STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER Seven Hills Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 2081 Langhorne Road Lynchburg, VA 24501	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interviews, employee record review, and facility documentation review the facility staff failed to implement their abuse policy by failure to ensure that one employee, CNA #3 (CNA3) was trained on the Abuse, Neglect, and Exploitation training out of a survey sample of five employee records. The findings included:The facility failed to implement their abuse policy with regards to the annual requirement for staff to receive abuse trianing for certified nursing assistant #3 (CNA3).On 4/30/26 at 8:30 am, an interview was conducted with CNA3. CNA's yearly training was discussed. CNA3 stated she was done with her training that was due, she said, I am good on all of my training.On 4/30/26 at 9:00 am, a review of CNA3's yearly training record was conducted. During the review, the training on CNA3's transcript had that her training on Cultural Competence Inservice, Abuse, Neglect, and Exploitation, and Abuse, Neglect, and Exploitation HIPAA for Long-Term Care Employees were overdue. The training was assigned on February 2, 2026, and was to be completed by the employee on February 28, 2026.On 4/30/26 at 9:00 am, The administrator provided the employee records to be reviewed and stated, this was the yearly training records for the employees. The administrator stated the employees were required to complete these training courses yearly and by the due date.On 4/30/26 a review of the facility policy titled, Abuse, Neglect, and Exploitation, read in part, Employee Training A. New employees will be educated on abuse, neglect, exploitation, and misappropriation of resident property during initial orientation. B. Existing staff will receive annual education through planned in-services and as needed. Training topics will include: C. 1. Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation. 2. Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property. 3. Recognizing signs of abuse, neglect, exploitation, and misappropriation of resident property, such as physical or psychosocial indicators. 4. Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources. 5. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as: a. Aggressive and/or catastrophic reactions of residents. b. Wandering or elopement-type behaviors. c. Resistance to care. d. Outbursts or yelling out; and e. Difficulty in adjusting to new routines or staff.On 4/30/26 at approximately 10:30 am, a meeting was held with the director of nursing (DON), the administrator, and the regional director of clinical services. During the meeting the DON stated she was a new hire, and the training should have been completed. No additional information was provided.No additional information was provided prior to exit conference

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

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, and facility documentation reviews, the facility staff failed to ensure that residents were protected during an allegation of abuse investigation and failed to investigate an allegation of verbal abuse involving one resident (Resident #1) in a survey sample of 10 residents. Resident #1 (R1) was the victim of two different abuse allegations and during the investigations on 5/30/25 and 10/30/25 the perpetrator was allowed to work to the end of their shift and worked their schedule days following, and while the investigation was being conducted. By allowing the perpetrator to continue to work, the facility did not protect the victim, and the perpertrator had unrestricted access to other residents; this noncompliance resulted in the identification of immediate jeopardy (IJ), and subsequent substandard quality of care. Following the removal of the IJ, the scope and severity was lowered to a level two, isolated. The findings included: The facility staff failed to ensure that the residents were protected during an abuse allegation investigation. The perpetrators were allowed to complete their shifts and work their scheduled days while the investigation was being conducted. This placed all the residents without protection from the perpetrator, which resulted in the identification of immediate jeopardy.On 4/28/26 at 2:00 pm, an interview was conducted with the administrator concerning the abuse policy. She said, abuse is to be reported to her immediately, the person is to be removed and sent home, the employee was suspended while we investigate, staff removed immediately from building, notify agencies-ombudsman, police if needed, adult protective services and OLC [Office of Licensure and Certification- state survey agency]. License is reported if abuse is founded. Findings are validated by witness, talking to other people in area, documentation including resident's statement. If it is new or history in past we try to see if it has been addressed. Follow up with education may need some counseling about abuse [sic]. On 4/28/26 at 3:30 pm, a review of the facility incident reports that involved R1 was conducted. There were two incident reports that involved R1. The first incident report was dated 5/30/25 and the second one was dated 10/30/25. The incidents were for allegations of abuse made by R1 against two staff members that had provided care for him.The first incident report dated 5/30/25 was reviewed. R1 reported an abuse allegation on certified nursing assistant, CNA1. The facility's report read, Resident alleges that the C.N.A. cleaning him up on the evening shift of 5/29/25 pushed him over so the fuxx hard that he hit his head on the siderail. R1 alleged she [CNA1] did it on purpose. R1 was assessed by the DON [director of nursing] with no injury noted. Resident contacted 911 on 5/29/25 who responded on site. The allegation reports required to notify state agencies were faxed on 5/30/25.During the review of the incident report there were four staff interviews conducted. The first interview was with the perpetrator, CNA1. The interview read, while assisting two other CNA's [certified nursing assistants] change a resident in room [room number redacted] B bed. The resident became very verbally and physically abusive because we had to turn him on his side to wipe him. While turning the resident on his side he reached over scratched a one of the CNA's arms and reached back and scratched and grabbed my arm all while being verbally abusive calling us dumb bitches and whores. After changing the resident, the verbal abuse only continued. The resident would shout out into the hallway saying he would beat our asses and how we were worthless whores. He also said he would get someone to f--k us up.The second interview was by a CNA5 that was in the room assisting with care. Her interview read in part, [name redacted] started to cuss us out calling us bitches and saying that he wanted to know who was coming to the room before we came in. We told him that we were about to roll him over to change so pull yourself over to the middle of the bed and he did. When we turned him, he did tap his head on the rail, but it was not hard or on purpose.The third interview was by another CNA6 hat was assisting with R1's care. This interview was R1 reporting what happened on 5/29/26. This aide was in the room assisting R1's roommate and R1 said to her, that bitch [name redacted] CNA1 rolled me too hard my eye hit the rail and my legs came out the bed. He also told me his mother told him to call (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the police and that's what he did [sic]. The fourth interview was from the director of nursing at that time, she interviewed R1 about the incident. R1 stated, CNA4 [name redacted] was my aid last night. She brought CNA1 [name redacted] in the room who came in with an attitude saying it don't matter who has you you need to let her clean you! CNA1 [name redacted] rolled me extra hard where I hit my right eye on the bed rail and my feet flew off the bed and CNA4 caught my legs.There were 12 resident's interviews included in the investigation report. Four of the residents stated that they did not know CNA1 in their interview, five of the residents had no issues with CNA1, and there were four interviews that stated, she pulls me over so hard she is too rough, she is a little rough almost throw you in the floor when she turn you over in bed, has a bad attitude and was rough with her one night. Resident does not want CNA in her room.On 4/28/26 a review of CNA1 timecard was reviewed. The timecard showed that CNA1 worked on 5/29/25, she clocked in at 12:02am and clocked out for the shift at 6:04am. On 5/29/26 she clocked in at 3:15pm and clocked out at 10:45pm. On 5/30/25 she clocked in at 11:54pm and clocked out at 4:29am. On 5/31/25 she clocked in at 11:37pm and clocked out at 11:44pm. The timecard shows that CNA1 was paid for the hours on her timecard.On 4/29/26 a notice of suspension pending investigation was provided for review. It was dated 5/30/25 and acknowledgment of receipt section was blank, no employee signature was present on the form, the administrator signature was dated 6/3/25 and there was a note written by the director of nursing at the time of the incident that read, presented verbally by DON [name redacted] dated 5/30/25. A note was on the front page of notice of suspension that read, mailed 6/4/25. There was a form titled, Employee Master, reviewed and read in part, .Termination involuntary policy violations termination date 5/31/25.On 4/29/26 the incident summary as reviewed. The notice was dated 6/4/25, and the date was the final notice of the findings for the incident on 5/30/25. There was a section in the final notice that read in part, .Actions VDH-OLC, Ombudsman and APS notified [notified on 5/30/25], MD Notified, RP notified, C.N.A. was suspended pending outcome of the investigation, alert residents interviewed regarding care and treatment of them [dated 6/3/25].The second incident report dated 10/30/25 was reviewed. R1 reported an allegation of abuse on CNA2. The incident report read, R1 [name redacted] called 911 to report that a staff member pushed his leg. Four staff members were present in the room at the time and all provide the same statement that no one harmed him. He became combative with staff and yelled and cursed staff members while they were providing ADL [activity of daily living] care. All were interviewed by police officer [name redacted] and provided written statements. The officer concluded that no harm was done to resident.The first interview reviewed was R1's interview of the incident. R1 was interviewed by a nurse about the incident that happened with CNA2. He stated he was calling the cops. He stated in the interview that CNA2 got a smirk and pushed left leg down harder. Also, stated CNA2 said, I want to fuck with you now. The verbal abuse that was reported by R1 in this interview, was never addressed in the facility's investigation.The second interview was by one of the staff assisting with R1's care and her interview stated that CNA2 lifted R1's leg to remove a pillow and some dirty sheets then sat his leg back down softly. After that R1 started yelling saying she cracked his leg and she replied with, I didn't crack nothing, then R1 started yelling and arguing and we left the room.The third interview with a staff member assisting with R1's care stated that he went in to help give a bed bath and change the sheets. R1 called CNA2 a bitch for moving his pillow from under his leg. When they went to turn R1 over he started to dig his fingernails in the staff's arm, so he walked out of the room.The fourth interview was CNA2's interview. Interview read in part, .to bathe him and wash him up. Off the gate he was already rude and calling people out of their name. He [R1] told me and another coworker to not pull on his leg, we stated that we have to move his leg to remove the pillow and fully clean him up. He [R1] stated that I [CNA2] cracked his leg and hip which I stated I didn't crack nothing went to get the unit manager or ADON to help us.The fifth interview was with another staff assisting with R1's care. The interview read in part, .walked in the room and explained what we were doing we then proceed to all pick up his leg to move the pillow and as we did that he[R1] screamed. We all (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	proceeded to leave the room because he started swinging on [name redacted] [coworker].There were 11 resident interviews conducted titled, Safety. One resident interviewed stated he does not feel safe on 2nd and 3rd shift and his reason was staff. The other residents did not have any concerns.A review of CNA2's timecard was conducted. She was allowed to complete her shift on 10/30/25 (clocked out at 2:59pm), reported to work on 10/31/25 (dayshift), 11/3/25 (day shift), and 11/4/25 (dayshift).A review of the incident summary that was submitted was dated 11/4/25. The notice stated this will serve as the final report of a facility reported incident regarding R1 on 10/30/25. The final report had a section labeled, Actions, and some of the actions were notifying state agencies, physicians, responsible party, resident's interviews, some of the interviews were completed on 10/30/25 and some were completed on 11/03/25. On 4/30/26 at 8:30 am, an interview was conducted with the administrator concerning the two incidents/allegations of abuse involving R1 that were reviewed.During the interview, the incident on 5/30/25, which happened on 5/29/25 was discussed. The administrator stated that she reported the incident when she was notified. She said, I think I was notified on the 30th. One of the staff interviews was discussed with the administrator. In the interview it was read in part, .that when we turned him, he did tap his head on the rail, but it was not hard or on purpose. The administrator said, I felt it was not done on purpose, but he may have tapped it. The administrator stated that the director of nursing interviewed R1, and the DON did not think it was anything intentional. When the administrator was questioned about the resident's interviews, several interviews were stating that the CNA1 was rough and when she turned you over in the bed, she was rough and felt like she was going to roll them on the floor. The administrator said, follow up with the person was done, I think the director of nursing did that to clarify it wasn't abuse.The facility reported incident that the facility provided for review had that R1 called 911 the evening of 5/29/26 and the police came to the facility. So, the allegation of abuse was made aware to staff the evening of the incident as evidenced by the police coming to the facility.The administrator was interviewed about the second incident dated 10/30/25. She stated that she looked at the interviews, that she was present during the police being at the facility and during the staff statements. CNA1 was in the building but she could not remember if she was interviewed first. The administrator said, I felt this was the investigation. I don't remember if she [CNA2] left the unit, but I did not say go home cause everyone stayed kinda together.These failures by the facility put all residents residing in the facility in immediate danger by not removing the perpetrator during an open investigation with allegations of abuse. The consequence could cause serious injury, serious harm, serious impairments up to and including death for residents the alleged perpetrator continues to have access to. On 4/29/26 at 9:51 am, a meeting was held with the administrator, the director of nursing, and the regional director of clinical services. They were informed that immediate jeopardy had been identified and a copy of the IJ template was provided. On 4/29/26 at 3:38 pm, the facility submitted a removal plan that read as follows: Plan Corrective Action for those residents found to be affected by the deficient practice: C.N.A. 1 was terminated from employment 05/31/2025C.N.A. 2 was terminated from employment 01/24/2026Resident # 1 was discharged from the facility 02/19/2026Corrective Actions taken for residents with potential to be affected by deficient practice:All FRI's from 05/29/2025 will be reviewed by the Administrator or Designee to determine if any staff members who had abuse allegations were allowed to work during an investigation. If staff were allowed to work during an investigation, Administrator or designee will further review the FRI to determine if a complete investigation occurred. Skin sweeps will be conducted by the DON or designee residents with BIMs below 12 to assess any indicators of abuse and family members will be interviewed. Residents with BIMS above 12 or above will be interviewed for any concerns of abuse.Systemic Changes put in place to ensure the deficient practice does not recur: Education will be provided to all staff by the Administrator or designee on the abuse policy and process prior to their next scheduled shift. Education will be provided by Corporate HR to the Administration on the abuse policy and process.Completion of the removal plan at12:00 am on 04/30/2026. On 4/30/26 at 8:45 am, the survey (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	team completed the following:1. Verified CNA #1 and #2 were terminated from employment, verified Resident # 1 was discharged from facility2. -reviewed the audit performed of facility reported incidents -reviewed head to toe skin assessments of residents with a BIMS below 12 - reviewed family interviews for residents with a BIMS below 12 -reviewed interviews for residents with a BIMS of 12 or above3. Interviewed staff for education regarding the abuse policy and procedures to follow. The IJ was determined to have been removed as of 12:00 am on 4/30/26, at which time the scope and severity was lowered to level two, isolated.On 4/30/26, the facility policy titled, Abuse, Neglect and Exploitation, read in part, It is the policy of this facility to provide protections 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. 2. The facility will designate an Abuse Coordinator in the facility who is responsible for reporting allegations or law. suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written.On 4/30/26 at10:35 am, the vice president of clinical services and the administrator was wanting to discuss their creditable evidence, dispute of Immediate Jeopardy Determination that they had presented earlier. The information provided was reviewed and it did not provide credible evidence that residents were protected from an alleged perpetrator during an abuse allegation.No additional information was provided prior to exit conference.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on facility document review, clinical record review, and staff interviews the facility failed to develop a complete and thorough comprehensive care plan to ensure person-centered interventions were present for one of 10 residents in the sample, Resident #1 (R1).The findings include:For R1, the facility failed to update the Comprehensive Care Plan to include personalized interventions that addressed R1's reasons for refusing care (pain) and measures to attempt to provide Activities of Daily Living (ADL) care in the presence of R1's refusals. According to R1's diagnoses recorded in the clinical record, diagnosis included but were not limited to: history of stroke secondary to carotid artery dissection, status post craniectomy, with residual left-sided hemiparesis, neuropathic pain, left hip avascular necrosis, degenerative disc disease of lower spine with chronic lower back pain, adult failure to thrive, and lower extremity weakness. On R1's most recent Minimum Data Set (MDS), a quarterly assessment with an assessment reference date (ARD) of 12/27/25, R1 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment indicating that R1 was cognitively intact. In section GG of this MDS, R1 was noted to be dependent on staff or require maximum assistance from staff for all ADLs except oral hygiene (supervision assist) and eating (set up assist). R1 had a care plan to address activities of daily living (ADL) created on 4/10/2024 with most recent revision on 9/29/2025. This care plan had a focus statement ADL self-care performance deficit r/t [related to] Hemiplegia, Stroke indicating that R1 required assistance from staff to perform ADLs. This care plan included only one intervention that was initiated on 4/10/2024 stating Resident will receive ADL assistance as needed. No additional interventions were added to the care plan after 4/10/2024, and no revisions were made to the existing intervention. During the clinical record review, it was noted that R1 refused ADL care almost daily. R1 frequently cited pain as the reason for refusing ADL care.R1 had a care plan for behaviors created on 3/22/2024 and revised on 1/20/2026. The focus statement of this care plan was The resident has a behavior problem, refusal of medications, weights and Showers, turn and repositioning, appointments, meals, change of bed linens, and refuses to get up in chair. Resident with inappropriate request with foul abusive language to staff. The following interventions were present on the care plan: Administer medications as ordered. Monitor/document for side effects and effectiveness created/initiated on 3/22/2024. If reasonable, discuss The resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident created/initiated on 3/22/2024. Resident to be evaluated by Psych Provider created/initiated on 4/23/2024.The care plan failed to include personalized interventions that specifically addressed R1's refusal of care. Clinical record review demonstrated a physician's order on 12/5/2025 to give additional pain medication one hour prior to showering on shower days. The care plan was not updated to include this intervention.An interview was conducted with the Assistant Director of Nursing (ADON) on 4/28/2026 at 2:51 PM. The ADON stated that R1 refused care every day. An interview was conducted with the MDS coordinator, Registered Nurse (RN) #1 on 4/28/2026 at 3:44 PM. RN #1 stated that care plans are revised/updated quarterly and annually with MDS assessments and daily as needed for changes or new orders. RN #1 stated that they would be notified by staff if something needs updated or changed in their daily care meetings. RN #1 stated that if behaviors are not documented in the clinical record, RN #1 would be notified in the morning meeting of issues.A facility policy titled Comprehensive Care Plans implemented on 11/1/2021 and most recently revised on 12/1/2022 states that It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. At a minimum, the comprehensive care plan with describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well- being and Any services (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment. The policy further states The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment and that Alternative interventions will be documented, as needed.On 4/30/2026 the above findings were presented to the Director of Nursing (DON) and administrator.No further information was provided prior to exit.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical reviews, and facility documentation the facility staff failed to ensure medications were administered according to professional standards of nursing practice. Specifically, nursing staff administered an incorrect medication dose over an extended period of time for one resident (Resident #2-R2) out of a survey sample of 10 residents. The findings included: For R2, the facility staff failed to follow professional standards of practice during medication administration that would have prevented R2 from receiving the wrong dose of medications. On 4/27/26 at 1:00 PM, a review of the clinical record was conducted. The progress notes were reviewed and R2's medications included Divalproex DR [delayed release] 250 mg (Divalproex is an anticonvulsant medication used to treat seizures) with the order/instructions to give two tablets in the morning and three tablets at bedtime. The medication administration record (MAR) was reviewed for the months of May 2025 and June 2025 and was signed off daily, indicating the medication Divalproex DR 250 mg give two tablets in the morning and three tablets in the evening, was administered.The SBAR (situation, background, assessment and recommendation) dated 6/20/25 was reviewed and R2's change in condition was altered mental status. An evaluation note was reviewed dated 6/20/25 and read in part .mother stated that mental status and demeanor is off and wants patient sent to the ER [emergency room] now for evaluation.The nurse practitioner had a progress note dated 6/23/25, explaining R2's hospitalization, and noted that R2 was receiving the incorrect dose of Divalproex DR (anticonvulsant medication) R2 was receiving 500 mg (milligrams) daily and not the ordered dose of 250 mg prescribed by the physician.On 4/27/26 at 2:34 PM, a telephone interview was conducted with a pharmacist at the facility's contracted pharmacy. The pharmacist stated that on 5/18/25, the pharmacy filled Divalproex DR 500 mg and dispensed 150 tablets to the facility. On 4/27/26 at 4:36 PM, conducted an interview with License Practical Nurse #3 (LPN3). During the interview she stated that she did not want to give the wrong information about R2's medication, so she wanted to meet with the Director of Nursing (DON) to obtain the information requested. LPN3 returned with a physician's order for Divalproex DR 250mg and stated that was the dosage R2 was receiving; however, with further discussion, LPN3 said, [R2's name redacted] was given the wrong dose of medication and that it was too much.On 4/28/26 at 12:21 PM, an interview conducted with the director of nursing (DON). The DON stated I expect the nurses to do the rights of medication administration, right dosage, right resident, right route and that if pharmacy sends the wrong medication, the nurses should be doing the rights of medication and catch it. On 4/28/26 at 2:09PM, a review of the facility's policy titled, Medication Administration, was conducted. The policy read in part, . Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review MAR [medication administration record to identify medication to be administered. Compare medication source (bubble pack, vial, etc) with MAR to verify resident name, medication name, form, dose, route and time.On 4/28/26 at 4:52PM, an interview was conducted with licensed practical nurse #1 (LPN1). LPN1 stated, when giving medications, you make sure that it's the right patient, right medication, right dose and the MAR matches the card of medications and if they do not match, you are supposed to correct it.On 4/28/26 at 5:01PM, an interview was conducted with licensed practical nurse #5 (LPN5). LPN5 stated, when giving medications you make sure it's the right resident, look at order to make sure card matches the order, make sure it is the right dose. LPN5 stated, I click off medications as I give them and if something is wrong and does not match, I call the doctor and notify the pharmacy. On 4/28/26 at 5:15PM, an end of day meeting was conducted with Administrator, DON, and Regional Director of Clinical Services (RDCS). RDCS stated the [NAME] standard of practice was the reference the facility used. During review of [NAME], [NAME] reads in part, .compare the medication label to the order in the patient's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Hills Rehabilitation and Nursing	2081 Langhorne Road Lynchburg, VA 24501

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medical record,On 4/29/26 at 10:08 AM, a telephone interview was conducted with a second pharmacist (Pharmacist #2). Pharmacist #2 stated that it was an error by the pharmacy that Divalproex DR 500 was sent 5/18/25 instead of Divalproex DR 250mg. There was no order change by the physician for Divalproex DR 500 mg medication in R2's medical record. On 4/30/26 at 9:30AM, The facility identified the significant medication error on 6/23/25 and the facility implemented a plan of correction which included following the standards of practice with medication administration. The RDCS presented the plan of correction and it was reviewed. During the review there was a pharmacy label that read Divalproex DR 500mg. Take two in the morning and three at bedtime. The action plan the facility presented was as follows: Quality Assurance Committee oversight.Medication cards were removed from the medication cartsMedication ordered with correct dosePharmacy was notified of error. NP [nurse practitioner] reviewed that orders and clarified that Divalproex DR should be sent for 250mgA MAR [medication administration record] to card audit was completedMedication administration education given to nursing staffNew medication cards sent for this resident were checked for accuracyThe completion date was 6/23/25 and the audits being conducted were MAR to card audit was completed on 8/25/25. The completion audit for accuracy of medication cards dispensed from the pharmacy was completed on 9/2025. The facility achived past non-compliance for this deficient practice. No other additional information was provided prior to exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. Based on staff interviews, clinical record review, and facility documentation review the facility staff failed to ensure effective pain management on multiple occassions, for one resident (Resident #1-R1) in a survey sample of 10 residents. The findings included:For R1 who had chronic pain syndrome related to degenerative disc disease of the lumbar spine and avascular necrosis of the left hip, the facility staff failed to provide non-pharmacological interventions and failed to ensure the resident's pain was controlled. On 4/27/26 at 1:19 pm, an interview was conducted with a licensed practical nurse, LPN#1 (LPN1). LPN1 stated, he [R1] was rude and disrespectful at times with the staff. LPN1 stated, staff ignored him at times and avoided going in his room because R1[name redacted] doesn't know how to talk to people.On 4/28/26 at 11:25 am, an interview with the physician assistant (PA) was conducted. The PA stated he began working at the facility in early February. The PA stated R1 had pain and several medical conditions that was painful. However, the PA stated R1 demonstrated drug-seeking behaviors, including requesting additional narcotic medication and attempting to negotiate care, such as stating he would agree to showering if given more narcotics. The PA stated he attempted to adjust R1's pain medication regimen to adequately manage pain while avoiding addiction related behaviors. The PA stated he was not aware of R1 obtaining outside medications from anyone.On 4/28/26 at 2:40 pm, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she began working at the facility in January and attempted to establish a good rapport with R1. She stated R1 refused care daily due to pain and wanted interventions to decrease his pain. The ADON stated that if R1 was sleepy, he appeared comfortable, but when care was provided, especially movement of his left leg, he would scream out in pain. The ADON stated R1 hated his left leg being moved and pain was the reason he declined care, refused staff assistance, and refused appointments. The ADON stated that on the day of a scheduled appointment, staff attempted to prepare R1 by washing him, limb by limb. She stated R1 refused to have linens changed and refused to attend the appointment due to pain. The ADON said, that pain was his reason he declined care and refused staff to do things. She stated he wanted to go to a facility closer to family and where he could use recreational drugs. The ADON stated R1 was asking the provider to increase his pain medications dosage and requested medical marijuana to help with his pain management.On 4/28/26 at 4:43 pm, an interview was conducted with a registered nurse, RN#1 (R1), who was the Minimum Data Set (MDS) coordinator. R1 stated care plans were reviewed and updated quarterly, annually, with MDS assessments, and with changes in physician orders or resident condition. RN1 stated that if an interventions was not effective, it should be changed. RN1 stated she reviewed the 24-hour report daily and discussed changes during morning meetings. RN1 stated that prior to her employment, floor nurses updated the care plans. She further said, changes discussed during interdisciplinary team (IDT) meetings were updated by her if they were reported to her. On 4/28/26 at 5:08 pm, an end of day meeting was held with the administrator, the director of nursing, and the regional director of clinical services and the above concerns were discussed. No additional information was provided at this time. On 4/29/26 at 10:00 am, a clinical record review was conducted. R1's care plan was reviewed. Review of R1's care plan identified bilateral hip pain and neuropathic pain. The care plan included goals for the resident to verbalize relief of pain, demonstrate the ability to cope with and complete activities with pain relief, remain free from interruption in normal activities due to pain. Interventions included administering analgesics as ordered anticipating the resident's need for pain relief and responding promptly to complaints of pain, and evaluating the effectiveness of pain interventions. The care plan also directed staff to review compliance with pain management interventions, alleviation of symptoms, dosing schedules, resident satisfaction with results, impact on functional ability, and impact on cognition. Review of the care plan failed to identify any non-pharmacological interventions to assist with alleviating the resident's pain. The care plan was initiated on 4/24/24 and was last revised on 12/22/2025. Further review of the clinical record (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was completed, including progress notes. On 2/13/26, a nursing note indicated the resident was seen for increased, uncontrolled pain with a reported pain score of 10/10. Staff were called to the resident's room for uncontrolled pain. The physician assistant evaluated the resident and provided a one-time order for hydrocodone/acetaminophen 10-325 mg. Additional documentation dated 2/16/26 noted chronic pain syndrome related to degenerative disc disease of the lumbar spine and avascular necrosis of the left hip. The resident was followed for pain management with ongoing symptom review, with pain reported as partially controlled throughout subsequent progress notes. The resident continued to report episodes of uncontrolled pain, with pain ratings up to 10/10, and analgesic dosages were adjusted according. However, there was no evidence of non-pharmacological interventions or other alternative pain management approaches being implemented or documented to assist in alleviating the resident's pain. On 4/29/26 a review was conducted of facility documentation that was provided. The policy titled, Pain Management, was reviewed and read in part, .The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents goals and preferences. 1. c. manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. On 4/30/26 at 10:00 am, a meeting was held with the administrator, the director of nursing, and the regional nurse of clinical services and the above findings were discussed. No additional information was obtained prior to exit conference.

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	495151	A. Building B. Wing	04/30/2026

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on staff interview, clinical record review, and facility documentation review the facility staff failed to ensure that pharmacy regimen reviews were completed and implemented timely for one resident, Resident #1 (R1) out of a survey sample of 10 residents. The findings included:R1's pharmacy regimen reviews were not completed or implemented timely.On 4/30/26 at 8:45 am, an interview was conducted with the director of nursing (DON). The DON explained the facility process of the drug regimen reviews. The DON stated that the coordinator from the pharmacy will let me know when she is coming and when reviews were ready . She stated that she will review and give to the doctor to review and sign. Once signed by the physician, the DON stated she gives the reviews to the unit managers to check and to make sure the suggestions was implemented. The DON said she makes a copy of all the reviews, place copies in a binder, and it was kept in her office. She stated she takes the original review to the medical records department and the review was scanned into the residents medical chart. On 4/30/26. a review of R1's clinical recorded was conducted. R1's pharmacy consultations were reviewed. R1 had a review that was completed on 2/18/2025 for a gradual dose reduction of his antipsychotic medication Quetiapine 100 mg was reduced to 75 mg, and this recommendation was not reviewed and completed until 3/25/25 with the physician's signature. On 2/18/26 a recommendation was completed for a current AIMS and this recommendation was not signed and completed until 3/27/25. On 7/29/25 a recommendation was requested for a gradual dose reduction for R1's antidepressant (Duloxetine 60 mg twice daily); however, this recommendation was not addressed until 9/5/25 by the physician. On 11/26/25 a recommendation for a dose reduction was made on R1's pantoprazole 40 mg everyday to 20 mg; however, the recommendation was not reviewed and signed by the physician until 12/24/25. On 4/30/26, a review of the facility policy was reviewed. The policy titled, Medication Regimen Review, read in part, .the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart. On 4/30/26 at 10:00 am, a meeting was held with the administrator, the director of nursing, and the regional director of clinical services and were made aware of the above concerns. No additional information was obtained prior to exit conference.

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on staff interviews, clinical record review, and facility documentation review, the facility staff failed to ensure resident #2 (R2) was free from significant medication error, which resulted in harm for one of ten residents in the survey sample.The findings included:The facility staff failed to ensure that R2 was administered the correct dosage of his medication daily. On 4/27/26 at 10:15 AM, a clinical record review was conducted. On 6/9/25 the nurse practitioner/Doctor of Nursing Practice (DNP) wrote a progress note that read in part, . the reason for visit was resident was having muscle weakness. A different nurse practitioner (NP) wrote a progress note dated 6/18/25 and 6/19/25 that the reason for the visit was that R2 was having weakness. On 6/9/25 Doctor of Nursing Practice (DNP) wrote in progress note the reason for visit was resident was having muscle weakness. The NP progress note dated 6/23/25, read in part. it was found to be due to an incorrect medication dose being dispensed (500mg vs 250). On 4/27/26 at 2:34 PM, a telephone interview was conducted with pharmacist #1. She stated on 5/18/25 R2 was dispensed 150 tablets of Divalproex DR 500mg and was delivered to the facility. The label on the medication card reads to give two in the morning and three in the evening, but the physicians order was to administer Divalproex DR 250mg tablets. On 4/27/26 at 3:24 PM, an interview was conducted with a Licensed Practical Nurse, LPN #3 (LPN3). During the interview, LPN3 stated that she would find out the dosage that R2 was being administered prior to going to the hospital on 6/20/25. LPN3 stated that she was the unit manager during this time and that she was not the nurse that assessed him that day.On 4/27/26 at 4:36 PM, LPN3 stated that R2 was being administered Divalproex DR 250mg and provided a copy of the physician's order. LPN3 stated that she was the nurse that assessed R2 on 6/20/25 prior to him being transported to the hospital. LPN3 stated that she did not observe any changes in condition with R2. LPN3 said, resident stays up late at night, his vital signs were within normal range, and that he knew where he was. During the interview, LPN3 stated, R2[name redacted] was given the wrong dose of medication and it was too much. LPN3 completed a change in condition assessment on 6/20/25 and documented that R2 had altered mental status. She stated his mother request for him to go to the hospital and that is the reason he was sent out.4/28/26 12:34 PM, a clinical record review was conducted. The hospital's discharge summary was reviewed and read in part, . motor weakness was possibly medication induced. R2'S lab work was reviewed on the hospital discharge summary, and R2 had a valproic acid lab level of 115. Normal range for a valproic acid level was 50-100, so R2's level was noted to be high. On 4/28/26 at 11:46 AM, an interview was conducted with physician's assistant (PA). PA stated that the side effects of receiving increased dosage of Divalproex DR could be drowsiness, muscle weakness, skin reactions, somnolence, nausea and vomiting. On 4/28/26 at 12:21 AM, an interview was conducted with the director of nursing (DON). The DON stated she expects the nurses to do the six rights of medication administration. The DON stated, right dosage, right resident, right route and if pharmacy sends the wrong medication, the nurses should be doing the rights of medication and catch it. DON stated, the facility has received medications from the pharmacy with the incorrect label several times. On 4/28/26 at 2:09 PM, a review of the facility's documentation was conducted. The facility's policy titled, Medication Administration, read in part, .Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review MAR to identify medication to be administered. Compare medication source (bubble pack, vial, etc) with MAR [medical administration record] to verify resident name, medication name, form, dose, route, and time.On 4/28/26 at 4:52 PM, an interview was conducted with LPN1. LPN1 stated, when giving medications, you should make sure that it's the right patient, right medication, right dose and the MAR matches the card of medications. She stated, sometimes they do not match, especially with milligrams and if they do not match, you are supposed to correct it. On 4/28/26 at 5:01 PM, an interview was conducted with LPN5. LPN5 stated, when (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	giving medications you make sure it's the right resident, look at order and make sure card matches the order, make sure it is the right dose. LPN5 stated I click off medications as I give them and if something is wrong and does not match, I call the doctor and notify the pharmacy.On 4/28/26 at 5:15 PM, an end of day meeting was conducted with Administrator, DON and Regional Director of Clinical Services (RDCS) and the above concerns were discussed. On 4/29/26 at 10:08 AM, a telephone interview was conducted with pharmacist #2. She stated that it was an error by the pharmacy that Divalproex DR 500 was dispensed on 5/18/25, which was not the correct dosage.On 4/30/26 at 9:30AM, The facility identified the significant medication error on 6/23/25 and the facility implemented a plan of correction. The RDCS presented the plan of correction and it was reviewed. During the review there was a pharmacy label that read Divalproex DR 500mg. Take two in the morning and three at bedtime. The action plan the facility presented was as follows: Quality Assurance Committee oversight.Medication cards were removed from the medication cartsMedication ordered with correct dosePharmacy was notified of error. NP [nurse practitioner] reviewed that orders and clarified that Divalproex DR should be sent for 250mgA MAR [medication administration record] to card audit was completedMedication administration education given to nursing staffNew medication cards sent for this resident were checked for accuracyThe completion date was 6/23/25 and the audits being conducted were MAR to card audit was completed on 8/25/25. The completion audit for accuracy of medication cards dispensed from the pharmacy was completed on 9/2025. The facility achived past non-compliance for this deficient practice. No other additional information was provided prior to exit conference. Past non-compliance was achieved.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on staff interviews and facility documentation review, the facility staff failed to effectively administer the facility by failure of the administrator, who was the abuse coordinator to effectively implement the facility's abuse policy to ensure measures were taken to protect residents when an allegation of abuse and/or neglect is being investigated and failure to conduct thorough investigations into allegations for one resident, Resident #1 (R1) out of a survey sample of 10 residents.The findings included:The facility's Abuse Coordinator, who was the administrator, failed to follow the abuse policy, protect the residents when an allegations of abuse was alleged, and initiate a thorough investigation into the allegations. On 4/28/26 during a review of facility incidents and investigation documentation revealed that R1 made allegations of abuse on two separate occassions (5/30/25 and 10/30/25) involving two different staff members, certified nursing assistant CNA1 and CNA2.Documentation showed that in both incidents, the alleged perpetrators were not removed from the facility and were allowed to continue working during the investigation period, which permitted them continued access to many residents within the facility.On 4/28/26 an interview was conducted with the administrator. During the interview, the administrator confirmed she was the Abuse Coordinator. She stated that when an allegation of abuse was made, she reported it immediately to the required state agencies, initiated an investigation, and removal and suspension of the alleged perpetrator from the facility pending the outcome of the investigation. The administrator confirmed this was the facility's policy for abuse allegations.Facility documentation confirmed that both perpetrators were allowed to remain in the facility and continued to work their schedules during the investigations. CNA1 was involved in the incident on 5/30/25 and her timecard revealed that she completed her shift on 5/29/25, the day the incident happened and was allowed to work on 5/30/25 and clocked in at the facility on 5/31/25 at 11:37 pm to 11:44 pm. CNA2 was involved in the second incident with R1 on 10/30/25. CNA2's timecard revealed that she completed her schedule shift on 10/30/25, worked her schedule shift on 10/31/25, 11/3/25, and on 11/4/25.R1 also made an allegation of verbal abuse which was not investigated by the facility. On 4/28/26 a review of the facility policy titled, Abuse, Neglect, and Exploitation, and read in part, 2. The facility will designate an Abuse Coordinator in the facility who is responsible for reporting allegations or law. suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written.Failure to remove the perpetrators, by the abuse coordinator during the investigations did not ensure the safety and protection of Resident #1 and other residents from potential abuse.On 4/28/25 an end of day meeting was conducted with the administrator, the director of nursing and the regional nursing consultant. No additional information was provided prior to exit