

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER South Boston Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 103 Rosehill Drive South Boston, VA 24592	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449</p> <p>Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to protect a resident's right to be free from sexual abuse for one resident (Resident #8 - R8) in a survey sample of 10 residents, which resulted in harm for R8.</p> <p>The findings included:</p> <p>On 10/22/24, during an entrance conference conducted at 1:45 p.m., the facility administrator was asked to provide any and all information the facility had with regards to a sexual assault. Following the entrance conference, the facility administrator stated that the incident binder with the facility's investigation and response to the sexual assault had been misplaced following a fire the facility had in August 2023. The administrator provided the surveyor with a binder and stated that it contained the information they had been able to re-create. According to the binder, R8 was the victim and R9 was the alleged perpetrator, identified as Resident #9 (R9). The survey team was also provided with a listing of current residents, it was noted that neither R8 or R9 were current residents of the facility and therefore were not able to be interviewed.</p> <p>On 10/23/24, a closed record review was conducted of R8's chart. This review revealed an entry by registered nurse #1 (RN #1) dated 12/17/22 at 12:25 p.m., that read, Recorder in room and observed male resident having sexual intercourse with resident in her bed with resident's legs spread open with one to each side of resident's waist. Bed noted to be at lowest position with cover on floor. Observed male resident with pants and brief down around his knees. Recorder stated for male resident to stop and get off of her. Male resident proceeded to stop engaging in the sexual activity, got off of resident and was noted be to be fully erect. No bodily fluid observed on penis. Male resident then stood up from bed, pulled up his pants and briskly walked out of resident's room and up hallway. Resident noted to have a flat affect to face. When asked what happened, resident stated, he hurt my breast and [NAME] Pam hurt. Resident observed lying flat in the bed with hospital gown raised up to her breasts exposing the underside of the breast. Resident's brief noted to be undone and exposing vagina. Resident assured that he would not be coming back into the room and covered with a sheet for privacy. Recorder called for staff member to stay with resident while recorder exited room and returned to nurse's station.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>There were multiple entries in R8's clinical record on 12/17/22, which included notification to the family of the incident, the doctor, who was on-site and gave an order to send R8 to the emergency room , as well as the police being notified. An entry dated 12/17/22 at 1:21 p.m., read, This writer called [hospital name redacted] ER [emergency room] to give report to nurse. After telling the nurse that the resident had been raped and would need a rape kit. This writer was told that [hospital name redacted] hospital could not accommodate the resident and could we send the resident to another facility. 911 transport was made aware of what the nurse had said. 911 driver stated that they could not bypass this hospital per their protocol and would first need to go to [hospital name redacted] ER.</p> <p>On 12/17/22 at 7:51 p.m., an entry was made by the physician into R8's chart that read in part, Pt [patient] raped by another resident this afternoon. No bleeding or injuries noted. The RP of both parties were notified, and pt was transferred to ED for forensic exam . A/P [active problem(s)]: 1. Non-consensual intercourse - forensic exam pending, but initial examination was normal. Perpetrator was turned over to legal authorities 2. OCD [obsessive compulsive disorder] with severe intellectual inability -chronic (food obsession); continue supportive care. Will continue to redirect behaviors. 3. Bipolar disorder - chronic, continue clomipramine and valproic acid . 6. MDD [major depressive disorder] chronic; continue sertraline; trazodone for sleep .</p> <p>Following R8's return to the facility on [DATE], there were multiple entries that indicated R8 appeared in no distress and was at baseline.</p> <p>According to a progress note dated 12/21/22, by a nurse practitioner, R8 was seen for abdominal pain. The note read in part, Asked to see re abd [abdominal] pain. Onset this morning. When queried she points to epigastric region as focus. Upon palp, flinches and guards to lower abd, suprapubic and pelvic palpation. Unable to do speculum exam. Outer vaginal canal, labia and surrounding skin w/o bleeding, discharge, skin tears or abrasions, no labial bruising . She does have significant cognitive and communication deficits . PMHx [past medical history]- Severe MR/DD [mental retardation and developmental disabilities], OCD/Bipolar/ anxiety . A/P [assessment/plan] Diffuse Abdominal pain, lower pelvic focus- no new GYN [gynecology] findings externally. Will obtain AXR [abdominal x-ray] r/o [rule out] GI/bowel issue, pelvic sono re pain, vaginal and urine cultures. #. Heartburn- will add Pepcid 20mg bid x 7 days then decr to qhs [every bedtime] (she does use prn topicals often). #. S/P [status post] sexual assault 12/18/22- forensic exam reportedly negative. No Sperm, no Trichomonas/fungal elements on vag swab/smear. Chlamydia/ Syphilis P per [hospital name redacted] documentation. Request results.</p> <p>On 10/23/24 at 4:03 p.m., an interview was conducted with RN #1. RN #1 reported that on 12/21/22, R8's roommate (resident #10- R10) came to the nursing station and was mumbling saying that she couldn't go to her room because . that man was on top of her roommate. RN #1 reported that she immediately went to R8's room and she observed R9 in the bed, on top of R8. R9 had his pants down, was on the bed on top of R8, and was making the . back and forth motion and was groping her breasts. RN #1 reported that R8's gown was pulled up; her breasts were exposed, and her incontinence brief was undone on one side. RN #1 reported that she told R9 to get off of her and when he stood up, she noted R9 had an erection. RN #1 said she was not aware if R9 made sexual penetration of R8 or not but it was sexual assault regardless. RN#1 stated that she observed R9 pull up his pants and exit the room. RN #1 reported that she called the following, the doctor, police, director of nursing, unit manager, administrator, and family of both residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During the above interview with RN #1, she reported that R8 was cognitively impaired and would not have been able to give consent to any sexual activity. RN #1 reported that R9 was able to ambulate independently, would refuse medications and care at times, and that staff had to redirect him often. RN #1 reported that following the incident R9 was taken into custody by the police and did not return to the facility. RN #1 reported that she had to go to court numerous times because the case kept being postponed but the last time was told she didn't have to come back anymore because it was dismissed, and that they had said that they were both cognitively impaired.</p> <p>On 10/24/24, a clinical record review was conducted of R9's closed record. According to a progress note written by a psychiatric mental health nurse practitioner on 12/12/22, prior to the incident, the note indicated R9 had diagnosis to include but not limited to, PTSD (post-traumatic stress disorder), alcohol abuse, schizoaffective disorder, psychosis, anxiety disorder, and sexual dysfunction. The note read in part, Patient is a [AGE] year-old male seen for follow-up with a psychiatric history of schizoaffective disorder, insomnia, PTSD, and inappropriate sexual behavior . He is alert and oriented x 2 [to person and place] and is reliable historian . His last mental health review was on 11/28/22 where he was stable . Since last review, patient had documented behaviors of resistance to care and walking away from the facility and would not come back with guidance from the police officer or staff. Staff also requested that R9 be seen for increased agitation, verbal and physical abuse, and combativeness at times. Staff also indicated paranoid delusions and documented that the patient will frequently state everyone is trying to kill me . Patient's PTSD is stable per staff and states that he has had not any further inappropriate sexual behaviors other than remarks to staff that are not sexual but continuing to be complementing .Care plan: Recommendation: The patient's inappropriate sexual behaviors are controlled on Provera .</p> <p>Within the documents tab of R9's chart there was a document titled, [R9's name redacted] email about case requesting approval for BDWO [bad debt write off]. That document was email correspondence from the business office manager to the administrator dated 8/7/23. Within the email, it read in part, . [R9's name redacted] had a history of criminal behavior prior to his admission to our facility and according to what I can recall on this case, it took a long time to get his social security reinstated. It may have been that [R9's name redacted] owed money back to the social security office and this is why the check was short in the month of February. As you recall, he left our facility on December 17, 2022, due to assault to one of our residents and currently is waiting trail This is a special circumstance, and the ex-resident is not currently receiving social security since he is considered to be an inmate.</p> <p>On 12/17/22 at 12:50 p.m., there was an entry made by the facility administrator that read, Late Entry: Alerted by staff members by phone regarding sexual activity of resident with female resident of facility. Resident reportedly left room of involved resident and walked out of facility. Staff advised to keep resident in sight continually pending arrival of police to facility. RP Cousin- [name redacted] at facility at approximately 3 pm. Spoke with her briefly regarding personal belongings which she will pick up at a later date.</p> <p>Another progress note dated 12/17/22 at 1:32 p.m., read, Resident's RR [responsible representative], [name redacted], returned call to the facility. RR was made aware by Dr. [doctor's name redacted] that the resident [R9]was found having sex with another resident that could not give consent. RR stated that she is on her way to facility per Dr. [doctor's name redacted].</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/24/24 at 1:58 p.m., an interview was conducted with CNA #4. CNA #4 was asked about the incident on 12/17/22 regarding R8 and R9. CNA #4 stated, she remembered bits and pieces. CNA #4 went on to report that R8's roommate had said, that crazy man is on top of [R8's name redacted]. CNA #4 reported that RN #1 started running to R8's room. CNA #4 said, when R9 came out of the room, he was trying to go out the front door and they had me stand at the door and the police pulled up then. CNA #4 reported that when the police asked R8 what happened she pointed to her breasts. CNA #4 reported that R9 used to get mad and throw tantrums, he was off that week, acting crazy like he wasn't taking his meds, calling people the B word. When asked about R9's behaviors CNA #4 reported the behaviors were only towards staff, not towards other residents until the incident on 12/17/22. When asked about R9's cognitive status, CNA #4 said, He was aware of things, but he was off a little bit. When asked about R8's functional status, CNA #4 said, She didn't talk too much, it was like a grown person in a kid's body, she had a kid mentality. When asked how R8 was following the incident, CNA #4 said, I don't think she was aware, but shortly after that, they sent her somewhere else.</p> <p>On 10/23/24-10/24/24, a review of the facility provided binder as evidence of their investigation and submission for consideration of past non-compliance was reviewed. Within the binder was a cover letter that read in part, This will serve as our plan of abatement for [facility name redacted] to: An allegation of sexual abuse made on 12/17/2022. Allegation background: An allegation of sexual abuse was made between resident #1 (female victim) and resident #2 (male perpetrator). Employee #1 observed resident #2 on top of resident #1 having sexual contact and she is unable to give consent. Employee #1 stopped the contact immediately. #2- Fire and building closed for over a year for remodeling and FRI investigations misplaced during the time .</p> <p>The document went on to list action that was conducted, which included R8 being sent to the hospital, R9 being taken into police custody. The document went on to read, To identify like residents that have the potential to be affected the SS [social services] director/designee completed interviews on capable residents to ensure no other resident had any sexual interactions. To identify like residents with cognitive deficits that have the potential to be affected, licensed nurses/designee had skin checks completed and observed for changes in behaviors, signs of withdrawal or change in normal activity for non-interview able residents. To prevent this from happening again the DON [director of nursing]/designee will educate current staff of the abuse policy and procedures with emphasis on types of abuse. Newly hired staff will be educated on abuse policy through the onboarding procedure. To monitor and maintain ongoing compliance, the DON/designee will conduct resident interviews on 10 capable residents weekly x 4 then monthly x 2 to identify any unreported incidents of abuse. Results will be taken to QAPI [quality assurance performance improvement] for review and revision as needed. (this monitoring is what is missing due to the fire and remodeling- validated that was completed by regional staff that are still in place). To monitor and maintain ongoing compliance the NHA [nursing home administrator]/designee will complete abuse questionnaires on five random employees weekly x 4 then monthly x 2 to determine continued education needs of staff. Results will be taken to QAPI for review and revision as needed. (this monitoring is what is missing due to the fire and remodeling- validated that was completed by regional staff that are still in place).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Search was held by many of the regional staff and administrative staff at [facility name redacted] for the missing binder with all the evidence that demonstrated this incident was properly investigated and mitigated. The binder is not able to be located after the fire last year in 2023 and the building being closed for over one year for remodeling. All contents of the building was packed up and moved or stored. Binder recreated on 9/10/2024 with the information that could be printed out of the system and any materials that could be found. An Ad hoc QAPI meeting was held on 12/19/2022 and again on 9/13/2024 to review event and QAPI plan with the medical director and IDT [interdisciplinary team] . Alleged DOC [date of compliance] 12/20/2022 .</p> <p>On 10/24/24, a sample of residents who were residents of the facility at the time of the 12/17/24 incident, was reviewed. This review revealed the following:</p> <ol style="list-style-type: none"> 1. Resident #2 (R2) had BIMS (brief interview for mental status) score was 13 out of 15, which indicated she was cognitively intact according to the minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/25/22. Within the clinical record there was no evidence that the social services staff conducted an interview with R2 following the incident on 12/17/22, to determine if she had been a victim of abuse. 2. Resident #3 (R3) had a BIMS score of 15 out of 15, indicating intact cognition, according to the MDS with an ARD of 11/6/22. There was no evidence within the clinical record that R3 was interviewed following the incident on 12/17/22. 3. Resident #7 (R7) had a BIMS score of 14 out of 15, indicating intact cognition, according to the MDS assessment with an ARD of 11/1/22. Within the clinical record, there was no evidence of R7 having been interviewed my social services staff regarding abuse. 4. For Resident #10 (R10), who was interviewable according to a BIMS score of 15 out of 15, indicating intact cognition, according to the MDS with an ARD of 9/24/22. There was no indication within the clinical record that R10 was interviewed following the incident on 12/17/22. 5. For Resident #5 (R5) who had a BIMS score of 9 out of 15, indicating moderate cognition, there was no indication that social services interviewed R5, and a weekly skin check was not performed until 12/22/22. <p>On 10/24/24 at 11:35 a.m., the facility administration and Regional Director of Clinical Services were advised that the submission of evidence for past non-compliance was missing a lot of the material needed to verify that the facility had made the necessary corrections.</p> <p>On 10/24/24 at 1:24 p.m., the administration team presented the survey team with additional information they had gathered in an effort to show that the facility had achieved past non-compliance. The information provided included the following:</p> <ol style="list-style-type: none"> 1. Forms titled, Weekly Skin Evaluations for various residents, which the RDCS said they had printed for some of the residents but didn't print all of them. The documents had dates of completion from 12/17/22-12/23/22. <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449</p> <p>Based on staff interview, clinical record review and facility documentation review, the facility staff failed to have credible evidence of a complete and thorough investigation being conducted following an incident of sexual assault involving two residents (Resident #8- R8 and resident #9-R9) in a survey sample of 10 residents.</p> <p>The findings included:</p> <p>For R8, who was sexually assaulted by R9, the facility staff failed to have credible evidence of a complete and thorough investigation of the incident.</p> <p>On 10/22/24, the survey team was provided with a listing of current residents, it was noted that R8 and R9, were neither a current resident of the facility and therefore were not able to be interviewed.</p> <p>On 10/22/24, during an entrance conference conducted at 1:45 p.m., the facility administrator was asked to provide all information the facility had with regards to a sexual assault. Following the entrance conference the facility administrator stated that the incident binder with the facility's investigation and response to the sexual assault had been misplaced following a fire the facility had in August 2023. The administrator provided the surveyor with a binder and stated that it contained the information they had been able to re-create. According to the binder R8 was the victim and R9 was the perpetrator.</p> <p>On 10/23/24, a closed record review was conducted of R8's chart. This review revealed an entry by registered nurse #1 (RN #1) dated 12/17/22 at 12:25 p.m., that read, Recorder in room and observed male resident having sexual intercourse with resident in her bed with resident's legs spread open with one to each side of resident's waist. Bed noted to be at lowest position with cover on floor. Observed male resident with pants and brief down around his knees. Recorder stated for male resident to stop and get off her. Male resident proceeded to stop engaging in the sexual activity, got off resident and was noted be to be fully erect. No bodily fluid observed on penis. Male resident then stood up from bed, pulled up his pants and briskly walked out of resident's room and up hallway. Resident noted to have a flat affect to face. When asked what happened, resident stated, he hurt my breast and [NAME] Pam hurt. Resident observed lying flat in the bed with hospital gown raised up to her breasts exposing the underside of the breast. Resident's brief noted to be undone and exposing vagina. Resident assured that he would not be coming back into the room and covered with a sheet for privacy. Recorder called for staff member to stay with resident while recorder exited room and returned to nurse's station.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER South Boston Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 103 Rosehill Drive South Boston, VA 24592	
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There were multiple entries in R8's clinical record on 12/17/22, which included notification to the family of the incident, the doctor, who was on-site and gave an order to send to the emergency room , and the police being notified. An entry dated 12/17/22 at 1:21 p.m., read, This writer called [hospital name redacted] ER [emergency room] to give report to nurse. After telling the nurse that the resident had been raped and would need a rape kit. This writer was told that [hospital name redacted] hospital could not accommodate the resident and could we send the resident to another facility. 911 transport was made aware of what the nurse had said. 911 driver stated that they could not bypass this hospital per their protocol and would first need to go to [hospital name redacted] ER.</p> <p>On 12/17/22 at 7:51 p.m., an entry was made by the physician into R8's chart that read in part, Pt [patient] raped by another resident this afternoon. No bleeding or injuries noted. The RP of both parties were notified, and pt was transferred to ED for forensic exam . A/P [active problem(s)]: 1. Non-consensual intercourse - forensic exam pending, but initial examination was normal. Perpetrator was turned over to legal authorities 2. OCD [obsessive compulsive disorder] with severe intellectual inability -chronic (food obsession); continue supportive care. Will continue to redirect behaviors. 3. Bipolar disorder - chronic, continue clomipramine and valproic acid . 6. MDD [major depressive disorder] chronic; continue sertraline; trazodone for sleep .</p> <p>On 10/23/24 at 4:03 p.m., an interview was conducted with RN #1. RN #1 reported that on 12/21/22, R8's roommate (resident #10- R10) came to the nursing station and was mumbling saying that she couldn't go to her room because that man was on top of her roommate. RN #1 reported she immediately went to R8's room and she observed R9 in the bed on top of R8. RN #1 reported she told R9 to get off her. RN #1 reported R8's gown was pulled up; her breasts were exposed, and her incontinence brief was undone on one side. R9 had his pants down and was on the bed on top of R8 and was making the back and forth motion and was groping her breasts. RN #1 told R9 to get off of her and when he stood up, she noted R9 had an erection. RN #1 said she was not aware if R9 made sexual penetration of R8 or not but it was sexual assault regardless, she observed R9 to put his pants on and he exited the room. RN #1 reported she called the following, the doctor, police, director of nursing, unit manager, administrator and family of both residents.</p> <p>During the above interview with RN #1, she reported that R8 was cognitively impaired and would not have been able to give consent to any sexual activity. She reported R9 was able to ambulate independently, would refuse medications and care at times and they had to redirect him often. RN #1 reported that following the incident R9 was taken into custody by the police and did not return to the facility. RN #1 reported she had to go to court numerous times because the case kept being postponed but the last time was told she didn't have to come back anymore because it was dismissed, and they said they were both cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/24/24, a clinical record review was conducted of R9's closed record. According to a progress note written by a psychiatric mental health nurse practitioner on 12/12/22, prior to the incident, the note indicated R9 had diagnosis to include but not limited to, PTSD (post-traumatic stress disorder), alcohol abuse, schizoaffective disorder, psychosis, anxiety disorder, and sexual dysfunction. The note read in part, Patient is a [AGE] year-old male seen for follow-up with a psychiatric history of schizoaffective disorder, insomnia, PTSD, and inappropriate sexual behavior . He is alert and oriented x 2 [to person and place] and is reliable historian . His last mental health review was on 11/28/22 where he was stable . Since last review patient had documented behaviors of resistance to care and walking away from the facility and would not come back with guidance from the police officer or staff. Staff also request the patient to be seen for increased agitation, verbal and physical abuse and combativeness at times. Staff also indicate paranoid delusions and states that the patient will frequently state everyone is trying to kill me. Patient's PTSD is stable per staff and states that he has had not any further inappropriate sexual behaviors other than remarks to staff that are not sexual but continuing to be complementing .Care plan: Recommendation: The patient's inappropriate sexual behaviors are controlled on Provera .</p> <p>On 12/17/22 at 12:50 p.m., there was an entry made by the facility administrator that read, Late Entry: Alerted by staff members by phone regarding sexual activity of resident with female resident of facility. Resident reportedly left room of involved resident and walked out of facility. Staff advised to keep resident in sight continually pending arrival of police to facility. RP Cousin- [name redacted] at facility at approximately 3 pm. Spoke with her briefly regarding personal belongings which she will pick up at a later date.</p> <p>Another progress note dated 12/17/22 at 1:32 p.m., read, Resident's RR [responsible representative], [name redacted], returned call to the facility. RR was made aware by Dr. [doctor's name redacted] that the resident was found having sex with another resident that could not give consent. RR stated that she is on her way to facility per Dr. [doctor's name redacted].</p> <p>A note dated 12/17/22 at 3 p.m., read, Resident in back of police car under police custody. Officer stated that resident will be charged and taken to local jail.</p> <p>On 10/24/24 at 10:58 a.m., an interview was conducted with the facility's former administrator (Administrative Employee #3- AE #3), who was the administrator on 12/17/22. AE #3 reported that following the incident R8 was sent to the hospital for evaluation and R9 left in handcuffs, never to return. AE #3 reported the facility conducted a full binder of information regarding the incident and it was packed away nice and neat. AE #3 reported that following the fire that occurred in Aug. 2023, the binder was stored in a safe in the therapy gym and was not aware it was not able to be located following re-opening of the facility. AE #3 reported that the social worker interviewed all alert residents, residents who were not interviewable had head to toe assessments conducted. When asked where that information was documented, the AE #3 stated, it was documented on paper and put in the binder, but she hoped it was also in the clinical records. When asked about the fire, AE #3 reported there was no internal damage within the facility other than a panel box in the kitchen, the damage sustained was to an exterior electrical room and the generator. No smoke was inside the building and the sprinkler system did not engage within the facility; therefore the records were intact following the fire and were just stored away for safekeeping since the facility was going to be closed and not occupied. The AE #3 reported on 9/15/23, when her employment ended the binder with all the information the facility did in response to the sexual assault was in the therapy gym.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/24-10/24/24, a review of the facility provided binder as evidence of their investigation and submission for consideration of past non-compliance was reviewed. Within the binder was a cover letter that read in part, This will serve as our plan of abatement for [facility name redacted] to: An allegation of sexual abuse made on 12/17/2022. Allegation background: An allegation of sexual abuse was made between resident #1 (female victim) and resident #2 (male perpetrator). Employee #1 observed resident #2 on top of resident #1 having sexual contact and she is unable to give consent. Employee #1 stopped the contact immediately. #2- Fire and building closed for over a year for remodeling and FRI investigations misplaced during the time .</p> <p>Within the facility provided binder, it read in part, .Search held by many of the regional staff and administrative staff at [facility name redacted] for the missing binder with all the evidence that this event was investigated. The binder is not able to be located after the fire last year in 2023 and the building being closed for over one year for remodeling. All contents of the building was packed up and moved or stored. Binder recreated on 9/10/2024 with the information that could be printed out of the system and any materials that could be found. An Ad hoc QAPI meeting was held on 12/19/2021 and again on 9/13/2024 to review event and QAPI plan with the medical director and IDT [interdisciplinary team] . Alleged DOC [date of compliance] 12/20/2022 .</p> <p>There was no evidence of any witness statements, staff or resident interviews, resident assessments, reports regarding the status of criminal charges for R9, etc.</p> <p>According to the facility policy titled, Virginia Resident Abuse Policy which read in part, . 7. Once the Administrator and DOH [department of health] are notified, an investigation of the allegation or suspicion will be conducted. a. Time frame for investigation. The investigation must be completed within five (5) working days from the alleged occurrence. b. Investigation protocol. The person investigating the incident should generally take the following actions: i. Interview the resident, the accused, and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident; came in close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident. ii. If there are no direct witnesses, then the interviews may be expanded . iii. Obtain written statements from the resident, if possible, the accused, and each witness. iv. Obtain all medical reports and statements from physicians and/or hospitals, if applicable. Review the resident's records . c. Documentation: Evidence of the investigation should be documented .</p> <p>On 10/24/24 at 2:30 p.m., the facility administrator stated to the survey team, We aren't denying it occurred, we know it was reported and he [R9] went to jail. She [R8] went to the hospital. I remember hearing about the book. I know the investigation was done, [company name redacted] is good about sending nurse consultants to help with investigation. The building was closed for a year, and we only opened two months ago. I know everything is not in there but please take into consideration we had a fire and were closed for a year. I feel we have provided evidence that an investigation was done for past non-compliance.</p> <p>On 10/24/24, during the exit conference the facility administrator, director of nursing, and RDCS were made aware that without the credible evidence of an investigation, the survey team would be unable to accept past non-compliance.</p> <p>No additional information was provided.</p>		

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<p>F 0917</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47067</p> <p>Based on observations, staff interview, and facility documentation review, the facility failed to provide functional furniture appropriate for resident use in 2 rooms (rooms 208 & 323), on 2 of 4 units.</p> <p>The findings included:</p> <p>On 10/24/24 a tour and observations of the nursing units 2 and 3 was conducted. The observation revealed that the closet door in room [ROOM NUMBER] had a broken hinge, preventing the closet door from closing. The closet door handle was also broken. During the tour, it was also observed that the closet door in room [ROOM NUMBER] was ajar. Closer inspection noted that the hinge was broken, preventing the closet door from being closed.</p> <p>On 10/24/24 at 11:45 a.m., a meeting with the administrator, director of nursing, and the regional director of clinical services was conducted. When these above findings were reported to the facility staff, the administrator stated, We have been painting the building and trying to replace the door handles and hinges as we go along.</p> <p>On 10/24/24 a review of facility documentation was conducted. The facility document titled, Resident Rights and Facility Responsibilities. read in part, it is the facility's policy to comply with all resident rights, and to communicate these rights to residents and their designated representatives.</p> <p>No additional information was provided.</p>		