STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 - Few	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** Based on clinical record review, interview, and facility documentation review, the facility failed to protect two of three residents (Resident (R) 109 and R81) reviewed for abuse from being sexually abused by R15 when the facility allowed the resident to sexually abuse vulnerable residents by not supervising R15, who had a known history of sexual inappropriateness out of 29 sample residents. This had the potential to affect all residents in the facility who were at risk for abuse. The facility's Administrator was informed on 05/07/26 at 1:33 PM that Immediate Jeopardy existed which also constituted Substandard Quality of Care (SQC) related to the facility's failure to ensure R109 and R81 were free from sexual abuse by R15 and was determined to exist on 03/15/25. The facility provided an Immediate Jeopardy Removal Plan that was accepted on 05/07/26 at 5:42 PM. The survey team validated implementation of the removal plan through interviews, and review of training records. Immediate Jeopardy was removed on 05/07/26 at 6:10 PM. After removal of the Immediate Jeopardy, the deficiency remained at a "G (isolated actual harm) scope and severity level, as the deficient practice resulted in harm. The findings include:1. Review of R15's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was re-admitted on [DATE] with diagnosis of unspecified dementia. Review of R15's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/18/25 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. 2. Review of R109's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted on [DATE] with diagnosis of non-Alzheimer's dementia. Review of R109's quarterly MDS with an ARD of 12/03/25 and located under the MDS tab of the EMR, revealed a BIMS was unable to be completed because the resident was rarely/never understood. Review of R109's Nurse's Note, dated 06/07/25 at 2:29 PM and located under the Progress Notes tab in the EMR, revealed that a Certified Nurse Aide (CNA) reported to Unit Manager (UM)/[Licensed Practical Nurse (LPN) 2] that [R15] was in activity room with other residents and was sticking his hand down the shirt of [R109] and had his hand in her pants. Resident removed from room, Assistant Director of Nursing (ADON) notified. Review of R109's Nurse's Note, dated 06/08/25 at 10:29 AM and located under the Progress Notes tab in the EMR, revealed that [R15] observed sticking his hand up [R109's] pants. Resident removed and physician notified of increased sexual behavior. During an interview on 05/06/26 at 1:40 PM, UM/LPN1 said staff came and got her on 06/08/25 and (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Few	reported that staff observed R15 putting his hand in R109's pants. She said R109 was nonverbal and would not have been able to call for help or report the incident. She stated both residents had already been separated but there was no change in R15's level of supervision. LPN1 said she was unaware if this had happened before and did not know there was a similar situation that occurred the day before on 06/07/25. She said there was no increase in R15's level of supervision on that day that she was aware of or any restrictions on his access to R109 or any other residents. LPN1 stated she did not report this incident, and she was unsure why. During an interview on 05/06/26 at 1:40 PM, UM/LPN2 stated he was working during the day shift on 06/07/26 when a CNA came and reported to him that R15 had his hand in R109's pants and in her shirt. He stated he went to the activity room and sure enough, he observed R15 with his hand in the crotch area of R109's pants and his hand in her shirt by her chest/breasts. He said he immediately separated them. He said R15 was taken back to his room. LPN2 said R109 was a nonverbal resident and would not have been able to report this incident. He said he was unaware if this had happened before with any other residents. He stated R15 had a history of inappropriateness towards staff and female residents. He said there had been no increase in R15's level of supervision that he had been aware of or any restrictions on his access to R109 or any other residents. He stated he reported it to ADON. LPN2 stated he did not complete any training at that time related to the facility abuse protocol. During an interview on 05/07/26 at 11:15 AM, CNA10 stated she was unaware of any inappropriate incidents that have occurred with R15 and she stated there had been no issues with his behaviors towards other residents. But when presented with the statement she wrote on 06/08/25, she stated she remembered observing R15 taking his hand and putting it up the bottom of R109's pants leg. CNA10 said R109 was sitting in her chair, due to another aide leaving her in the hallway to answer another residents' call light. She stated R109 was nonverbal and cognitively impaired and would not have been able to yell out. She stated she told R15 no and removed him and placed him by the nurses' station and reported it to UM/LPN1. CNA10 said R15 was capable of self-propelling and could move throughout the facility freely. She said she was not told to keep checking on him after what she observed and she had no idea if there were any changes in his level of care or supervision. And she stated she was unaware of any history of any behaviors or any other incidents involving R109. 3. Review of R81's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted on [DATE] with diagnosis of unspecified dementia. Review of R81's quarterly MDS with an ARD of 04/11/26 and located under the MDS tab of the EMR, revealed a BIMS score of three out of 15, which indicated the resident was severely cognitively impaired. Review R81's Nurse's Note, dated 03/17/25 at 6:42 AM, written by LPN2 and located under the Progress Notes tab in the EMR, revealed R15 had to be redirected for sexual behavior after he was observed attempting to rub another resident's leg. The resident was redirected and moved beside staff for closer observation. During an interview on 05/06/26 at 2:40 PM, CNA3 stated she worked the 11:00 PM to 7:00 AM shift on 03/17/25. She said she did not remember what happened specifically that night, but she was aware of concerns about R15's behaviors towards female residents. CNA3 stated she was not aware of any concerns with R109, but she was aware of concerns with R81. She said she observed R15 putting his hand in R81's pants and in her shirt. She stated that it happened on more than one occasion. CNA3 said R15 was just redirected and was moved to the nurse's station or back to his (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	room. She said she never reported it because nurses observed this behavior too and they were aware. She stated she was never aware of any increase in R15 supervision or any changes in his plan of care or restrictions in his interactions with other residents. During an interview on 05/06/26 at 4:40 PM, the Director of Nursing (DON) said the facility concluded that R15 sexually groped R109 on two separate occasions. She stated she was unaware there had been any incidents that involved R81. She said she did not think that R15 was currently a risk to other residents in the facility because there had not been any other incidents reported by staff. She confirmed that the two incidents that involved R109 and the incidents involving R81 were never reported to her. Review of the facility's policy titled, Abuse, Neglect and Exploitation, revised 02/11/26, revealed it is the policy of this facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. No additional information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview, and facility documentation review, the facility failed to implement its abuse prevention and investigation policies to ensure the safety of two of three residents (Resident (R) 109 and R81) reviewed for abuse out of 29 sample residents. This had the potential to affect all residents in the facility who were at risk for abuse. The facility's Administrator was informed on 05/07/26 at 1:33 PM that Immediate Jeopardy existed which also constituted Substandard Quality of Care (SQC) related to the facility's failure to ensure R109 and R81 were free from sexual abuse by R15 and was determined to exist on 03/15/25. The facility provided an Immediate Jeopardy Removal Plan that was accepted on 05/07/26 at 5:42 PM. The survey team validated implementation of the removal plan through interviews, and review of training records. Immediate Jeopardy was removed on 06/07/26 at 6:10 PM. After removal of the Immediate Jeopardy, the deficiency remained at a "G" scope and severity for isolated actual harm.The findings include:1. Review of R15's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was re-admitted on [DATE] with diagnosis of unspecified dementia. Review of R15's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/18/25 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. 2. Review of R109's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted on [DATE] with diagnosis of non-Alzheimer's dementia. Review of R109's quarterly MDS with an ARD of 12/03/25 and located under the MDS tab of the EMR, revealed a BIMS was unable to be completed since the resident was rarely/never understood. Review of facility's Reported Incident (FRI) revealed date of incident 06/07/25 and date of report 06/10/25. Describe incident It was reported to Administration today that on 06/07/25, R15 was found with his hand down R109's shirt and in her pants. The employee immediately separated them. This occurred in the Activity Room after lunch. It was also identified that on 06/08/25, R15 was found with his hand up the pant leg of R109's to her knee. When noticed staff immediately separated them. Review of facility's Five Day Letter, dated 06/17/25 and written by Administrator, revealed it was reported that R15 was found with his hand down R109's shirt and in her pants on 06/07/25. This occurred in the Activity Room after lunch. The employee that saw this immediately redirected him and separated them. It was also identified that on 06/08/25, that R15 was found with his hand up the pant leg of R109 to her knee. This occurred by the nursing station. Staff immediately redirected and separated them. Further review revealed the conclusion that R15 had no other behaviors as described above. Safety checks were no longer occurring. Will continue to monitor both residents' psychosocial well-being. R15 will also continue to be monitored by psych services. Review of facility's Witness Statement, dated 06/08/25 and written by Certified Nurse Aide (CNA) 10, revealed she came around the corner, and saw R15 with his hand up R109's pants leg. CNA10 stopped him and moved him away from R109 and reported it to Unit Manager (UM)/Licensed Practical Nurse (LPN) 2. Review of facility's Witness Statement, dated 06/07/25 and written by CNA9, revealed after picking up trays and starting on rounds, she passed the activity room and saw R15 with his hand down R109's (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	shirt and into her pants. R15 was rubbing his hand around and she told him to stop, and he ignored her, so she moved him away. She took him to his room and laid him down and returned to R109 and asked her if she was ok, but she did not respond. Reported to the nurses on duty. Review of facility's Witness Statement, dated 06/08/25 and written by Assistant Director of Nursing (ADON), revealed it was reported by CNA9 and UM/LPN2 that R15 was observed with his hand down the shirt and pants of R109. R15 had gotten out of his wheelchair and walked over to R109. R15 was removed from area and R109 did not appear distressed. R15 was care planned for inappropriate sexual behavior. Will document on 72-hour note. Review of Nurse's Note, dated 06/07/25 at 2:29 PM and located under the Progress Notes tab of the EMR, revealed that a Certified Nurse Aide (CNA) reported to UM/[LPN2] that [R15] was in activity room with other residents and was sticking his hand down the shirt of [R109] and had his hand in her pants. Resident removed from room, ADON notified. Review of Nurse's Note, dated 06/08/25 at 10:29 AM and located under the Progress Notes tab of the EMR, revealed that [R15] observed sticking his hand up [R109's] pants. Resident removed and physician notified of increased sexual behavior. During an interview on 05/06/26 at 1:40 PM, UM/LPN1 said staff came and got her on 06/08/25 and reported that staff observed R15 putting his hand in R109's pants. She said R109 was nonverbal and would not have been able to call for help or report the incident. LPN1 stated both residents had already been separated but there was no change in R15's level of supervision. She said she was unaware if this had happened before and did not know there was a similar situation that occurred the day before on 06/07/26. LPN1 said there was no increase in R15's level of supervision on that day that she was aware of any restrictions on his access to R109 or any other residents. She stated she did not report this incident, but she was unsure why. During an interview on 05/06/26 at 1:40 PM, UM/LPN2 stated he was working during the day shift on 06/07/25 when a CNA came and reported to him that R15 had his hand in R109's pants and in her shirt. He stated he went to the activity room and sure enough, he observed R15 with his hand in the crotch area of R109's pants and his hand in her shirt by her chest/breasts. He said he immediately separated them. He said R15 was taken back to his room. LPN2 said R109 was a nonverbal resident and would not have been able to report this incident. He said he was unaware if this had happened before with any other residents. He stated R15 had a history of inappropriateness towards staff and female residents. LPN2 said there had been no increase in R15's level of supervision that he had been aware of or any restrictions on his access to R109 or any other residents. He stated he reported it to ADON. LPN2 stated he did not complete any training at that time related to the facility abuse protocol. During an interview on 05/07/26 at 11:15 AM, CNA10 stated she was unaware of any inappropriate incidents that have occurred with R15 and she stated there had been no issues with his behaviors towards other residents. But when presented with the statement she wrote on 06/08/25, she stated she remembered observing R15 taking his hand and putting it up the bottom of R109's pants leg. She said R109 was sitting in her chair, due to another aide leaving her in the hallway to answer another residents' call light. R109 was nonverbal and cognitively impaired and would not have been able to yell out. She told R15 no and removed him and placed him by the nurses' station and reported it to UM/LPN1. She said R15 was capable of self-propelling and could move throughout the facility freely. She said she was not told to keep checking on him after what she observed and she had no idea if there were any changes in his level of care or supervision. And she stated she was unaware of any (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	history of any behaviors or any other incidents involving R109. 3. Review of R81's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted on [DATE] with diagnosis of unspecified dementia. Review of R81's quarterly MDS with an ARD of 04/11/26 and located under the MDS tab of the EMR, revealed a BIMS score of three out of 15, which indicated the resident was severely cognitively impaired. Review R81's Nurse's Note, dated 03/17/25 at 6:42 AM, written by LPN2 and located under the Progress Notes tab of the EMR, revealed R15 had to be redirected for sexual behavior after he was observed attempting to rub another resident's leg. The resident was redirected and moved beside staff for closer observation. During an interview on 05/06/26 at 2:40 PM, CNA3 stated she worked the 11:00 PM to 7:00 AM shift on 03/17/25. She said she did not remember what happened specifically that night, but she was aware of concerns about R15's behaviors towards female residents. CNA3 stated she was not aware of any concerns with R109, but she was aware of concerns with R81. She said she observed R15 putting his hand in R81's pants and in her shirt. CNA3 stated that it happened on more than one occasion. She said R15 was just redirected and was moved to the nurse's station or back to his room. CNA3 said she never reported it because nurses observed this behavior too and they were aware. She stated she was never aware of any increase in R15's supervision or any changes in his plan of care or restrictions in his interactions with other residents. During an interview on 05/06/26 at 4:40 PM, the Director of Nursing (DON) said she was unaware that an incident occurred on 03/17/25 and did not become aware of the incidents that occurred to R109 on 06/07/25 and 06/08/25 until 06/10/25. Therefore, she confirmed that although the facility's policy required reporting and investigation of allegations of abuse, the investigation was not conducted until 06/10/25. She further stated no protective measures or increase in R15's level of supervision was put into place prior to that date. Review of the facility's policy titled, Abuse, Neglect and Exploitation, revised 02/11/26, revealed it is the policy of this facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. No additional information was provided.

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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** Based on clinical record review, interview, and facility documentation review, the facility failed to report allegations of abuse in a timely manner for two of three residents (Resident (R) 109 and R81) reviewed for abuse out of 29 sample residents. This had the potential to affect all residents in the facility who were at risk for abuse. The findings include:1. Review of R15's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was re-admitted on [DATE] with diagnosis of unspecified dementia. Review of R15's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/18/25 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. 2. Review of R109's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted on [DATE] with diagnosis of non-Alzheimer's dementia. Review of R109's quarterly MDS with an ARD of 12/03/25 and located under the MDS tab of the EMR, revealed the BIMS was unable to be completed since the resident was rarely/ never understood. Review of facility's Reported Incident (FRI) revealed date of incident 06/07/25 and date of report 06/10/25. Describe incident It was reported to Administration today that on 06/07/25, [R15] was found with his hand down [R109's] shirt and in her pants. The employee immediately separated them. This occurred in the Activity Room after lunch. It was also identified that on 06/08/25, R15 was found with his hand up the pant leg of R109's to her knee. When noticed, staff immediately separated them. Review of Nurse's Note, dated 06/07/25 at 2:29 PM and located under the Progress Notes tab of the EMR, revealed that a Certified Nurse Aide (CNA) reported to Unit Manager (UM)/Licensed Practical Nurse [(LPN) 2] that [R15] was in activity room with other residents and was sticking his hand down the shirt of [R109] and had his hand in her pants. Resident removed from room, Assistant Director of Nursing (ADON) notified. Review of Nurse's Note, dated 06/08/25 at 10:29 AM and located under the Progress Notes tab of the EMR, revealed that [R15] observed sticking his hand up [R109's] pants. Resident removed and physician notified of increased sexual behavior. During an interview on 05/06/26 at 1:40 PM, UM/LPN1 said staff came and got her on 06/08/25 and reported that staff observed R15 putting his hand in R109's pants. She stated she did not report this incident, and she was unsure why. During an interview on 05/06/26 at 1:40 PM, UM/LPN2 stated he was working during the day shift on 06/07/25 when a CNA came and reported to him that R15 had his hand in R109's pants and in her shirt. He reported it to ADON. During an interview on 05/06/26 at 4:03 PM the former ADON stated the incident that occurred on 06/07/25 was reported to her by nursing staff but she did not do anything further with that information because she considered herself management. She was under the impression making her aware was all that had to be done, and she never reported it to the Director of Nursing (DON), the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator, or the state survey agency (SSA). She understood now that it should have been reported. 3. Review of R81's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted on [DATE] with diagnosis of unspecified dementia. Review of R81's quarterly MDS with an ARD of 04/11/26 and located under the MDS tab of the EMR, revealed a BIMS score of three out of 15, which indicated the resident was severely cognitively impaired. Review R81's Nurse's Note, dated 03/17/25 at 6:42 AM and located under the Progress Notes tab of the EMR, revealed R15 had to be redirected for sexual behavior after he was observed attempting to rub another resident's leg. The resident was redirected and moved beside staff for closer observation. During an interview on 05/06/26 at 4:40 PM the DON said none of the incidents that occurred on 03/17/25, 06/07/25, and 06/08/25 were reported to her but they should have been. Review of the facility's policy titled, Abuse, Neglect and Exploitation, revised 02/11/26, revealed The facility will have written procedures that include Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. No additional information was provided.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview, and facility documentation review, the facility failed to conduct thorough abuse investigations for three of three residents (Resident (R) 15, R109, and R81) reviewed for abuse out of 29 sample residents. This had the potential to affect all residents in the facility who were at risk for abuse. The findings include:1. Review of R15's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was re-admitted on [DATE] with diagnosis of unspecified dementia. Review of R15's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/18/25 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. 2. Review of R109's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted on [DATE] with diagnosis of non-Alzheimer's dementia. Review of R109's quarterly MDS with an ARD of 12/03/25 and located under the MDS tab of the EMR, revealed a BIMS was unable to be completed since the resident was rarely/never understood. Review of facility's Reported Incident (FRI) revealed date of incident 06/07/25 and date of report 06/10/25. Describe incident It was reported to Administration today that on 06/07/25, [R15] was found with his hand down [R109's] shirt and in her pants. The employee immediately separated them. This occurred in the Activity Room after lunch. It was also identified that on 06/08/25, [R15] was found with his hand up the pant leg of R109's to her knee. When noticed staff immediately separated them. Review of facility's Five Day Letter, dated 06/17/25 and written by Administrator, revealed it was reported that R15 was found with his hand down R109's shirt and in her pants on 06/07/25. This occurred in the Activity Room after lunch. The employee that saw this immediately redirected him and separated them. It was also identified that on 06/08/25, that R15 was found with his hand up the pant leg of R109 to her knee. This occurred by the nursing station. Staff immediately redirected and separated them. Further review revealed that the incidents on 06/07/25 and 06/08/25 were not investigated until 06/10/25. Additionally, the 06/10/25 investigation was not thorough and did not include interviews with all staff who had knowledge of the incidents or any other staff who may have had knowledge of R15's behavior or known about other residents that may have been affected. 3. Review of R81's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted on [DATE] with diagnosis of unspecified dementia. Review of R81's quarterly MDS with an ARD of 04/11/26 and located under the MDS tab of the EMR, revealed a BIMS score of three out of 15, which indicated the resident was severely cognitively impaired. Review of R81's Nurse's Note, dated 03/17/25 at 6:42 AM and located under the Progress Notes tab of the EMR, revealed R15 had to be redirected for sexual behavior after he was observed attempting to rub another resident's leg. The resident was redirected and moved beside staff for closer observation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/06/26 at 4:40 PM, the Director of Nursing (DON) said the facility did not investigate the incidents that occurred on 06/07/25 and 06/08/25 until 06/10/25. She also stated she did not interview all the staff with knowledge of these incidents nor did she try to interview other staff who may have had knowledge of other incidents involving this resident or potential other residents. She stated she should have interviewed all staff with any knowledge. She confirmed the incident that occurred on 03/17/25 was never investigated and it should have been. Review of the facility's policy titled, Abuse, Neglect and Exploitation, revised 02/11/26, revealed an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include 1. Identifying staff responsible for the investigation. 2. Exercising caution in handling evidence that could be used in a criminal investigation 3. Investigating different types of alleged violations. 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations' 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation. B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed. C. increased supervision of the alleged victim and residents. D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. E. Protection from retaliation. F. Providing emotional support and counseling to the resident during and after the investigation, as needed. No additional information was provided.