STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495166	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stratford Healthcare Center	508 Rison Street Danville, VA 24541

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on staff interview, facility document review, and clinical record review, the facility staff failed to report an incident of visitor-to-resident abuse within two (2) hours of the observed abuse for one (1) of four (4) residents sampled. (Resident #1) The findings were: For Resident #1, facility staff failed to report an incident of visitor-to-resident sexual abuse within two (2) hours of the incident. On 11/10/24 at 3:08 p.m., three (3) staff members observed a visitor (another resident's family member) and resident touching each other inappropriately while together in an alcove off the main hallway. The incident was reported on 11/11/24, over two (2) hours after the incident. Resident #1's diagnoses list included but was not limited to unspecified dementia, major depressive disorder, and cognitive communication deficit. The most recent minimum data set (MDS) with an assessment reference date of 10/16/24 assigned the resident a brief interview for mental status summary score of 03 (three) out of 15 in Section C (Cognitive Patterns) indicating severely impaired cognition. Section GG (Functional Abilities) coded Resident #1 had no impairments for upper or lower extremities and did not use any mobility devices. Resident #1 was coded as independently being able to eat, perform oral hygiene, dress her upper and lower body, and putting on/taking off footwear. Resident #1's care plan included a problem area of Behavioral Symptoms. The problem area read, Resident exhibits the following inappropriate behaviors: makes overly affectionate advances toward male residents such as kissing and hugging, continues to have affectionate behaviors, At {sic} risk for inappropriate advances from male residents or visitors on 11/10-24 {sic}. Actual allegation of sexual encounter from a visitor. Resident #1's clinical record included a progress note written by the director of nursing (DON), dated 11/11/24 at 4:53 p.m. which was documented as a late entry on 11/18/24 at 4:55 p.m. The note read, Resident was asked if she felt safe in the facility, responded yes. Resident states she does not recall incident from 11/10/24 that involved a visitor inappropriately touching resident. Resident was safeguarded from the individual in question and charges were taken out at the RP's [responsible party] request. MD aware and evaluation completed. The assistant director of nursing (ADON) documented an interdepartmental team (IDT) progress note dated 11/14/24 which read, in part, .FRI [facility reported incident] investigation for sexual abuse pending determination . (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: 495166	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Stratford Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 508 Rison Street Danville, VA 24541	

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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 initial FRI report was dated 11/11/24 with the incident date being 11/10/24 with the details of Resident #1 and a visitor related to another resident observed, by staff, touching each other inappropriately in the cutaway area near the break room. The resident and visitor separated after being seen by staff. The follow up investigation was concluded on 11/18/24 and read in part, . the facility is substantiating sexual abuse from a visitor, (name omitted) he has been banned from the facility. The facility, after thorough investigation could not determine if this action was consensual. (Resident #1) has experienced no negative outcome, her behavior has remained at baseline. Resident was assessed by MD and was found to have no injuries, and reported to the MD that she had not been hurt . The FRI document read that on 11/11/24, the responsible party, physician, adult protective services, and law enforcement were notified of the incident. The surveyor requested and the DON provided a timeline of the facility staff's reporting of the alleged abuse incident: • Video footage showed the incident happened between 3:08 p.m. and 3:11 p.m. on 11/10/24. • At 3:12 p.m. on 11/10/24 a certified nursing assistant (CNA #6) unsuccessfully attempted to reach the DON and did not leave a message. • The DON attempted to return the CNA #6's call on 11/10/24 at 8:02 p.m. with no answer. • On 11/11/24 at 8:00 a.m., the DON spoke with the CNA #6 who told the DON to look at the camera video. The DON spoke with the housekeeping/maintenance director who had been the manager-on-duty on 11/10/24 who stated it was reported to him the resident and visitor were hugging inappropriately. The DON did not receive a call from the manager on duty (housekeeping/maintenance director) on 11/10/24. CNA #6 was interviewed via phone on 12/10/24 at 4:36 p.m. The nursing assistant acknowledged she attempted to call the DON after the incident on 11/10/24 but was unable to reach her. The CNA's written statement indicated she reported the incident to the manager on duty. In the morning of 11/11/24 the DON asked CNA #6 about the occurrence. On 12/10/24 at 11:35 a.m., Resident #1 was interviewed by a surveyor. The resident reported feeling safe in the facility and reported the staff were nice to her. The resident was walking around her room, smiling and pleasant. (continued on next page)

Printed: 11/21/2025
Form Approved OMB
No. 0938-0391

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Virginia Resident Abuse Policy with an effective date of May 2008 and a last revision date of 07/11/24 was provided by the DON on 12/09/24 and reviewed. The policy read in part, 6) Initial Reports a. Timing. All allegations of Abuse, Neglect, Involuntary Seclusion, injuries of Unknown Source, and Misappropriation of resident property must be reported immediately* to the Administrator, Director of Nursing (DON) and to the applicable State Agency. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the DOH immediately, but not later than 2 hours after the allegation is made The DON and regional director of clinical services (RDCS) were interviewed on 12/10/24 at 5:10 p.m. with the concern for the abuse incident reporting timing discussed. The DON reported the facility staff substantiated the incident based on the video footage and the fact Resident #1 was unable to recall the incident when interviewed, She was unable to say either way about consent. The DON acknowledged the facility staff reported this abuse incident more than two (2) hours after it occurred; it was reported the following day. No further information was provided prior to the 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for one (1) of four (4) residents sampled. (Resident #1) The findings were: The facility staff failed to ensure Resident #1's clinical record included a medical resident's evaluation of the resident following an abusive incident observed by staff members which occurred on 11/10/24. Resident #1's diagnoses list included but was not limited to unspecified dementia, major depressive disorder, and cognitive communication deficit. The most recent minimum data set (MDS) with an assessment reference date of 10/16/24 assigned the resident a brief interview for mental status summary score of 03 (three) out of 15 in Section C (Cognitive Patterns) indicating severely impaired cognition. Section GG (Functional Abilities) coded Resident #1 had no impairments for upper or lower extremities and did not use any mobility devices. Resident #1 was coded as independently being able to eat, perform oral hygiene, dress her upper and lower body, and putting on/taking off footwear. Resident #1's care plan included a problem area of Behavioral Symptoms. The problem area read, Resident exhibits the following inappropriate behaviors: makes overly affectionate advances toward male residents such as kissing and hugging, continues to have affectionate behaviors, At {sic} risk for inappropriate advances from male residents or visitors on 11/10-24 {sic}. Actual allegation of sexual encounter from a visitor. Resident #1's clinical record included a progress note written by the director of nursing (DON), dated 11/11/24 at 4:53 p.m. which was documented as a late entry on 11/18/24 at 4:55 p.m. The note read, Resident was asked if she felt safe in the facility, responded yes. Resident states she does not recall incident from 11/10/24 that involved a visitor inappropriately touching resident. Resident was safeguarded from the individual in question and charges were taken out at the RP's [responsible party] request. MD aware and evaluation completed. The surveyor requested the medical provider's evaluation mentioned in the progress note. On 12/10/24 at 4:55 p.m. the DON and regional director of clinical services (RDCS) were interviewed. The DON reported there were medical residents who work under Resident #1's primary medical provider. The residents come to the facility daily to see that primary medical provider's patients who may need a new prescription or have changes, for example. The residents do not act on anything without notifying the primary medical provider. The DON stated one of these residents evaluated Resident #1 on 11/11/24 following the visitor-to-resident abuse incident which occurred on 11/10/24. The evaluation was not documented. The DON acknowledged there was no evidence of the resident's evaluation in the clinical record or elsewhere. During a meeting with the DON and RDCS on 12/10/24 at 6:05 p.m., the concern regarding Resident #1 receiving a medical resident evaluation which was not documented was discussed. No further information was provided prior to the exit conference.