. On 1/22/25 at approximately 9:30 a.m., R8 was interviewed in her room. During the conversation, R8 began making reports of being threatened by the prior administrator. The surveyor requested that the resident allow the surveyor to get someone from facility administration to be a part of the conversation to hear what she was reporting. The facility's interim administrator then accompanied the surveyor back to R8's room. R8 identified resident #16 (R16) by name and reported, [R16's name redacted] says he is going to kill me or says suck my d*ck. I don't like it because I wasn't raised like that. I have been molested three times and I can't do this! On 1/22/25 -1/23/25, a clinical record review was conducted of R8 and R16's clinical records. R8's diagnosis included, but were not limited to major depressive disorder, insomnia, generalized anxiety disorder, borderline personality disorder, bipolar disorder, and schizoaffective disorder. According to R8's most recent minimum data set (MDS) (an assessment tool) with an assessment reference date of 12/28/24, R8 scored a 13 out of 15 on the brief interview for mental status, which indicated she was cognitively intact. According to a Trauma Informed Care Screen dated 4/21/24 and 5/22/24, R8 reported having been a victim of physical abuse, verbal abuse, emotional neglect, having a family member who was an alcoholic/addict, and sexual violence. The most recent trauma screen noted that R8 answered yes to the following questions: Have you had a nightmare about event(s) or thought about the event (s) when you did not want to? Have you tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? Have you been constantly on guard, watchful, or easily startled? Have you ever felt numb or detached from people, activities, or your surroundings? According to the screening form R8 was asked, What if any mental health treatment have you had in the past? R8's response was recorded as, I see a doctor. According to R8's care plan included interventions that included, but were not limited to, Team Health to provide psych services and medication management, Psychiatric FNP [family nurse practitioner] has [R8's name redacted] on caseload and handles said medication management, Geri Med Psych services in following resident, I have counseling services available to me, Discuss with psych services need for medication and/or medication adjustment, and Coordinate psychology or psychiatric services on admission and as needed . (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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a psychiatry services progress note dated 3/13/24, it read in part, .Staff requested patient be seen today for follow-up as she was reportedly involved with receiving inappropriate comments from another resident a month ago. Patient endorses that she has not had any concerns with the other residents since then. Patient reports that she is always felt on edge and is unsafe in her environment even prior to coming to the facility due to past trauma . On 3/14/24, a note by the psychiatric provider read in part, . Patient continues to endorse difficulty with sleep and now reports that her difficulty with sleep may be associated with feeling uncomfortable about the resident across from her room she has had previous interactions with. Patient reports that they used to go together. At this time, patient does not get along well with this resident, and she feels that patient could get in his wheelchair and rolled into her room. Therefore, patient reports that she does not sleep well at night because of this worry. Patient endorses a history of trauma including abuse from her previous husband. She endorses some intrusive thoughts, flashbacks, and paranoia related to past trauma. Patient does have history of schizoaffective disorder, but patient's paranoia appears to be more related to past trauma at this time. She reports that she has experienced auditory and visual hallucinations at times as well, but none noted at this moment. She endorses that she feels uncomfortable. She also endorses that there was another incident a couple of months ago with a different resident who touched her leg, and she has made this report to staff, and they have made appropriate investigation regarding this as this was just reported to staff yesterday. Patient endorses that she does feel comfortable moving about the facility otherwise. Patient has a friend at present today whom she wanted me to continue to talk with her with the friend present as well. Patient is alert oriented x 3 today. Will give more time for patient's Remeron to help with patient's insomnia and make referral for behavioral health therapist to start work with patient regarding past trauma. Will discuss alternatives with staff in regard to possibly offering patient a room change to a different hall to help her with feeling more comfortable . According to R8's clinical record, she was being seen at least monthly by a psychiatric provider through April 2024. The visits then went to quarterly, with visits noted on 6/20/24 and 9/3/24. There is no evidence that R8 had been seen by any mental health professional since 9/3/24 at the time of this inspection in January 2025. On 1/28/25 at approximately 9 a.m., another interview was conducted with R8. R8 reported, I have been sexually abused when I was [AGE] years old by my dad, then at school a guy molested me. Then I got married and my husband tied me to the bed and brought his buddies in and they cut me inside where I couldn't have kids anymore. It's been one nightmare after another. I wouldn't have another man if he was made of gold. I asked myself, why me? Its so hard to understand why people pick on me. When asked if the facility knew of her history of abuse, R8 said, yes. R8 went on to state that she used to see a psychiatrist regularly which helped but until this week it has been a while since she saw someone. When asked about R16, resident #8 said, he has been after me a while. He pulled his pants down and said, 'I love you baby, and I want you.' He would get in front of me and say, 'I'll kill you b*tch, I will blow you up.' He tried to pour a cup of coffee on me. When asked if she feels safe and that the facility is trying to take measures to protect her, R8 said, At times but not all the time. They should have done more. When this one on one with him stops its going to start right back up with him doing what he is doing, but God is going to take care of me. 2. For R16, who had a long-standing history of mental health issues that included a hospitalization due to behavior, and continued to exhibit on-going behaviors, the facility staff failed to provide ongoing behavioral health services. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #16 (R16), who had a long-standing mental health history, was not being seen routinely by a psychiatric provider. R16's visits were routine until 8/12/24, then had another visit on 10/14/24 and no further visits until hospitalized in December 2024. According to R16's clinical record, the resident's diagnosis included, but were not limited to schizoaffective disorder, delusional disorders, insomnia, unspecified dementia, and major depressive disorder. During R16's most recent hospitalization behaviors were displayed that warranted a psychiatric consult. The note dated 12/7/24, read in part, . was cooperative with care until this morning prior to discharge, he became upset and threatened to blow up the building with people in it. Psychiatry was consulted for concern of this behavior . He states that he has to tell people he is going to kill them so he can go to sleep, but he would never harm anybody . He does state that he was 'cursing and stuff' he apologizes for this . there was concern that reduction in psychotropic medications may have contributed to his decompensation. Nursing staff was able to call and speak with patient's regular nurse at [this nursing facility's name redacted]. She reports that this behavior is typical for him. He will have an outburst like this wanted to time a week [sic] [one to two times a week] . This has quite consistent with behavior witnessed this morning . Patient has a long psychiatric history. He was admitted here in July of 2023 for threatening behaviors and outbursts . R16 has not seen a psychiatric provider since his readmission to the facility on [DATE]. On 1/24/25 at 2:30 p.m., an interview was conducted with the medical nurse practitioner, who is the primary provider at the facility. During this interview, the nurse practitioner said, we have not had an on-site psychiatric provider since I have been here and have only had 1 telehealth psych visit. From what I am told, we now have a psych provider who will be coming. According to the facility assessment provided to the survey team, the facility plan read in part, [Facility name redacted] has a Psychiatric FNP who provides services in the facility a minimum of once weekly and provides on-call services when not in the building . If the resident's needs exceed what the facility can provide, [hospital name redacted] has a psychiatric wing that can provide hospitalization and stabilization for the resident. A Counselor provides services in the facility weekly On 1/28/25, the facility administrator and Regional [NAME] President of Operations (RVPO) reported that they had routine psychiatric services until their provider resigned around mid-October of 2024. They presented a typed document that read, [facility name redacted] entered into an agreement with [psychiatric provider name redacted] on 1/24/24. They provided psychiatric services through 10/14/24, at which time the provider resigned. From 10/14/24 until 1/23/25 [company name redacted] provided telehealth psychiatric services for acute needs and managed day to day by the primary care medical team. They also stated, a new provider visited the facility for the first time on 1/24/25. No further information was provided.

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F 0742

Level of Harm - Immediate jeopardy to resident health or safety

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 41449

Based on observation, resident and staff interviews, clinical record review, and facility documentation review, the facility staff failed to ensure residents with mental disorders and a history of trauma, receive appropriate treatment and services to attain their highest practicable mental and psychosocial well-being for two residents (Resident #8 and Resident #16) in a survey sample of 19 residents.

The fidnings included:

1. For Resident #8 who had a known history of trauma, the facility staff failed to ensure she received appropriate treatment and services, including trauma-informed care, to attain the highest practicable mental and psychosocial well-being.

On 1/22/25 at approximately 9:30 a.m., R8 was interviewed in her room. During the conversation, R8 began making reports of being threatened by the prior administrator. The surveyor requested that the resident allow the surveyor to get someone from facility administration to be a part of the conversation to hear what she was reporting. The facility's interim administrator then accompanied the surveyor back to R8's room. R8 identified resident #16 (R16) by name and reported, [R16's name redacted] says he is going to kill me or says suck my d*ck. I don't like it because I wasn't raised like that. I have been molested three times and I just can't do this!

On 1/22/25 -1/23/25, a clinical record review was conducted of R8's clinical record. R8's diagnosis included, but were not limited to major depressive disorder, insomnia, generalized anxiety disorder, borderline personality disorder, bipolar disorder, and schizoaffective disorder. According to R8's most recent minimum data set (MDS) (an assessment tool) with an assessment reference date of 12/28/24, R8 scored a 13 out of 15 on the brief interview for mental status, which indicated she was cognitively intact.

According to a Trauma Informed Care Screen dated 4/21/24 and 5/22/24, R8 reported having been a victim of physical abuse, verbal abuse, emotional neglect, having a family member who was an alcoholic/addict, and sexual violence. The most recent trauma screen noted that R8 answered yes to the following questions: Have you had a nightmare about event(s) or thought about the event (s) when you did not want to? Have you tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? Have you been constantly on guard, watchful, or easily startled? Have you ever felt numb or detached from people, activities, or your surroundings? According to the screening form R8 was asked, What if any mental health treatment have you had in the past? R8's response was recorded as, I see a doctor.

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to R8's care plan included interventions that included, but were not limited to, Team Health to provide psych services and medication management, Psychiatric FNP [family nurse practitioner] has [R8's name redacted] on caseload and handles said medication management, Geri Med Psych services in following resident, I have counseling services available to me, Discuss with psych services need for medication and/or medication adjustment, and Coordinate psychology or psychiatric services on admission and as needed . According to R8's care plan, on 4/21/24 a Trauma Informed Care focus area was implemented in R8's care plan. The interventions read as, Coordinate psychology or psychiatric services on admission and as needed, Encourage to express feelings, concerns and thoughts in a private 1:1 setting., If increase in anxiety or sudden mood change occurs please observe for potential triggers and document., Provide meaningful activities- I enjoy Bingo, spending time with my friends, coloring, completing crafts, decorating my room, assisting in decorating the bulletin board, etc., and When I experience a trigger I often cry. Please observe for any environmental factors that could have been triggering to Resident and document. There was no evidence of identification of R8's triggers, nor any interventions with regards to R16's repeated abusive behaviors towards this resident. According to a psychiatry services progress note dated 3/13/24, it read in part, .Staff requested patient be seen today for follow-up as she was reportedly involved with receiving inappropriate comments from another resident a month ago. Patient endorses that she has not had any concerns with the other residents since then. Patient reports that she is always felt on edge and is unsafe in her environment even prior to coming to the facility due to past trauma . On 3/14/24, a note by the psychiatric provider read in part, . Patient continues to endorse difficulty with sleep and now reports that her difficulty with sleep may be associated with feeling uncomfortable about the resident across from her room she has had previous interactions with. Patient reports that they used to go together. At this time, patient does not get along well with this resident, and she feels that patient could get in his wheelchair and roll into her room. Therefore, patient reports that she does not sleep well at night because of this worry. Patient endorses a history of trauma including abuse from her previous husband. She endorses some intrusive thoughts, flashbacks, and paranoia related to past trauma. Patient does have history of schizoaffective disorder, but patient's paranoia appears to be more related to past trauma at this time. She reports that she has experienced auditory and visual hallucinations at times as well, but none noted at this moment. She endorses that she feels uncomfortable. She also endorses that there was another incident a couple of months ago with a different resident who touched her leg, and she has made this report to staff, and they have made appropriate investigation regarding this as this was just reported to staff yesterday. Patient endorses that she does feel comfortable moving about the facility otherwise. Patient has a friend at present today whom she wanted me to continue to talk with her with the friend present as well. Patient is alert oriented x 3 today. Will give more time for patient's Remeron to help with patient's insomnia and make referral for behavioral health therapist to start work with patient regarding past trauma. Will discuss alternatives with staff in regard to possibly offering patient a room change to a different hall to help her with feeling more comfortable . According to R8's clinical record, she was being seen at least monthly by a psychiatric provider through April 2024. The visits then went to quarterly, with visits noted on 6/20/24 and 9/3/24. There is no evidence that R8 had been seen by any mental health professional since 9/3/24 at the time of this inspection in January 2025, nor was there any reference to a room change. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/23/25, during a follow-up interview, R8 reported being afraid of R16 and gets another resident, identified as Resident #2, to accompany her because .she watches out for me. During this interview, R8 was observed breaking eye contact, tucking her head downwards while speaking, with hands slightly trembling. He said, 'Come on Baby, suck my d-ck!' He would say we need to go to bed in his room . I told him No! and he said, Ok, B-tch, I will just f-ck the hell out of you then! Sometimes I'm afraid to go to sleep. I've gotten so afraid at night, that he is gonna come in here. On 1/23/25, an interview was conducted with R2, who reports she has witnessed R16 threaten to hit R8, this can happen on a daily basis, she cries and gets upset about it, I have to calm her down. She (R8) is scared of him. At times, he says hateful things to her, sometimes he approaches her and intimidates her . her hands start shaking. [R8] said he makes her very nervous; I try to help and break it up. He says, Suck my d-ck b-tch, I will blow this place up. R2 went on to report that R8 would wake her up to go with her to the dining/activity room. R2 reported she is not personally afraid of R16, that R16 used to say those things to her, .but R8 gets so upset her hands shake. On 1/28/25 at approximately 9 a.m., another interview was conducted with R8. R8 reported, I have been sexually abused when I was [AGE] years old by my dad, then at school a guy molested me. Then I got married and my husband tied me to the bed and brought his buddies in and they cut me inside where I couldn't have kids anymore. It's been one nightmare after another. I wouldn't have another man if he was made of gold. I asked myself, why me? Its so hard to understand why people pick on me. When asked if the facility knew of her history of abuse, R8 said, Yes. R8 went on to state that she used to see a psychiatrist regularly which helped but until this week it has been a while since she saw someone. When asked about R16, R8 said, He has been after me a while. He pulled his pants down and said, 'I love you baby, and I want you.' He would get in front of me and say, 'I'll kill you b*tch, I will blow you up.' He tried to pour a cup of coffee on me. When asked if she feels safe and that the facility is trying to take measures to protect her, R8 said, At times but not all the time. They should have done more. When this one on one with him stops, its going to start right back up with him doing what he is doing, but God is going to take care of me. 2. For Resident #16, with known behaviors, the facility staff failed to provide appropriate treatment and services to correct the assessed problem for a resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty. Resident #16 (R16), who had a long-standing mental health history, was not being seen routinely by a psychiatric provider. R16's visits were routine until 8/12/24, then had another visit on 10/14/24 and no further visits until hospitalized in December 2024. According to R16's clinical record, the resident's diagnosis included, but were not limited to schizoaffective disorder, delusional disorders, insomnia, unspecified dementia, and major depressive disorder. Review of R16's clinical record revealed an entry dated 1/15/25 that read, resident cursing at another resident in dining room. he returned to his room. currently q15 minute checks. his mood at this time is pleasant and cooperative. According to R16's care plan, behaviors to include I can be physically abusive to others. I have a HX of assaultive behavior towards staff and throwing items (cups, etc.) at other residents, I can be verbally abusive to others. When I feel provoked, I can began [sic] to swear/cuss, I am to have my coffee placed in a thermal blue mug with a tight fitting lid. I have a history of tossing my coffee at others when I become agitated. Initiated on 10/23/23, the most recent revision to R16's behavioral care plan was performed on 5/15/24. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to interviews conducted by the survey team, the facility social worker, five CNA's, three nurses, the activities director, and the maintenance director had all been aware of and verbalized that R16 has long standing behaviors of saying he is going to blow this place up and shouting, Suck my d-ck. All 11 of the staff interviewed also expressed being aware of R16 making targeted sexual comments to R8 repeatedly. When asked about interventions implemented to address these inappropriate behaviors, staff stated that 15 min checks were done, but mostly offering snacks works, and that sometimes R16's escalating behaviors required the removal of the other residents from the dining room, which is where he likes to sit the most. According to the facility social worker, who also serves as the grievance coordinator, another resident, identified as R18, had also verbalized being upset about R16's ongoing verbally aggressive and sexually inappropriate comments in the dining/activity room. When questioned about R16's behaviors, the facility social worker stated that R16 is easily agitated, yells, curses, but stated that she doesn't know how to stop the cursing and allow him freedom of expression. According to the facility social worker, another resident (identified as Resident #18) had expressed concerns and had been upset about R16's verbal comments. R18 was interviewed on 1/23/25 and reported that R16 was yelling and cursing R8 and it upset her. R18 said she started to pray and avoids him (R18) because his cursing and yelling upsets her. According to nursing staff working the unit where R16 lives, R16 was placed on 15-minute checks. According to the facility documentation the checks were performed 1/15/25 from 4:45 p.m., until they were discontinued on 1/17/25 at 6:45 p.m. No explanation was provided as to why the checks were started or stopped. Staff was unable to identify any non-pharmalogical safeguards that were implemented to prohibit or prevent further potentially abusive behaviors. Each day of survey, R16 was observed to ambulate independently throughout the facility on two of three nursing units and in the dining room, without any direct supervision or restricted access to R8, whom he was known to target. According to R16's clinical record, the resident has diagnosis to include, but not limited to: schizoaffective disorder, dementia, delusional disorder, and major depressive disorder. According to a psychiatric progress note dated 7/29/24, R16 had a verbal altercation recently with another resident . staff report increased mood liability. R16 was last seen by a psychiatric provider on 12/7/24 while hospitalized , which noted in part, . confused at baseline but was cooperative with care until this morning prior to discharge, he became upset and threatened to blow up the building with people in it. Psychiatry was consulted for concern of his behavior . he states that he has to tell people he is going to kill them so he can go to sleep .Nursing staff was able to call and speak with the patient's regular nurse at [this nursing facility name redacted]. She reports that this behavior is typical for him . Patient has a long psychiatric history. He was admitted here in July of 2023 for threatening behaviors and outbursts . At the time of R16's discharge from the hospital, according to the psychiatry note and discharge summary, the hospital recommended R16's Seroquel dose return to previous dose of 250 mg twice daily to help maintain stability. Upon readmission to the facility on [DATE], R16 was receiving 50 mg of Seroquel three times daily until 12/27/24, when it was increased to 100 mg three times daily. As of 1/24/25, R16 continues to receive Seroquel 100 mg three times daily. R16's clinical record indicated no psychiatric services since R16 was readmitted on [DATE]. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/24/25 at 2:30 p.m., an interview was conducted with the medical nurse practitioner, who is the primary provider at the facility. During this interview, the nurse practitioner said, We have not had an on-site psychiatric provider since I have been here and have only had 1 telehealth psych visit. From what I am told, we now have a psych provider who will be coming. On 1/24/25 at 10:35 a.m., the survey team identified the facility was in immediate jeopardy and substandard quality of care, as confirmed by the state agency. The survey team met with the administrator, director of nursing, and corporate staff to make them aware that Immediate Jeopardy (IJ) was identified for failure to ensure residents with mental disorders and a history of trauma, receive appropriate treatment and services to attain their highest level of well-being. Specifically, IJ was determined to have started on 4/21/24, when R8 had a trauma screening that identified her past trauma and facility staff were made aware but failed to identify her triggers and how R16's repeated aggression towards her affects her and what interventions facility staff were to employ in those instances. On 1/24/25 at 6:15 p.m., the facility submitted an approved IJ removal plan that read as follows: The facility has taken immediate action to ensure residents who display behaviors or those who are diagnosed with mental disorder or psychosocial adjustment difficulty, as well as those who have a history of trauma and/or post-traumatic stress disorder, receive appropriate treatment and services to effectively address the assessed problems. 1. For Resident #8 Psychosocial assessments were completed Psych services was on-site to see resident. 2. For Resident #16 Psychiatric Services were onsite to see resident. Completed review of Resident #16 medications and changes made to psychotropic dosing. Resident has been placed on 1-1 to provide diversion if behaviors are exhibited. 3. Will identify residents that have exhibited behaviors in the last 7 days, residents with the diagnosis of PTSD, residents with a history of trauma and/or a mental disorder. The care plans of those residents identified above will be reviewed to ensure they have the appropriate interventions and updated as indicated. They will also refer to psych services as indicated. 4. All current residents will be reviewed to ensure they have received a trauma screening to identify triggers and care plans updated as indicated. 5. Medical Director notified. 6. Completion 1/24/25 at 11:59 p.m. On 1/27/25, the survey team completed the following to verify that the immediate jeopardy had been abated: Observations were made of R16 to ensure 1:1 supervision was being provided. A review of the logs from 1/24/25-1/27/24, were reviewed, which indicated R16 had been on continuous 1:1 supervision. R16's clinical record did reveal that R16's Seroquel dose had been increased on 1/24/25, to the pre-hospitalization dosage of 250 mg, BID [twice daily]. Progress notes from the psychiatric provider was reviewed to ensure Resident #16 and Resident #18 was seen. An audit of 100% of the residents was conducted to ensure each resident had a trauma screening. The residents the facility identified as having had behaviors in the past 7 days, those with a diagnosis of PTSD, and a history of trauma and/or a mental disorder were compared to the list of referrals made to the psychiatric provider. It was identified that psychiatric service referrals were not made until 1/27/25 and that numerous residents identified by the facility staff were not referred for psych services. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Alleghany Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 Main Street Clifton Forge, VA 24422	

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A sample of the residents identified with behaviors, diagnosis of PTSD, and a history of trauma or a mental disorder was selected. The care plans for each of those sampled residents was reviewed to ensure interventions were in place for the identified area of concern. On 1/27/25 at 2:30 p.m., the facility administrator, director of nursing, and corporate staff were made aware that because multiple residents identified by the facility staff as being in the identified groups were not referred to psych services, the survey team was not able to abate IJ at F742. On 1/27/25 at approximately 4 p.m., the facility presented the survey team with a revised IJ removal plan that had a completion date of 1/27/25 at 4:45 p.m. On 1/28/25, the survey team again compared the list of residents identified with behaviors, diagnosis of PTSD, history of trauma, and/or mental disorders were referred to psych services. The previously identified residents who had not been interviewed were interviewed by facility staff and the omitted residents had been referred to psych services. Thus, verifying full implementation of the abatement plan and that the risk for serious injury, serious harm, serious impairment, or death had been eliminated, IJ was removed on 1/28/25 at 9:15 a.m., with the scope and severity of the remaining noncompliance lowered to a Level Three, Isolated. According to the facility assessment provided to the survey team, the facility plan read in part, [Facility name redacted] has a Psychiatric FNP who provides services in the facility a minimum of once weekly and provides on-call services when not in the building . If the resident's needs exceed what the facility can provide, [hospital name redacted] has a psychiatric wing that can provide hospitalization and stabilization for the resident. A Counselor provides services in the facility weekly On 1/28/25, the facility administrator and Regional [NAME] President of Operations (RVPO) reported that they had routine psychiatric services until their provider resigned around mid-October of 2024. They presented a typed document that read, [facility name redacted] entered into an agreement with [psychiatric provider name redacted] on 1/24/24. They provided psychiatric services through 10/14/24, at which time the provider resigned. From 10/14/24 until 1/23/25 [company name redacted] provided telehealth psychiatric services for acute needs and managed day to day by the primary care medical team. They also stated, a new provider visited the facility for the first time on 1/24/25. No further information was provided.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49456 Based on observation, staff interviews, resident interviews, and facility documentation, the facility staff failed to provide meals at an appetizing temperature for residents on one of three units. The findings included: The staff failed to serve residents food that reached an appropriate temperature to be appetizing. On 1/21/25 at 11:45 a.m., a tour of the kitchen was conducted. During the tour the temperature logs were reviewed and the steam table where the food was being served. No issues were noted during the tour. On 1/21/25 at 12:15 p.m., the lunchtime meal was observed. The meal cart reached the A-wing at 12:20 p.m. The surveyor had requested a test tray be placed on the meal cart, and the test tray was obtained at 12:35 p. m., as the last resident tray was being served. The meal served was a cheeseburger, mashed potatoes, cole slaw, and a fruit bowl. The regional dietary manager was present, and temperatures were obtained. The hot foods were observed as not reaching the proper temperatures. The cheeseburger temperature was 90 degrees, and mashed potatoes were 120 degrees. The temperatures were obtained of the cold foods and no concerns were noted. The surveyor and regional dietary manager both took bites of each of the food items and the regional dietary manager agreed, the meal was not appetizing in appearance, taste, or temperature. The cheeseburger and mashed potatoes were cold, observing that the cheese was not melted on the burger. On 1/21/25 at 12:45 p.m., an interview was conducted with the district dietary manager. The district dietary manager said, The meal is not appetizing, and we need to change how they plate the food. On 1/22/25 at 10:15 a.m., an interview was conducted with Resident #3 (R3). R3 said, The food is lousy and lukewarm a lot of the times, that's the way they serve the food. On 1/22/25 at 10:32 a.m., an interview was conducted with Resident #1 (R1). R1 said, Food is cold when served. Menus are not followed, and a lot of people don't eat the food. On 1/22/25 at approximately 2:00 p.m. a review of facility documentation was conducted. The facility document titled, Serving Food, read in part, .serve food at the proper temperatures, attractively and under sanitary conditions. Foods should be maintained on serving line outside the danger zone (below 41 degrees Fahrenheit or above 135 degrees or 140 degrees Fahrenheit per state guidelines). On 1/22/25 at 4:30 p.m., an end of day meeting was conducted with the administrator, director of nursing, and regional vice president of operations, during which the above concerns were discussed. No additional information was provided prior to exit conference.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **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 effectively administer the facility to ensure residents are free from abuse and fully implement their abuse policy, having the potential to affect residents on 2 of 3 nursing units. The findings included: 1. For Residents #8, who suffered psychosocial harm, the facility administrator, who is the facility's abuse coordinator and was aware of R16's on-going behaviors resulting in mental abuse, verbal abuse, and sexual abuse, failed to implement effective corrective measures to protect all the residents sharing the same common areas with Resident #16, who was the alleged perpetrator. On 1/22/24 at approximately 9:30 a.m., during an interview with resident #8 (R8), the resident verbalized to the surveyor and facility administrator that Resident #16 (R16) had told R8 to Suck my di*k. R8 went on to state that she had been molested three times in the past and I just can't handle this. The administrator was observed making notes during this interview. A comprehensive review of R8's chart documented that facility staff had been aware of R8's history of abuse and trauma according to a Trauma Informed Care Screen dated 4/21/24 and another dated 5/22/24. In those assessments R8 reported having been a victim of physical abuse, verbal abuse, emotional neglect, having a family member who was an alcoholic/addict, and sexual violence. The most recent trauma screen noted that R8 answered Yes to the following questions: Have you had a nightmare about event(s) or thought about the event (s) when you did not want to? Have you tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? Have you been constantly on guard, watchful, or easily startled? Have you ever felt numb or detached from people, activities, or your surroundings? According to the screening form R8 was asked, What if any mental health treatment have you had in the past? R8's response was recorded as, I see a doctor. However, no triggers were identified or interventions to implement trauma informed care, as well no recent psych services to support R8's mental health needs. According to R8's nursing progress notes, multiple entries were noted that documented that R8 had been a victim of abuse by R16. On 6/10/23 at 8:20 p.m., an entry was noted in R16's chart that documented that it took three persons to restrain R16 from physically attacking R8, while cursing and threatening to kill her. The note also documented, Resident continued with threatening behaviors and began to threaten his family . Squad was called, and resident was sent to ER [emergency room]. According to R8's chart, a note dated 6/25/23 documented that R8 was found in her room crying, indicating that R16 had rolled over her foot with his wheelchair. This nurses' note indicated that R8 had reported that R16 had threatened her life and that she didn't feel safe, which was reported to the RN Supervisor, who came into the facility to access the altercation. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R16's chart documented a note on 6/25/23, which read, Resident kicked resident [R8's medical record number redacted] rolling walker in the dining room after [R8's medical record number redacted] did not move it out of his way. Resident was also threatening to kill everyone and blow up the building when asked to leave the dining room RN supervisor was called in to help with the situation between the two residents. Will continue to observe resident. On 10/22/23, a nursing entry in R16's documented that R16 had thrown coffee on R8 and that both the on-call nurse and administrator had been notified of the altercation. According to facility documentation, a facility investigation was initiated on 1/16/25, regarding R8 reporting that R16 had made sexually inappropriate comments to her. On 1/21/25, a note was entered that read, During this time SSD (social services director) spoke with [R8's name redacted] after hearing her yell at another Resident [R16's medical record number redacted] to shut up across the hallway from her room. SSD let [R8's name redacted] know that she needed to be respectful of other Residents. The issue resolved following discussion. No further exploration of what preceded the outburst was documented. Starting 1/22/25 at 10:09 a.m., staff interviews conducted by the survey team included the facility social worker, five CNA's, three nurses, the activities director, and the maintenance director had all been aware of and verbalized that R16 has long standing behaviors of saying he is going to blow this place up and shouting, Suck my d*ck. All 11 of the staff interviewed expressed being aware of R16 making targeted sexual comments to R8 repeatedly. When asked about interventions implemented to address these inappropriate behaviors, staff stated that 15 min checks were done, but mostly offering snacks works, and that sometimes R16's escalating behaviors required the removal of the other residents from the dining room, which is where he likes to sit the most. Some of the staff reported that the prior Administrator, who was in that role until just a month ago, would go to [NAME] and buy R16 chicken to calm him down. was conducted with the facility's social worker (SW). When asked if she had any knowledge about R8 being a victim of sexual abuse, the SW said, I do recall her mentioning she had an ex-significant other that she had issues with. On 1/22/25-1/23/25, a clinical record review was conducted of R16's chart. This review revealed numerous entries notating behaviors that occurred in the presence of, or directed at other residents, in addition to almost daily refusals of treatment and medications. The notes were dated, 4/16/23, 4/17/23, 4/25/23, 5/6/23, 5/10/23, 5/14/23, 5/19/23, 6/8/23, 6/9/23, 6/10/23, 6/11/23, 6/12/23, 6/17/23, 6/22/23, 6/23/23, 6/25/23, 6/26/23, 6/29/23, 7/22/23, 7/23/23, 7/27/23, 7/28/23, 9/5/23, 9/29/23, 9/30/23, 10/2/23, and 10/11/23. On 10/23/23, 11/3/23, 11/6/23, 11/8/23, 12/2/23, 12/6/23, 1/5/24, 2/3/24, and on 3/22/24, scissors were removed from R16's possession. Additional entries regarding R16's behaviors were dated 3/24/24, 6/8/24, 7/6/24, 10/2/24, 11/9/24, and 11/25/24. A note dated 12/9/24 documented that R16 threw his oxygen tank, knocked over his dresser, and rammed his wheelchair into his neighbor's door, including that residents were complaining about his verbal abuse. No evidence was found that the facility had taken any action to implement safeguards to protect the targeted residents or to adequately investigate the documented resident to resident incidents. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At the time of the survey being conducted in January 2025, there was no evidence that R16 had not seen a psychiatrist since hospitalization in early December 2024. According to the hospital discharge summary and psychiatry consultation dated 12/7/24, both documents directed that R16's Seroquel dose return to the prior dosage of 250 mg twice daily. According to R16's physician orders and medication administration records, upon readmission to the nursing facility R16 was receiving 50 mg three times daily from 12/8/24-12/27/24. On 12/27/24, the Seroquel dose was increased to 100 mg three times daily. On 1/23/25 at approximately 10 a.m., an interview was conducted with the facility administrator and Regional [NAME] President of Operations (RVPO). The administrator was asked, can you tell me what abuse is? The administrator said, Not off the top of my head, I would like to refer to my policy. The administrator was asked the same question regarding neglect and gave the same response, wanting to refer to the policy. When asked the same questions, the RVPO defined abuse as willful intent causing harm and neglect as willful intent to not provide something. When asked if a resident had to suffer harm for it to be considered abuse, the RVPO stated, No. On 1/23/25 at approximately 11:30 a.m., during an interview with certified nursing assistant #15 (CNA #15) and CNA #16, both reported R16 took the oxygen tank out to throw at us, we ran up the hall. CNA #15 stated they got the administrator to intervene, as they were both scared that R16 would throw the oxygen tank, but neither CNA #15 & CNA #16 could recall specifically when the incident occurred. On 1/23/25, during a later interview with the facility administration, the administrator, and director of nursing discussed that a daily meeting is held with the management team and interdisciplinary team, during which progress notes and grievances are reviewed. On 1/23/25, during a follow-up interview, R8 reported being afraid of R16 and gets another resident, identified as Resident #2, to accompany her because .she watches out for me. During this interview, R8 was observed breaking eye contact, tucking her head downwards while speaking, with hands slightly trembling. He said, 'Come on Baby, suck my d-ck!' He would say we need to go to bed in his room . I told him No! and he said, Ok, B-tch, I will just f-ck the hell out of you then! Sometimes I'm afraid to go to sleep. I've gotten so afraid at night, that he is gonna come in here. On 1/23/25, an interview was conducted with Resident #2 (R2), who reported that she has witnessed R16 threaten to hit R8, This can happen daily, [R8] cries and gets upset about it. I have to calm her down. [R8] is scared of him. At times, he says hateful things to her, sometimes he approaches her and intimidates her, and her hands start shaking. She said he makes her very nervous. I try to help and break it up. He says, Suck my d-ck b-tch, I will blow this place up. R2 went on to report that R8 would wake her to go with her to the dining/activity room. R2 reported she is not personally afraid of R16, and that he used to say that stuff to her, .but R8 gets so upset her hands shake. On 1/23/25 at approximately 6 p.m., the survey team met with the facility administrator, director of nursing, and corporate level staff. When questioned about facility actions regarding R16's abusive behaviors, the administrator, DON, regional vice-president of operations, and the regional clinical director all stated that they had not been aware that the behaviors had been to the level of severity as shared by the survey team and indicated that R16 would be put on 1:1 supervision immediately. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/23/25, the facility administrator provided the survey team with a copy of a facility incident summary and investigation initiated on 1/16/25, which was completed on 1/22/25. Review of this documentation revealed that during the investigation, the facility had not interviewed other residents to determine if they had been affected by R16's behaviors. The facility had also not interviewed facility staff or reviewed R16's chart to determine the severity of R16's behaviors. When questioned about facility actions regarding R16's aggressive behaviors, the administrator, DON, the regional vice-president of operations, and the regional clinical director all stated that they had not been aware that the behaviors had been to this severity and involved prior incidents with other residents, but indicated that R16 would be put on 1:1 supervision immediately. When requested, the facility administration had no evidence that measures had been implemented to protect residents, that interventions had been implemented to prevent or prohibit further abuse violations, or that all allegations of abuse had been reported or investigated as required. On 1/24/25 at 2:30 p.m., an interview was conducted with the nurse practitioner (NP). The NP was asked about R16's behaviors and Seroquel dosing. The NP stated she was not aware of the order/recommendation from the hospital for R16's Seroquel to return to the dose of 250 mg twice daily and stated had she seen the addendum with that recommendation she would have followed it because, I do follow what is on the hospital discharge summary. The NP also stated she was aware of R16 having some behaviors, but it had been reported the behaviors were related to his pain management and had just increased his Gabapentin. The NP said, We have not had an on-site psych provider since I started in December. We have only had 1 telehealth psych visit; from what I am told we now have a psych provider starting. The NP went on to state that she was not aware of R16 making abusive sexual comments to other residents or the instances of R16 attempting to throw his oxygen cylinder. On 1/28/25, the RVPO stated, in the review of R16's clinical chart, they had identified multiple instances of behaviors that rose to the level of being reported as abuse and would be preparing a report to cover each of the occurrences. 2. For R17, who reported an allegation of abuse and neglect by which certified nursing assistant #1 (CNA #1), which resulted in psychosocial harm, the facility administrator reviewed and signed off on the grievance without effectively responding to the allegations. On 1/22/25, during a review of facility documentation, it was noted that on 1/19/25, R17 reported an allegation of verbal abuse and neglect by CNA #1 to the nurse, who completed a grievance form. Within the grievance documentation it read, CNA [CNA #1's name redacted] became very smart and rude with resident when she asked to have her shower. Resident shower days are designated to Monday and Thursday. However, resident wanted one due to feeling unsanitary. Resident was very upset and even called her husband wanting to go home . resident became very emotional . Resident became hesitant on using her call light as well, because she didn't want any more attitude. According to a document dated 1/20/25, where the social worker interviewed R17, it was noted, Resident reports that when the aide came in and spoke to her about getting a shower Saturday the aide was very rude and told her 'Absolutely not tonight' and continued to state that 'Saturday was not her day' for a scheduled shower. [R17's name redacted] also reported that later that night she had an accident and needed to be changed she said that the other aide came in and told her that she was passing snacks and would have to come back after doing that to assist her. I don't want her in here if she's going to talk to me like that. Resident is concerned other people are being talked to that way. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/22/25 at 3:25 p.m., during a meeting with the facility administrator, director of nursing, and Regional [NAME] President of Operations, they were asked to explain the protocol when an allegation of abuse is brought forward. The administrator explained that it goes on a facility reported incident form, We start an investigation and report the incident. On 1/23/25 at 8:45 a.m., an interview was conducted with R17. R17 was very complimentary of the care she has received at the facility. When asked about the incident involving CNA #1, R17 said, I was told when I came that Wednesday and Saturdays were my shower days. I was so excited and told my husband I was going to get a shower. It was about 8:15 p.m., I rang to see when I would get the shower. She [CNA #1] came in and said, 'absolutely not, no ma'am, I'm not giving you a shower tonight. Tuesday and Fridays was your shower day and tomorrow, Sunday is the makeup day. I called my husband crying and told him to come get me. Thank God they had me medicated. This girl needs to know if I have to deal with her, I will slap her. If she talks to me like this, how is she talking to other residents. The next day my husband called and said I had 2 choices; I could tell them, or he would be down here Monday morning. The next morning [nurse's name redacted, identified as registered nurse #2- RN #2] came in and knew something was wrong. I burst out crying. Sunday when [certified nursing assistant #4's name redacted] got her stuff done, she gave me a shower. On 1/23/25, the facility social worker said during an interview that she felt the allegation rose to the level of abuse and neglect. She said when this happens, she takes the grievance to the administrator and in this case took R17's grievance to the administrator, who was the abuse coordinator. However, the facility administrator failed to respond to the incident as an allegation of abuse and treated it as a grievance. When asked about R17's abuse allegations, the facility administrator reported that he considered it a poor customer service issue, indicating that he had not reported or investigated the allegations. The administrator said, I may be wrong, but I will have to live with that. A review of CNA#1's timecard revealed that she continued to work, without any suspension, and was not restricted from having access to R17 and other residents. The job description of the facility administrator was reviewed. It read in part, General Purpose: To lead and direct the overall operations of the facility in accordance with customer needs, government regulations and company policies, with focus on maintaining excelling care for the residents while achieving the facility's business objectives. Oversee regular rounds to monitor delivery of nursing care, operation of support departments, cleanliness and appearance of the facility; morale of the staff; and ensure resident needs are being addressed . Protect residents from neglect, mistreatment, and abuse . According to the facility's abuse policy, it noted in section 2. Types of Abuse: . G. Mental Abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. H. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability . (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's abuse policy went on to read in part, . G. Procedure for Reporting Abuse. i. All incidents of resident abuse are to be reported immediately to the licensed nurse in charge, Director of nursing, or the Administrator. Once reported to one of those three officials, the prescribed forms are to be completed and delivered to the Abuse Coordinator or his/her designee for an investigation. ii. The facility shall report to the state agency and one or more law enforcement entities any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. iii. And if the events that caused the suspicion resulted in serious bodily injury the facility must report within 2 hours after forming the suspicion. If the events that caused the suspicion did NOT result in serious bodily injury the facility shall report within 24 hours The facility administration was or should have been aware of R16's ongoing behavioral issues, that R8 being a target of his behaviors on numerous occasions, and that other residents were being subjected to frequent abusive behaviors, particularly if the facilty's abuse policies and procedures had been fully implemented to conduct thorough investigations, to report alleged violations as required, and to implement safeguards to protect all residents from further potential abuse/neglect. The administrator was also aware of R17's allegations as indicated by his signature on the grievance form. Despite the knowledge of these allegations, the facility administrator failed to administer the facility in a manner to ensure abuse policies and procedures were fully implemented, to ensure residents were free from abuse, protected from alleged perpetrators, and that residents received appropriate services for their conditions/behaviors. On 1/28/25, mid-morning, the facility's administrator, director of nursing, and corporate staff was made aware of the concern that the facility was not being effectively administered. No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alleghany Health and Rehab	1725 Main Street Clifton Forge, VA 24422

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 41449 Based on staff interview and facility documentation review, the facility staff failed to have credible evidence that the facility assessment was reveiwed at least annually and failed to ensure that the facility assessment involved the appropriate participants, which had the potential to affect all operations and residents residing on 3 of 3 nursing units. The findings included: The facility staff failed to have credible evidence of the active involvement of direct care staff and solicit input from residents, resident representatives, and family members in the development of the facility assessment and that it was reviewed annually. On 1/27/25, a review of the facility assessment was conducted. This review revealed no evidence of when the facility assessment had been last reviewed and who had been involved in that process. Within the facility assessment the data listed included Quality Measure reports dated December 2018-February 2019, and August 2023-October 2023. The facility Administrator and Regional [NAME] President of Operations (RVPO) were asked to provide the survey team with the details of when it was reviewed and who was involved. On 1/27/25, in the afternoon the facility Administrator and RVPO told the survey team that they had been unable to find any further information with regards to the facility assessment. The Administrator stated it had been uploaded online in July 2024, so they can only assume it was discussed around that time frame. However, they had no evidence of who was involved in the process and development/revision of the facility assessment. On 1/28/25 at 11:20 a.m., the survey team met with the facility administrator, Director of Nursing and three corporate management staff to discuss that the facility had failed to provide credible evidence of direct care staff, residents, resident representatives or family members being involved and/or their input being solicited for the development of and/or review of the resident assessment and it being reviewed annually. The facility policy titled, Facility Assessment was received and reviewed. The document read in part, . The facility will review and update the facility assessment, as necessary, and at least annually . II. Scheduling of assessment and on-going process requirements: The governing body will assist with completion of the facility assessment. Members of the governing body include, but are not limited to the regional and corporate team . There was additional pages titled, Facility Assessment Addendum, which read in part, . Facility Assessment Meeting Planning: Meeting #1- discuss the purpose of the facility assessment, what information you will need from each member, decide who will be included and plan how you will engage the residents, RR's [resident representatives] and families- discuss a timeframe to gather the information to discuss in meeting #2 . No additional information was provided.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 41449 Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to utilize outside resources to ensure ongoing psychiatric services were available to residents needing such service, having the ability to affect residents on 3 of 3 nursing units. The findings included: The facility staff failed to provide outside resources to ensure ongoing and consistent psychiatric services were available to all residents who may have required mental health services, as they had no routine provider from October 2024 until 1/23/25. On 1/24/25 at 2:30 p.m., an interview was conducted with the medical nurse practitioner, who is the primary provider at the facility. During this interview, the nurse practitioner said, We have not had an on-site psychiatric provider since I have been here and have only had 1 telehealth psych visit. From what I am told, we now have a psych provider who will be coming. According to the facility assessment provided to the survey team, the facility noted, Resident/Facility Data which noted, 66 residents with dementia, 9 with sundowners, 32 with a behavioral health diagnosis and 32 being seen by behavioral health services. The facility plan read in part, [Facility name redacted] has a Psychiatric FNP who provides services in the facility a minimum of once weekly and provides on-call services when not in the building . If the resident's needs exceed what the facility can provide, [hospital name redacted] has a psychiatric wing that can provide hospitalization and stabilization for the resident. A Counselor provides services in the facility weekly On 1/28/25, the facility administrator and Regional [NAME] President of Operations (RVPO) reported that they had routine psychiatric services until their provider resigned around mid-October of 2024. A new provider visited the facility for the first time on 1/24/25. During the time from mid-October through January 23, 2025, the facility only had telehealth visits and management of mental health issues by the medical providers. No further information was provided.

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 41449 Based on staff interview, the facility staff failed to maintain an active transfer agreement with a hospital, having the potential to affect residents on 3 of 3 nursing units. The findings included: On 1/27/25 at approximately 9 a.m., the facility administrator was asked to provide the survey team with a copy of their transfer agreement. On 1/27/25 in the mid-morning, the survey team was asked to provide clarification to the Administrator and corporate staff regarding the transfer agreement requested. The surveyor explained that the hospital transfer agreement as required in federal regulation F843 was being reviewed as part of the extended survey and was requested for review to determine compliance. According to the facility assessment provided to the survey team, the facility noted, Resident/Facility Data which noted, 66 residents with dementia, 9 with sundowners, 32 with a behavioral health diagnosis and 32 being seen by behavioral health services. The facility plan read in part, . If the resident's needs exceed what the facility can provide, [hospital name redacted] has a psychiatric wing that can provide hospitalization and stabilization for the resident On the afternoon of 1/27/25, the administrator returned the paper, which listed the survey team's requested items and had noted beside transfer agreement don't have one, and verbally told the survey team they did not have an active transfer agreement, nor a policy related to the transfer agreement. The facility had no evidence of having a transfer agreement with the said hospital for psychiatric services nor any other hospital for emergency medical services that may be needed by their resident population. On 1/28/25 at 11:20 a.m., the survey team met with the facility Administrator, Director of Nursing and three corporate management staff to discuss the above findings. No additional information was provided prior to conclusion of the survey. On 1/30/25, the facility administrator submitted via email a transfer agreement between the facility's prior ownership and a local hospital that was executed July 2009. Also included was another agreement dated 2006 between the hopsital and the facilities owner before the most recent prior owner of the nursing facility.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 49456 Based on staff interviews and facility documentation, the facility staff failed to provide Quality Assurance and Performance Improvement (QAPI) training for one employee (the director of nursing) in a survey sample of 10 employee records reviewed for training. The findings included: The facility staff failed to have the required QAPI training for one employee, the director of nursing. On 1/27/25 at approximately 2:00 p.m., the surveyor requested 10 employee's files as part of the sufficient staffing and extended survey training review. The list of employees was given to the staff development coordinator, a registered nurse, RN#5 (RN5). On 1/28/25 at 9:00 a.m., the employee files were obtained from R5 and reviewed. During the review of the staff files for training, the director of nursing had not completed Quality Assurance and Performance Improvement training for the year 2024. She completed her training on the morning of 1/28/25, after the training records has been requested by the surveyor. On 1/28/25 at 12:45 p.m., a meeting was held with the regional vice president of operations, administrator and the director of nursing. During this meeting they were made aware of the above concerns. No additional information was provided prior to exit conference.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 49456 Based on staff interviews and facility documentation, the facility staff failed to provide annual infection control training for one employee (the director of nursing) in a survey sample of 10 employee records reviewed. The findings included: The facility staff failed to have the required annual infection control training for one employee. On 1/27/25 at approximately 2:00 p.m. the surveyor requested 10 employee's files for the sufficient staffing and extended survey training review. The list of employees was given to the staff development coordinator, a registered nurse, RN#5 (RN5). On 1/28/25 at 9:00 a.m. the employee files were obtained from R5 and were reviewed. During the review of the staff files for training, the director of nursing, who was the infection preventionist for the facility had not completed her annual infection control training for 2024. On 1/28/25 at 11:00 a.m. an interview was conducted with the director of nursing (DON). The director of nursing brought her infection control in long term care facilities certificate and stated that she was sure she had completed the annual infection control prevention training every year but was only able to show proof for the year of 2023. On 1/28/25 at 12:45 p.m. a meeting was held with the regional vice president of operations, administrator and the director of nursing. During this meeting they were made aware of the above concerns. The regional vice president of operations and director of nursing stated they would try to locate any prior training. No additional information was provided prior to exit conference.