

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/22/2025
NAME OF PROVIDER OR SUPPLIER  Henrico Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  561 North Airport Drive Highland Springs, VA 23075	

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.  (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:  495193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/22/2025
NAME OF PROVIDER OR SUPPLIER  Henrico Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  561 North Airport Drive Highland Springs, VA 23075	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, clinical record review, and facility documentation, the facility staff failed to report allegations of abuse or neglect for 1 Resident (#114) in a survey sample of 55 Residents. The findings included: For Resident #114, the facility staff failed to report the resident eloping from the facility on several occasions. Resident #114 was admitted to the facility on [DATE] with diagnoses that included but were not limited to pancreatic cancer, bile duct obstruction, palliative care, chronic bronchitis, muscle weakness, depression, general anxiety disorder, insomnia due to medical condition, psychotic disorder with hallucinations due to a known physiological condition (paranoid schizophrenia), and psychotic disorder with delusions due to a known physiological condition (paranoid schizophrenia). Resident #114's most recent BIMS (Brief Interview of Mental Status) scored the Resident at 15/15 indicating no cognitive impairment. Resident #114's clinical record included a document entitled Provider Attestation for Schizophrenia/Schizoaffective/Schizophreniform Diagnosis that listed the medications for this diagnosis as Seroquel ER 150 mg per day, Depakote 500 mg 2 times daily and Haldol 10 mg 2 times daily. All meds read for diagnosis of Psychotic disorder with hallucinations due to a known physiological illness. On 7/16/25 the Administrator was asked for all reportable incidents involving Resident #114 during the time of his stay at the facility. The Administrator supplied 2 documents entitled Facility Reported Incident one was dated 8/10/24 and the other was dated 8/11/24. The Administrator was asked if this was all of them and she stated it was. A review of the clinical record revealed the following excerpts: 6/13/24 7:25 p.m. Resident was involved in a verbal/physical altercation with another resident in which Mr. V. [NAME] pushed [Resident name redacted] on her right shoulder, grabbed her right leg, stomped her glasses and kicked her phone in the grass. Writer questioned Resident about the incident, and he stated that she triggered him by saying what she said to him. 6-26-24 6:12 am. - On this date 06/12/2024 during my shift, resident was seen going out of the facility 0540, when asked where he was going, resident says what kind of question are you asking me, I want to get a cigarette lighter at nearby store. All effort to redirect him back to the facility was prove abortive until a staff followed him and drove him back to the facility. 6/29/24 5:16 - Resident was noted to be seen by staff at 0130. Staff went to resident room to check on him and he was nowhere to be found. Resident apparently had left the building unbeknownst to staff. Staff immediately did a sweep of the interior and exterior of the facility unable to locate Mr. [NAME]. Police were called and given a picture and description of the clothing the resident was wearing when last seen. Staff notified DON, RP and provider. Officers spoke with other officers in a different jurisdiction which stated they had him at [Convenience store name redacted] Staff was told by officers they would have to transport [Resident 114 name redacted] back to facility 6/29/24 5:58 a.m. - This writer saw resident at 0130 entered the dining room and later went to resident room to check on him and he was nowhere to be found. Resident had walk [sic] away from the building unknown to staff. Sweeping of the interior and exterior of the facility was done still unable to find [Resident #114 name redacted] Police were called and given a picture and description of the clothing the resident was wearing when last seen. DON was notified, RP and provider. Officers spoke with other officers in a different jurisdiction which stated they found him at [convenience store name redacted]. Staff was [sic] told by officers they would have to transport [Resident#114 name redacted] back to facility. Staff drove to the location where he was found (approximately 7.1 miles away from the facility) and bring [sic] him back to the facility. Head to toe Skin assessment was done and intact. Resident was later sent out to hospital for psych consult EMS notified and resident was transported to the hospital by 2 EMS at 0535. 7/2/24 9:30 a.m.- I was able to find legal Guardian's phone number. I called her to speak about resident's wander guard. She said that resident has a history of wandering, and she would really appreciate him having a wander guard. She asked if it had a tracking device, and I explained that it only alerted us when he went out the building. She said that it was fine and appreciated the call. On 7/16/25 at approximately 11:45 a.m. an interview was conducted with the Administrator; she was asked why the first 3 incidents of elopement were not reported to the OLC and other entities as required by regulations. The Administrator stated that Resident #114 had a High BIMS score and therefore he could leave the facility if he signed himself out. She stated that he did not sign himself out of the facility. The Administrator was asked if Resident #114 had Any conditions that would affect his decision-making ability, she stated that he had a diagnosis of Schizophrenia. On 7/17/25 an interview was conducted with Employee L who was asked if a Resident with a BIMS of 15 can leave the facility unescorted. Employee L stated that it would depend on the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/22/2025
NAME OF PROVIDER OR SUPPLIER  Henrico Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  561 North Airport Drive Highland Springs, VA 23075	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/22/2025
NAME OF PROVIDER OR SUPPLIER  Henrico Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  561 North Airport Drive Highland Springs, VA 23075	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, clinical record review and facility documentation, the facility staff failed to ensure residents were free from accidents and hazards for 3 Residents (#'s 114, 59, and 65) in a survey sample of 55 residents. The Findings included:1. For Resident #114 the facility staff failed to provide adequate supervision to prevent the residents from eloping from the facility.Resident #114 was admitted to the facility on [DATE] with diagnoses that included but were not limited to pancreatic cancer, bile duct obstruction, palliative care, chronic bronchitis, muscle weakness, depression, general anxiety disorder, insomnia due to medical condition, psychotic disorder with hallucinations due to a known physiological condition (paranoid schizophrenia), and psychotic disorder with delusions due to a known physiological condition (paranoid schizophrenia).Resident #114's most recent BIMS (Brief Interview of Mental Status) scored the Resident at 15/15 indicating no cognitive impairment. Resident #114's clinical record included a document entitled Provider Attestation for Schizophrenia/Schizoaffective/Schizophreniform Diagnosis that listed the medications for this diagnosis as Seroquel ER 150 mg per day, Depakote 500 mg 2 times daily and Haldol 10 mg 2 times daily. All meds read for diagnosis of Psychotic disorder with hallucinations due to a known physiological illness.On 7/14/25 at approximately 1:30 p.m. Residents were observed sitting in front of the building without supervision from staff. On 7/15/25- 7/17/25 at various times throughout the day residents were observed without supervision, outdoors in front of the building in wheelchairs or independently ambulating. Supervision was provided to Residents in the gazebo smoking, and fluids were provided to the residents at the exit door on south hall that leads to the gazebo. No supervision or fluids were being offered at the front main entrance. A review of the clinical record revealed the following excerpts: 6/13/24 7:25 p.m. Resident was involved in a verbal/physical altercation with another resident in which Mr. V. [NAME] pushed [Resident name redacted] on her right shoulder, grabbed her right leg, stomped her glasses and kicked her phone in the grass. Writer questioned Resident about the incident, and he stated that she triggered him by saying what she said to him. 6/26/24 6:12 am. - On this date 06/12/2024 during my shift, resident was seen going out of the facility 0540, when asked where he was going, resident says what kind of question are you asking me, I want to get a cigarette lighter at nearby store. All effort to redirect him back to the facility was prove abortive until a staff followed him and drove him back to the facility. 6/29/24 5:16 - Resident was noted to be seen by staff at 0130. Staff went to resident room to check on him and he was nowhere to be found. Resident apparently had left the building unbeknownst to staff. Staff immediately did a sweep of the interior and exterior of the facility unable to locate Mr. [NAME]. Police were called and given a picture and description of the clothing the resident was wearing when last seen. Staff notified DON, RP and provider. Officers spoke with other officers in a different jurisdiction which stated they had him at [Convenience store name redacted] Staff was [sic] told by officers they would have to transport [Resident 114 name redacted] back to facility 6/29/24 5:58 a.m. - This writer saw resident at 0130 entered the dining room and later went to resident room to check on him and he was nowhere to be found. Resident had walk [sic] away from the building unknown to staff. Sweeping of the interior and exterior of the facility was done still unable to find [Resident #114 name redacted] Police were called and given a picture and description of the clothing the resident was wearing when last seen. DON was notified, RP and provider. Officers spoke with other officers in a different jurisdiction which stated they found him at [convenience store name redacted]. Staff was [sic] told by officers they would have to transport [Resident#114 name redacted] back to facility. Staff drove to the location where he was found (approximately 7.1 miles away from the facility) and bring [sic] him back to the facility. Head to toe Skin assessment was done and intact. Resident was later sent out to hospital for psych consult EMS notified and resident was transported to the hospital by 2 EMS at 535. 7/2/24 9:30 a.m.- I was able to find legal Guardian's phone number. I called her to speak about resident's wander guard. She said that resident has a history of wandering, and she would really appreciate him having a wander guard. She asked if it had a tracking device, and I explained that it only alerted us when he went out the building. She said that it was fine and appreciated the call.On 7/16/24 at approximately 11:45 a.m. an interview was conducted with the Administrator; she was asked why the first incidents of elopement were not reported to the OLC and other entities as required by CMS Guidelines. The Administrator stated that Resident #114 had a High BIMS score and therefore he could leave the facility if he signed himself out. She stated that he had scored high on his RIMS and then eloped. She stated that he did not sign himself out of the facility. The</p>		