STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495185	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waverly Rehabilitation and Healthcare Center	456 E Main St Waverly, VA 23890

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and facility documentation review, the facility staff failed to ensure correct completion and acknowledgment of receipt of an insurance Advance Beneficiary Notice [ABN] of Non-Coverage, for one Resident (#1) in a survey sample of 6 Residents.The findings included.For Resident #1 the facility failed to ensure Resident #1 signed and acknowledged receipt of the notice of loss of insurance coverage and her right to appeal the decision.On 5-12-26 at approximately 2:00 PM the business office manager was given the name of the client record required for ABN notices review. She returned with Resident #1's ABN notice which was not dated, nor signed.Page 1 documented Resident #1's name and Effective Date Coverage of Your Current Skilled Nursing Facility Services Will End: 7-14-25. The document informed that a request for immediate appeal should be made as soon as possible but no later than noon on the day before the effective date. The document provided a telephone number to contact QIO Livanta LLC for appeal at [PHONE NUMBER].Additional information on page 2 optional documented: Emergency contact #1 was called on 7-11-25 at 4:32 PM on Telephone Number [number given] to inform that Resident's last covered day of skilled service will be 7-14-25. Name of emergency contact is [name given] niece. Resident's niece verbalized understanding. Notice given by [name] Social Services Director. Resident not informed due to cognitive deficit. The document was not signed by the Resident nor the emergency contact and no date was documented by the signature line.On the last page #3 titled Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) the document revealed, Beginning on 7-15-25 you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. CARE: In patient nursing facility stay. Reason Medicare May Not Pay: No longer requires skilled care on a daily basis. Estimated Cost: $281.00 per day. OPTIONS: CHECK ONLY one box. We can't choose a box for you. Option 1 - I want the care listed above. I want Medicare to be billed for an official decision on payment. Which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, I can appeal to Medicare by following the directions on MSN.Option 2 - I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. I cannot appeal because Medicare won't be billed.Option 3 - I don't want the care listed above. I understand that I'm not responsible for paying, and I can't appeal to see if Medicare would pay. Option 3 was checked as chosen by the facility staff.On 5-13-26 at 10:00 AM, the Social Services Director was interviewed and stated she had not mailed a copy of the document for signature to the emergency contact listed, nor had she given a copy to the Resident.On 5-13-26 at 3:00 PM during the end of day meeting when asked about the ABN notice not being filled out completely and the Resident not making a choice out of the three options, nor did anyone receive the notice, the Administrator stated it was not completed correctly and they had no further information to provide.

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to protect the resident's right to be free from abuse and neglect for two residents (Residents #3 & #4) in a survey sample of six residents. The findings included. For Resident #3, the facility staff failed to prevent verbal abuse, failed to fully investigate that abuse, failed to report it to the state agency, and failed to train staff timely on abuse after abuse occurred. Resident #3 was originally admitted to the facility on [DATE] with the diagnoses of, but not limited to, Stroke, hypertension, depression, and chronic obstructive respiratory disease. The Resident's most recent Minimum Data Set (MDS) to the alleged incident coded Resident #3 with moderate cognitive impairment, is able to be understood and understand others. The Resident required limited assistance from staff for bed mobility, transfers and ambulation, he was independent for eating, toileting, and hygiene, and was ambulatory with a walker or wheelchair. On 5-12-26 at 10:30 a.m. Resident #3's electronic clinical record was reviewed. Nursing, Social work, and physician Progress revealed no indication of any incident on 5-14-24 with Certified Nursing Assistant [CNA] students, nor the Administrator.Review of the Resident's care plan revealed a care plan entry on 5-15-24 for sexual abuse of a minor [under the age of 18 years] high school CNA student. The interventions were 1:1 with a staff member at all times for 1 day on 5-14-26, which was later changed to every 15 minute checks by staff on 5-15-26, and he was moved to a private room. The current Administrator, and the Director of Nursing [DON] who were not employed at the facility when the incident took place were interviewed individually and were asked for all documentation relating to this incident. The Social Worker was interviewed and was admitted ly present and current staff during the incident and did remember the incident and recounted it accurately according to other staff member interviews. She stated she knew of the allegation, however, had learned about it after the fact and did not witness any of it. She stated that the police were called and responded to the alleged sexual abuse incident, and Resident #3 went to court where it was decided he would not be prosecuted, rather, he would be on good behavior for 1 year. At the end of that year if no further incidents occurred, the charges would be dropped. The Resident expired before the year was completed and had been on hospice for quite a while with no further incidents. Two staff members were interviewed and agreed to the interview via cellular telephone only on grounds of anonymity who stated they were concerned about retaliation. They stated that they did remember the former Administrator yelling at Resident #3 to get back in his room and not to come out., after he attempted to walk down the hallway with students in the building immediately following the incident. A letter from the former Administrator to the Virginia Department of Health Professionals [DHP] was supplied, which revealed this complaint involving the former Administrator had been received by that agency and was investigated. The letter was a reply from the former Administrator to the DHP's request for information. The Administrator's letter denied having yelled at Resident #3 when he attempted to leave his room after the sexual abuse of the CNA student had taken place. The current Administrator stated she could find no investigation nor documents related to the incident other than the 15-minute check sheets which had been documented by staff on the days involved. Those were supplied. She further stated that the former DON had allegedly conducted the investigation and was no longer employed by the facility. The Administrator stated she contacted everyone she knew at the corporate office level and they said they had no documents relating to the incident. The Administrator was asked for a copy of the abuse policies, and they were supplied. One follows below. All residents will be kept safe and protected from any form of Verbal/physical/mental/sexual/financial abuse or neglect. Any employee that is proven to have verbally/physically/ mentally/sexually/financially abused or neglected a resident will be immediately terminated from employment at [name of company] Healthcare. The Department of Health will be (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified. If the employee is licensed, the appropriate licensing agency will be notified. All employees will be oriented to [name] Healthcare's policy concerning resident abuse during their orientation.All incidents of all possible verbal/physical/ mental/sexual/financial abuse or neglect of a resident will be immediately brought to the attention of the shift supervisor and notify the Abuse Coordinator (Administrator).An investigation will consist of interviews with the resident, other residents who are in the area when the incident occurred, and staff members from all departments that were working in that particular unit/area. The results of the investigation will be reviewed with the Director of Nursing, Department Supervisor, and Administrator.If it can be proven that a specific employee did abuse a resident, he/she will be terminated immediately. The Department of Health will be notified of the incident as well as the name of the employee. If the employee is licensed, the appropriate licensing agency will be notified.If the investigation is unable to place responsibility for abuse to any particular employee, the Director of Nursing and HR Designee will in-service employees of the specific unit about the facility policy regarding abuse. Attendance records and documents will be kept on file in the HR Designee office.FAILURE TO REPORT SUSPECTED ABUSE WILL BE CONSIDERED ABUSE AND GROUNDS FOR TERMINATION.Employee education records were supplied and revealed education for all staff on abuse dated 6-26-24. Forty-three [43] days after the incident on 5-14-24.On 5-13-26 at 3:30 p.m. an end-of-day meeting with the Administrator, DON, and Corporate Director of Nursing was held. A request for any additional information was made. They stated none was available. They were made aware that no investigation of abuse by the former Administrator, no report to the state agency, not implementing their abuse policies, and no follow up report constituted deficient practice. 2. For Resident #4, the facility staff failed to prevent neglect by withholding medication and Activities of Daily Living [ADL] care on 6-14-24, failed to fully investigate that neglect/abuse, failed to report it to the state agency, and failed to train staff timely on abuse/neglect after neglect occurred. Resident #4 was originally admitted to the facility on [DATE] with the diagnoses of, but not limited to, Anorexia, anxiety, depression, hypertension, dementia, malnutrition, and hypothyroid disease. The Resident was ordered to begin hospice on 2-7-26 and expired 2-14-26. The Resident's most recent Minimum Data Set (MDS) to the alleged incident coded Resident #4 with severe cognitive impairment. The Resident was completely dependent on staff for all activities of daily living [ADL] care such as dressing, hygiene and bathing. The Resident was incontinent of bowel and bladder. On 5-12-26 at 10:30 a.m. Resident #4's electronic clinical record was reviewed. Nursing, Social work, and physician Progress revealed no indication of any incident on 6-14-24 with withholding of care and medication for that day. On 6-13-24 Resident #4's roommate was documented to have thrown water on Resident #4, and in her bed where she was sleeping. The Resident was cleaned by staff and moved to another room. On 6-14-24 the Resident was in the new room. Review of the Resident's care plan revealed no care plan entry for the abuse from her first roommate having thrown water on her in bed. There were entries with interventions notating her complete dependence on staff for ADL care and medication administration. The current Administrator, and the Director of Nursing [DON] who were not employed at the facility when the incidents took place were interviewed individually and asked for all documentation relating to this incident, and the allegation that Resident #4 did not receive care nor medications on 6-14-24. The DON stated she knew of the termination of the two staff members and knew it had been found that the 2 staff involved had been guilty of neglect. She further stated they could not find any records of the investigations nor the reports to the state agency. The Social Worker was interviewed and was admitted ly present and current staff during the incidents and did remember it and recounted it accurately. She stated she knew of the allegations, however, had learned about it after the fact and did not witness any of it. She stated that the Resident was moved because of her room-mate's behavior issue, and that the 2 staff members involved in the 6-14-24 incident were both terminated as it was true that Resident #4 had not received care nor medications on that day. Medication records for Resident #4 were reviewed and revealed signatures indicating medications had been administered on 6-14-24. The DON stated she could not (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	account for the signatures, and they were from different nurses and not the nurse who was assigned that day.The current Administrator stated she could find no investigation nor documents related to the incidents. She further stated that the former DON had allegedly conducted the investigation and was no longer employed by the facility. The Administrator stated she contacted everyone she knew at the corporate office level and they said they had no documents relating to the incidents. The Administrator was asked for a copy of the abuse policies, and they were supplied. One follows below. All residents will be kept safe and protected from any form of Verbal/physical/mental/sexual/financial abuse or neglect. Any employee that is proven to have verbally/physically/ mentally/sexually/financially abused or neglected a resident will be immediately terminated from employment at [name] Healthcare. The Department of Health will be notified. If the employee is licensed, the appropriate licensing agency will be notified. All employees will be oriented to [name] Healthcare's policy concerning resident abuse during their orientation.All incidents of all possible verbal/physical/ mental/sexual/financial abuse or neglect of a resident will be immediately brought to the attention of the shift supervisor and notify the Abuse Coordinator (Administrator).An investigation will consist of interviews with the resident, other residents who are in the area when the incident occurred, and staff members from all departments that were working in that particular unit/area. The results of the investigation will be reviewed with the Director of Nursing, Department Supervisor, and Administrator.If it can be proven that a specific employee did abuse a resident, he/she will be terminated immediately. The Department of Health will be notified of the incident as well as the name of the employee. If the employee is licensed, the appropriate licensing agency will be notified.If the investigation is unable to place responsibility for abuse to any particular employee, the Director of Nursing and HR Designee will in-service employees of the specific unit about the facility policy regarding abuse. Attendance records and documents will be kept on file in the HR Designee office.FAILURE TO REPORT SUSPECTED ABUSE WILL BE CONSIDERED ABUSE AND GROUNDS FOR TERMINATION.Employee education records were supplied and revealed education for all staff on abuse dated 6-26-24. thirteen [13] days after the first incident on 6-13-24.On 5-13-26 at 3:30 p.m. an end-of-day meeting with the Administrator, DON, and Corporate Director of Nursing was held. A request for any additional information was made. They stated none was available. They were made aware that no investigation of abuse, no report to the state agency, not implementing their abuse policies, and no follow up report constituted deficient practice.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to investigate, report to the State Agency, and implement the facility abuse policies for two Residents (Residents #3 & #4) in a survey sample of six Residents. The findings included. 1. For Resident #3, the facility staff failed to investigate, report, and implement the facility abuse policies after a staff member witnessed and made an allegation of verbal abuse. Resident #3 was originally admitted to the facility on [DATE] with the diagnoses of, but not limited to, Stroke, hypertension, depression, and chronic obstructive respiratory disease. The Resident's most recent Minimum Data Set (MDS) to the alleged incident coded Resident #3 with moderate cognitive impairment, is able to be understood and understand others. The Resident required limited assistance from staff for bed mobility, transfers and ambulation, he was independent for eating, toileting, and hygiene, and was ambulatory with a walker or wheelchair. On 5-12-26 at 10:30 a.m. Resident #3's electronic clinical record was reviewed. Nursing, Social work, and physician Progress revealed no indication of any incident on 5-14-24 with Certified Nursing Assistant [CNA] students, nor the Administrator.Review of the Resident's care plan revealed a care plan entry on 5-15-24 for sexual abuse of a minor [under the age of 18 years] high school CNA student. The interventions were 1:1 with a staff member at all times for 1 day on 5-14-26, which was later changed to every 15 minute checks by staff on 5-15-26, and he was moved to a private room. The current Administrator, and the Director of Nursing [DON] who were not employed at the facility when the incident took place were interviewed individually and were asked for all documentation relating to this incident. The Social Worker was interviewed and was admitted ly present and current staff during the incident and did remember the incident and recounted it accurately according to other staff member interviews. She stated she knew of the allegation, however, had learned about it after the fact and did not witness any of it. She stated that the police were called and responded to the alleged sexual abuse incident, and Resident #3 went to court where it was decided he would not be prosecuted, rather, he would be on good behavior for 1 year. At the end of that year if no further incidents occurred, the charges would be dropped. The Resident expired before the year was completed and had been on hospice for quite a while with no further incidents. Two staff members were interviewed and agreed to the interview via cellular telephone only on grounds of anonymity who stated they were concerned about retaliation. They stated that they did remember the former Administrator yelling at Resident #3 to get back in his room and not to come out., after he attempted to walk down the hallway with students in the building immediately following the incident. A letter from the former Administrator to the Virginia Department of Health Professionals [DHP] was supplied, which revealed this complaint involving the former Administrator had been received by that agency and was investigated. The letter was a reply from the former Administrator to the DHP's request for information. The Administrator's letter denied having yelled at Resident #3 when he attempted to leave his room after the sexual abuse of the CNA student had taken place. The current Administrator stated she could find no investigation nor documents related to the incident other than the 15-minute check sheets which had been documented by staff on the days involved. Those were supplied. She further stated that the former DON had allegedly conducted the investigation and was no longer employed by the facility. The Administrator stated she contacted everyone she knew at the corporate office level and they said they had no documents relating to the incident. The Administrator was asked for a copy of the abuse policies, and they were supplied. One follows below. All residents will be kept safe and protected from any form of Verbal/physical/mental/sexual/financial abuse or neglect. Any employee that is proven to have verbally/physically/ mentally/sexually/financially abused or neglected a resident will be immediately terminated from employment at [name of company] Healthcare. The Department of Health will be notified. If the employee is licensed, the appropriate licensing agency will be notified. All employees (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will be oriented to [name] Healthcare's policy concerning resident abuse during their orientation.All incidents of all possible verbal/physical/ mental/sexual/financial abuse or neglect of a resident will be immediately brought to the attention of the shift supervisor and notify the Abuse Coordinator (Administrator).An investigation will consist of interviews with the resident, other residents who are in the area when the incident occurred, and staff members from all departments that were working in that particular unit/area. The results of the investigation will be reviewed with the Director of Nursing, Department Supervisor, and Administrator.If it can be proven that a specific employee did abuse a resident, he/she will be terminated immediately. The Department of Health will be notified of the incident as well as the name of the employee. If the employee is licensed, the appropriate licensing agency will be notified.If the investigation is unable to place responsibility for abuse to any particular employee, the Director of Nursing and HR Designee will in-service employees of the specific unit about the facility policy regarding abuse. Attendance records and documents will be kept on file in the HR Designee office.FAILURE TO REPORT SUSPECTED ABUSE WILL BE CONSIDERED ABUSE AND GROUNDS FOR TERMINATION.Employee education records were supplied and revealed education for all staff on abuse dated 6-26-24. Forty-three [43] days after the incident on 5-14-24.On 5-13-26 at 3:30 p.m. an end-of-day meeting with the Administrator, DON, and Corporate Director of Nursing was held. A request for any additional information was made. They stated none was available. They were made aware that no investigation of abuse by the former Administrator, no report to the state agency, not implementing their abuse policies, and no follow up report constituted a deficient practice. 2. For Resident #4, the facility staff failed to prevent neglect by withholding medication and Activities of Daily Living [ADL] care on 6-14-24 and failed to implement their abuse policies after an allegation of abuse was made. Resident #4 was originally admitted to the facility on [DATE] with the diagnoses of, but not limited to, Anorexia, anxiety, depression, hypertension, dementia, malnutrition, and hypothyroid disease. The Resident was ordered to begin hospice on 2-7-26 and expired 2-14-26. The Resident's most recent Minimum Data Set (MDS) to the alleged incident coded Resident #4 with severe cognitive impairment. The Resident was completely dependent on staff for all activities of daily living [ADL] care such as dressing, hygiene and bathing. The Resident was incontinent of bowel and bladder. On 5-12-26 at 10:30 a.m. Resident #4's electronic clinical record was reviewed. Nursing, Social work, and physician Progress revealed no indication of any incident on 6-14-24 with withholding of care and medication for that day. On 6-13-24 Resident #4's roommate was documented to have thrown water on Resident #4, and in her bed where she was sleeping. The Resident was cleaned by staff and moved to another room. On 6-14-24 the Resident was in the new room. Review of the Resident's care plan revealed no care plan entry for the abuse from her first roommate having thrown water on her in bed. There were entries with interventions notating her complete dependence on staff for ADL care and medication administration. The current Administrator, and the Director of Nursing [DON] who were not employed at the facility when the incidents took place were interviewed individually and asked for all documentation relating to this incident, and the allegation that Resident #4 did not receive care nor medications on 6-14-24. The DON stated she knew of the termination of the two staff members and knew it had been found that the 2 staff involved had been guilty of neglect. She further stated they could not find any records of the investigations nor the reports to the state agency. The Social Worker was interviewed and was admitted ly present and current staff during the incidents and did remember it and recounted it accurately. She stated she knew of the allegations, however, had learned about it after the fact and did not witness any of it. She stated that the Resident was moved because of her room-mate's behavior issue, and that the 2 staff members involved in the 6-14-24 incident were both terminated as it was true that Resident #4 had not received care nor medications on that day. Medication records for Resident #4 were reviewed and revealed signatures indicating medications had been administered on 6-14-24. The DON stated she could not account for the signatures, and they were from different nurses and not the nurse who was assigned that day.The current Administrator stated she could find no investigation nor documents (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	related to the incidents. She further stated that the former DON had allegedly conducted the investigation and was no longer employed by the facility. The Administrator stated she contacted everyone she knew at the corporate office level and they said they had no documents relating to the incidents. The Administrator was asked for a copy of the abuse policies, and they were supplied. One follows below. All residents will be kept safe and protected from any form of Verbal/physical/mental/sexual/financial abuse or neglect. Any employee that is proven to have verbally/physically/ mentally/sexually/financially abused or neglected a resident will be immediately terminated from employment at [name] Healthcare. The Department of Health will be notified. If the employee is licensed, the appropriate licensing agency will be notified. All employees will be oriented to [name] Healthcare's policy concerning resident abuse during their orientation.All incidents of all possible verbal/physical/ mental/sexual/financial abuse or neglect of a resident will be immediately brought to the attention of the shift supervisor and notify the Abuse Coordinator (Administrator).An investigation will consist of interviews with the resident, other residents who are in the area when the incident occurred, and staff members from all departments that were working in that particular unit/area. The results of the investigation will be reviewed with the Director of Nursing, Department Supervisor, and Administrator.If it can be proven that a specific employee did abuse a resident, he/she will be terminated immediately. The Department of Health will be notified of the incident as well as the name of the employee. If the employee is licensed, the appropriate licensing agency will be notified.If the investigation is unable to place responsibility for abuse to any particular employee, the Director of Nursing and HR Designee will in-service employees of the specific unit about the facility policy regarding abuse. Attendance records and documents will be kept on file in the HR Designee office.FAILURE TO REPORT SUSPECTED ABUSE WILL BE CONSIDERED ABUSE AND GROUNDS FOR TERMINATION.Employee education records were supplied and revealed education for all staff on abuse dated 6-26-24. thirteen [13] days after the first incident on 6-13-24.On 5-13-26 at 3:30 p.m. an end-of-day meeting with the Administrator, DON, and Corporate Director of Nursing was held. A request for any additional information was made. They stated none was available. They were made aware that no investigation of abuse, no report to the state agency, not implementing their abuse policies, and no follow up report constituted a deficient practice.

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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 staff interview, facility documentation review, and clinical record review, the facility staff failed to report neglect and abuse for two Residents (Residents #3 & #4) in a survey sample of six residents. For Resident #3, the facility staff failed to report an allegation of verbal abuse.The findings included.Resident #3 was originally admitted to the facility on [DATE] with the diagnoses of, but not limited to, Stroke, hypertension, depression, and chronic obstructive respiratory disease.The Resident's most recent Minimum Data Set (MDS) to the alleged incident coded Resident #3 with moderate cognitive impairment, is able to be understood and understand others. The Resident required limited assistance from staff for bed mobility, transfers and ambulation, he was independent for eating, toileting, and hygiene, and was ambulatory with a walker or wheelchair.On 5-12-26 at 10:30 a.m. Resident #3's electronic clinical record was reviewed. Nursing, Social work, and physician Progress revealed no indication of any incident on 5-14-24 with Certified Nursing Assistant [CNA] students, nor the Administrator.Review of the Resident's care plan revealed a care plan entry on 5-15-24 for sexual abuse of a minor [under the age of 18 years] high school CNA student. The interventions were 1:1 with a staff member at all times for 1 day on 5-14-26, which was later changed to every 15 minute checks by staff on 5-15-26, and he was moved to a private room.The current Administrator, and the Director of Nursing [DON] who were not employed at the facility when the incident took place were interviewed individually and were asked for all documentation relating to this incident.The Social Worker was interviewed and was admitted ly present and current staff during the incident and did remember the incident and recounted it accurately according to other staff member interviews. She stated she knew of the allegation, however, had learned about it after the fact and did not witness any of it. She stated that the police were called and responded to the alleged sexual abuse incident, and Resident #3 went to court where it was decided he would not be prosecuted, rather, he would be on good behavior for 1 year. At the end of that year if no further incidents occurred, the charges would be dropped. The Resident expired before the year was completed and had been on hospice for quite a while with no further incidents.Two staff members were interviewed and agreed to the interview via cellular telephone only on grounds of anonymity who stated they were concerned about retaliation. They stated that they did remember the former Administrator yelling at Resident #3 to get back in his room and not to come out., after he attempted to walk down the hallway with students in the building immediately following the incident.A letter from the former Administrator to the Virginia Department of Health Professionals [DHP] was supplied, which revealed this complaint involving the former Administrator had been received by that agency and was investigated. The letter was a reply from the former Administrator to the DHP's request for information. The Administrator's letter denied having yelled at Resident #3 when he attempted to leave his room after the sexual abuse of the CNA student had taken place.The current Administrator stated she could find no investigation nor documents related to the incident other than the 15-minute check sheets which had been documented by staff on the days involved, or any credible evidence that the allegation/incident had been reported to the state survey agency or adult protective services. Those were supplied. She further stated that the former DON had allegedly conducted the investigation and was no longer employed by the facility. The Administrator stated she contacted everyone she knew at the corporate office level and they said they had no documents relating to the incident. 2. For Resident #4, the facility staff failed to report an allegation of abuse/neglect to the state agency after the willful abuse by a roommate on 6-13-24, and the withholding of medication and Activities of Daily Living [ADL] care by staff was identified as having occurred on 6-14-24.Resident #4 was originally admitted to the facility on [DATE] with the diagnoses of, but not limited to, Anorexia, anxiety, depression, hypertension, dementia, malnutrition, and hypothyroid disease. The Resident was ordered (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495185	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waverly Rehabilitation and Healthcare Center	456 E Main St Waverly, VA 23890

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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	to begin hospice on 2-7-26 and expired 2-14-26.The Resident's most recent Minimum Data Set (MDS) to the alleged incident coded Resident #4 with severe cognitive impairment. The Resident was completely dependent on staff for all activities of daily living [ADL] care such as dressing, hygiene and bathing. The Resident was incontinent of bowel and bladder.On 5-12-26 at 10:30 a.m. Resident #4's electronic clinical record was reviewed. Nursing, Social work, and physician Progress revealed no indication of any incident on 6-14-24 with withholding of care and medication for that day. On 6-13-24 Resident #4's roommate was documented to have thrown water on Resident #4, and in her bed where she was sleeping. The Resident was cleaned by staff and moved to another room. On 6-14-24 the Resident was in the new room.Review of the Resident's care plan revealed no care plan entry for the abuse from her first roommate having thrown water on her in bed. There were entries with interventions notating her complete dependence on staff for ADL care and medication administration. The current Administrator, and the Director of Nursing [DON] who were not employed at the facility when the incidents took place were interviewed individually and asked for all documentation relating to this incident, and the allegation that Resident #4 did not receive care nor medications on 6-14-24. The DON stated she knew of the termination of the two staff members and knew it had been found that the 2 staff involved had been guilty of neglect. She further stated they could not find any records of the investigations nor the evidence that the incident was reported to the state agency.The Social Worker was interviewed and was admitted ly present and current staff during the incidents and did remember it and recounted it accurately. She stated she knew of the allegations, however, had learned about it after the fact and did not witness any of it. She stated that the Resident was moved because of her room-mate's behavior issue, and that the 2 staff members involved in the 6-14-24 incident were both terminated as it was true that Resident #4 had not received care nor medications on that day.Medication records for Resident #4 were reviewed and revealed signatures indicating medications had been administered on 6-14-24. The DON stated she could not account for the signatures, and they were from different nurses and not the nurse who was assigned that day.The current Administrator stated she could find no investigation nor documents related to the incidents. She further stated that the former DON had allegedly conducted the investigation and was no longer employed by the facility. The Administrator stated she contacted everyone she knew at the corporate office level and they said they had no documents relating to the incidents.The Administrator was asked for a copy of the abuse policies, and they were supplied. One follows below. All residents will be kept safe and protected from any form of Verbal/physical/mental/sexual/financial abuse or neglect. Any employee that is proven to have verbally/physically/ mentally/sexually/financially abused or neglected a resident will be immediately terminated from employment at [name] Healthcare. The Department of Health will be notified. If the employee is licensed, the appropriate licensing agency will be notified. All employees will be oriented to [name] Healthcare's policy concerning resident abuse during their orientation.All incidents of all possible verbal/physical/ mental/sexual/financial abuse or neglect of a resident will be immediately brought to the attention of the shift supervisor and notify the Abuse Coordinator (Administrator) FAILURE TO REPORT SUSPECTED ABUSE WILL BE CONSIDERED ABUSE AND GROUNDS FOR TERMINATION.On 5-13-26 at 3:30 p.m. an end-of-day meeting with the Administrator, DON, and Corporate Director of Nursing was held. A request for any additional information was made. They stated none was available. They were made aware that no report to the state agency about an allegation of abuse and neglect was made, which constituted deficient practice.

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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 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 staff interview, facility documentation review, and clinical record review, the facility staff failed to investigate neglect and abuse for two Residents (Residents #3 & #4) in a survey sample of six residents. For Resident #3, the facility staff failed to conduct a thorough investigation of an allegation of abuse.The findings included.Resident #3 was originally admitted to the facility on [DATE] with the diagnoses of, but not limited to, Stroke, hypertension, depression, and chronic obstructive respiratory disease.The Resident's most recent Minimum Data Set (MDS) to the alleged incident coded Resident #3 with moderate cognitive impairment, is able to be understood and understand others. The Resident required limited assistance from staff for bed mobility, transfers and ambulation, he was independent for eating, toileting, and hygiene, and was ambulatory with a walker or wheelchair.On 5-12-26 at 10:30 a.m. Resident #3's electronic clinical record was reviewed. Nursing, Social work, and physician Progress revealed no indication of any incident on 5-14-24 with Certified Nursing Assistant [CNA] students, nor the Administrator.Review of the Resident's care plan revealed a care plan entry on 5-15-24 for sexual abuse of a minor [under the age of 18 years] high school CNA student. The interventions were 1:1 with a staff member at all times for 1 day on 5-14-26, which was later changed to every 15 minute checks by staff on 5-15-26, and he was moved to a private room.The current Administrator, and the Director of Nursing [DON] who were not employed at the facility when the incident took place were interviewed individually and were asked for all documentation relating to this incident.The Social Worker was interviewed and was admitted ly present and current staff during the incident and did remember the incident and recounted it accurately according to other staff member interviews. She stated she knew of the allegation, however, had learned about it after the fact and did not witness any of it. She stated that the police were called and responded to the alleged sexual abuse incident, and Resident #3 went to court where it was decided he would not be prosecuted, rather, he would be on good behavior for 1 year. At the end of that year if no further incidents occurred, the charges would be dropped. The Resident expired before the year was completed and had been on hospice for quite a while with no further incidents.Two staff members were interviewed and agreed to the interview via cellular telephone only on grounds of anonymity who stated they were concerned about retaliation. They stated that they did remember the former Administrator yelling at Resident #3 to get back in his room and not to come out., after he attempted to walk down the hallway with students in the building immediately following the incident.A letter from the former Administrator to the Virginia Department of Health Professionals [DHP] was supplied, which revealed this complaint involving the former Administrator had been received by that agency and was investigated. The letter was a reply from the former Administrator to the DHP's request for information. The Administrator's letter denied having yelled at Resident #3 when he attempted to leave his room after the sexual abuse of the CNA student had taken place.The current Administrator stated she could find no investigation nor documents related to the incident other than the 15-minute check sheets which had been documented by staff on the days involved. Those were supplied. She further stated that the former DON had allegedly conducted the investigation and was no longer employed by the facility. The Administrator stated she contacted everyone she knew at the corporate office level and they said they had no documents relating to the incident.The Administrator was asked for a copy of the abuse policies, and they were supplied. One follows below. All residents will be kept safe and protected from any form of Verbal/physical/mental/sexual/financial abuse or neglect. Any employee that is proven to have verbally/physically/ mentally/sexually/financially abused or neglected a resident will be immediately terminated from employment at [name of company] Healthcare. The Department of Health will be notified. If the employee is licensed, the appropriate licensing agency will be notified. All employees will be oriented to [name] Healthcare's policy concerning resident abuse during their orientation.All incidents of all possible verbal/physical/ mental/sexual/financial abuse or neglect of a (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident will be immediately brought to the attention of the shift supervisor and notify the Abuse Coordinator (Administrator).An investigation will consist of interviews with the resident, other residents who are in the area when the incident occurred, and staff members from all departments that were working in that particular unit/area. The results of the investigation will be reviewed with the Director of Nursing, Department Supervisor, and Administrator.If it can be proven that a specific employee did abuse a resident, he/she will be terminated immediately. The Department of Health will be notified of the incident as well as the name of the employee. If the employee is licensed, the appropriate licensing agency will be notified.If the investigation is unable to place responsibility for abuse to any particular employee, the Director of Nursing and HR Designee will in-service employees of the specific unit about the facility policy regarding abuse. Attendance records and documents will be kept on file in the HR Designee office.Employee education records were supplied and revealed education for all staff on abuse dated 6-26-24. Forty-three [43] days after the incident on 5-14-24.On 5-13-26 at 3:30 p.m. an end-of-day meeting with the Administrator, DON, and Corporate Director of Nursing was held. A request for any additional information was made. They stated none was available. They were made aware that no investigation of abuse by the former Administrator, and no follow up investigation report constituted deficient practice. 2. For Resident #4, the facility staff failed to fully investigate an allegation of abuse on 6-13-24 involving the willful attack with water by a roommate, and neglect by the the willful withholding of medication and Activities of Daily Living [ADL] care by staff on 6-14-24.Resident #4 was originally admitted to the facility on [DATE] with the diagnoses of, but not limited to, Anorexia, anxiety, depression, hypertension, dementia, malnutrition, and hypothyroid disease. The Resident was ordered to begin hospice on 2-7-26 and expired 2-14-26.The Resident's most recent Minimum Data Set (MDS) to the alleged incident coded Resident #4 with severe cognitive impairment. The Resident was completely dependent on staff for all activities of daily living [ADL] care such as dressing, hygiene and bathing. The Resident was incontinent of bowel and bladder.On 5-12-26 at 10:30 a.m. Resident #4's electronic clinical record was reviewed. Nursing, Social work, and physician Progress revealed no indication of any incident on 6-14-24 with withholding of care and medication for that day. On 6-13-24 Resident #4's roommate was documented to have thrown water on Resident #4, and in her bed where she was sleeping. The Resident was cleaned by staff and moved to another room. On 6-14-24 the Resident was in the new room.Review of the Resident's care plan revealed no care plan entry for the abuse from her first roommate having thrown water on her in bed. There were entries with interventions notating her complete dependence on staff for ADL care and medication administration. The current Administrator, and the Director of Nursing [DON] who were not employed at the facility when the incidents took place were interviewed individually and asked for all documentation relating to this incident, and the allegation that Resident #4 did not receive care nor medications on 6-14-24. The DON stated she knew of the termination of the two staff members and knew it had been found that the 2 staff involved had been guilty of neglect. She further stated they could not find any records of the investigations nor the reports to the state agency.The Social Worker was interviewed and was admitted ly present and current staff during the incidents and did remember it and recounted it accurately. She stated she knew of the allegations, however, had learned about it after the fact and did not witness any of it. She stated that the Resident was moved because of her room-mate's behavior issue, and that the 2 staff members involved in the 6-14-24 incident were both terminated as it was true that Resident #4 had not received care nor medications on that day.Medication records for Resident #4 were reviewed and revealed signatures indicating medications had been administered on 6-14-24. The DON stated she could not account for the signatures, and they were from different nurses and not the nurse who was assigned that day.The current Administrator stated she could find no investigation nor documents related to the incidents. She further stated that the former DON had allegedly conducted the investigation and was no longer employed by the facility. The Administrator stated she contacted everyone she knew at the corporate office level and they said they had no documents relating to the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incidents.The Administrator was asked for a copy of the abuse policies, and they were supplied. One follows below. All residents will be kept safe and protected from any form of Verbal/physical/mental/sexual/financial abuse or neglect. Any employee that is proven to have verbally/physically/ mentally/sexually/financially abused or neglected a resident will be immediately terminated from employment at [name] Healthcare. The Department of Health will be notified. If the employee is licensed, the appropriate licensing agency will be notified. All employees will be oriented to [name] Healthcare's policy concerning resident abuse during their orientation.All incidents of all possible verbal/physical/ mental/sexual/financial abuse or neglect of a resident will be immediately brought to the attention of the shift supervisor and notify the Abuse Coordinator (Administrator).An investigation will consist of interviews with the resident, other residents who are in the area when the incident occurred, and staff members from all departments that were working in that particular unit/area. The results of the investigation will be reviewed with the Director of Nursing, Department Supervisor, and Administrator.If it can be proven that a specific employee did abuse a resident, he/she will be terminated immediately. The Department of Health will be notified of the incident as well as the name of the employee. If the employee is licensed, the appropriate licensing agency will be notified.If the investigation is unable to place responsibility for abuse to any particular employee, the Director of Nursing and HR Designee will in-service employees of the specific unit about the facility policy regarding abuse. Attendance records and documents will be kept on file in the HR Designee office Employee education records were supplied and revealed education for all staff on abuse dated 6-26-24. thirteen days after the first incident on 6-13-24.On 5-13-26 at 3:30 p.m. an end-of-day meeting with the Administrator, DON, and Corporate Director of Nursing was held. A request for any additional information was made. They stated none was available. They were made aware that no investigation of abuse, and no follow up investigation report constituted deficient practice.