STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/17/2023 through 07/19/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicaid standard survey was conducted 07/17/2023 through 07/19/2023. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Two complaints (VA00057708- substantiated with deficiency and VA00057096-substantiated with deficiency), were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 130 certified bed facility was 126 at the time of the survey. The survey sample consisted of 29 current Resident reviews and two closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		8/31/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and review of facility's documentation, it was determined that the facility failed to promote and enhance each resident's right to a dignified and respected existence for three of 31 residents in the survey sample, Resident #60, #50 and #35. The findings included:	F 550	FTag 550 resident Rights/Exercise of Rights. The three residents found to have been affected by the deficient practice were identified. Social Workers met with the resident's weekly for a period of 2 months to provide support and active listening. Completed 4/21/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 1. For Resident #60, the facility staff failed to ensure the resident was treated with dignity and respect. The resident had been sexually abused by a staff member. Resident #60 was admitted to the facility on 1/20/2005. A review of the facility synopsis of event dated 4/10/23 revealed "Incident Type: allegation of abuse/mistreatment. (Resident #60) reported an incident to the nursing supervisor. He stated that while getting his brief changed two days ago, his CNA (certified nursing assistant) mouth touched his penis for two seconds." The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 7/6/23, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring total dependence for transfer and bathing; extensive assistance for bed mobility, dressing, hygiene and independent for eating / locomotion. A review of the comprehensive care plan dated 4/12/23 revealed, "PROBLEMS: Resident has a history of trauma. He reports he was sexually abused. APPROACHES/TASKS: Nursing will continue to offer counseling and will coordinate counseling services, if accepted by resident. Resident-specific ways to comfort resident if a trigger occurs: Allow resident to express feelings and validate them. Refer to SW (social worker) or chaplain for support. Resident-specific ways to decrease triggers: Resident requests to have female CNA's (certified nursing assistants). Staff	F 550	All residents residing at TVH have the potential to be affected by the same deficient practices. Social Workers interviewed all residents in the facility. Completed 4/13/23. Social Services/Designee will be responsible for monitoring residents for abuse and ensuring that the right to quality of care and quality of life is maintained. Should an allegation of abuse arise it will be reported to the QAPI committee. Completed 4/13/23. The Director of Social Services/Designee has in-serviced staff on resident rights and abuse. Completed 4/21/23. Education will be done at hire, annually, and as needed. Completed 8/31/23. The Director of Social Services/Designee will meet with the residents on the second Tuesday of each month to review residents rights and abuse. All residents are invited. Any allegations of abuse will be investigated immediately per TVH Abuse Policy #707.4 and 707.5.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3	F 550		

to speak calmly and tell him what they want to do beforehand (changing clothes, all activities of daily living). Staff will ensure safety of resident by ensuring physical setting is safe and interpersonal interactions promote a sense of safety. Staff will promote collaboration and mutuality with resident by partnering with him and sharing power and decision-making. Staff will promote trustworthiness and transparency by maintaining transparency and building and maintaining trust with resident. Staff will uphold resident's empowerment and choice by supporting shared decision-making, choice, and goal setting. Staff will honor resident's self-advocacy skills."

A review of the physician's progress note dated 4/10/23 at 3:33 PM, revealed, "Seen for recent incident regarding abuse. Resident mentioned the same story about the aide having an inappropriate contact with him; he refused to allow me to examine him as he said there were no injuries and he was in no pain. I asked again and he was very clear that he did not wish to be examined. He was upset at the incident and was agreeable to follow-up and get some therapy/counseling on the next behavioral health visit."

A review of Resident #60's "Trauma Assessment" dated 4/11/23, revealed, "Is there a history of trauma, briefly describe the event: Resident reported on April 7th the 3-11 shift that his assigned CNA was changing him on the bed. CNA was reported to put his mouth briefly on resident's penis. Resident asked him to stop and he did. Self-Reporting Scale 0-10 (0= does not impact me at all 10= this impacts me a great deal). Using a Self-Reporting Scale, how much

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4	F 550		

does this trauma impact your daily life: Resident said 10. What coping skills do you use to deal with thoughts of the traumatic event? Resident is unable to articulate an answer to this. Would you like the opportunity to meet with a counselor/therapist to discuss traumatic events that may continue to impact your life? Resident told me no - that he would talk with staff as needed. He told physician that he would. Is there anything you would like your social worker to know? Want to be able to talk with someone. Wants to sit outside. Wants to talk with his father and stepmother. Work with a female CNA only."

A review of the 4/11/23 3:22 PM care coordination note, revealed, "Resident came to see me today. He talked a little about the incident that occurred on 4/7. Resident asked to call his parents - we called his step-mother and they talked for about 10 minutes. Resident's mood was calm, he said it was his 1st time coming to the first floor today. He went to recreational therapy and pt (physical therapy). He did not appear upset or frightened."

A review of the 4/17/23 11:00 AM care coordination note, revealed, "Checked on resident this morning. He said he enjoyed participating in the Walk-in-Roll event on Saturday the 15th. He declined to come to the 1st floor to socialize. He said he didn't feel like it. He had his tv on and was playing a computer game."

A review of the 4/17/23 psychological services progress note, revealed, "Patient readily discussed the recent incident of sexual abuse by a staff person, relating preoccupation about the incident and anxiety about his future safety and worry about interpersonal relationships. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5	F 550		

related about how he had been a resident for a long time and previously felt safe there. Help patient to develop plan for coping with anxiety and build ways to improve self-esteem."

A review of the social services note dated 4/20/23 at 3:56 PM, revealed, "Resident came to writer's office, requested to speak with writer in his room. Writer provided active listening and therapeutic support. Helped resident to recall several strategies he uses to self-soothe, validated feelings. Resident expressed gratitude for counseling support, staff support.

A review of the social services note dated 4/26/23 at 10:49 AM, revealed, "Resident came to see SW (social worker) today for supportive listening. He said he was feeling fine."

A review of the social services note dated 5/4/23 at 3:29 PM, revealed, "Today, resident came to SW and asked to call his step-mother. We called her and resident said he was feeling sad from thinking about the traumatic event that occurred. Resident said he wanted to talk with the chaplain. SW took resident to see the chaplain and they have talked. Resident has come to see SW several times and said he was doing okay. His father/step-mother will come to visit this week (May 6 or 7)."

An interview was conducted on 7/18/23 at 2:00 PM with Resident #60. When asked if he could describe the events related to the sexual abuse, Resident #60 stated, from what I can remember, he was changing me and he bent down and he touched his mouth to my penis. Police talked to me and filed a report. It was a Friday on Good Friday and I had just come back from services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 6	F 550		

and it happened. Ever since then, I am not the same, I have been talking with the staff working here. He (CNA #5) is not here. I have talked with the police and detective a couple of times. It was a bad situation. I felt bad. I told him to stop. It was not good for me. When asked how he felt now, Resident #60 stated, better now. I feel safe here and felt safe before.

An interview was conducted on 7/18/23 at 2:45 PM with LPN (licensed practical nurse) #7. When asked about the resident being treated with respect and dignity, LPN #7 stated, no, his rights to being treated with dignity and respect were not being honored.

ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the interim administrator was made aware of the above concern on 7/19/23 at 9:05 AM.

According to the facility's policy "Resident Rights and Abuse Prohibition" which reveals, "The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident."

No further information was provided prior to exit.

2. For Resident #50, the facility staff failed to ensure the resident was treated with dignity and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 7	F 550		

respect. The resident had been sexually abused by a staff member.

Resident #50 was admitted to the facility on 1/6/2004. A review of the facility synopsis of event dated 4/14/23 revealed "Incident Type: allegation of abuse/mistreatment. (Resident #50) reported an incident to the social worker, that while being cared for his CNA (certified nursing assistant) mouth touched him inappropriately."

The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 5/18/23, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility: total dependence for transfer, dressing, eating, hygiene, bathing and locomotion.

A review of the comprehensive care plan dated 4/14/23 revealed, "PROBLEMS: Resident has a history of trauma. He reports a former caregiver was sexually inappropriate with him.
APPROACHES/TASKS: Nursing will continue to offer counseling and will coordinate counseling services, if accepted by resident.
Resident-specific ways to comfort resident if a trigger occurs: He reports he enjoys going to a local park/garden. Encourage him to speak with a trusted staff member. Resident-specific ways to decrease triggers: Resident stated none. Staff will ensure safety of resident by ensuring physical setting is safe and interpersonal interactions promote a sense of safety. Staff will promote collaboration and mutuality with resident by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 8	F 550		

partnering with him and sharing power and decision-making. Staff will promote trustworthiness and transparency by maintaining transparency and building and maintaining trust with resident. Staff will uphold resident's empowerment and choice by supporting shared decision making, choice, and goal setting. Staff will honor resident's self-advocacy skills."

A review of the social services note dated 4/13/23 at 12:58 PM, revealed, "Today, resident came to my office and asked to call his mother. He had reported that while being taken care of by a staff person, he was touched inappropriately. His mother, DON (director of nursing), Medical director and CEO (chief executive officer) were notified. The police and health department were also notified."

A review of Resident #50's "Trauma Assessment" dated 4/14/23, revealed, "Is there a history of trauma, briefly describe the event: Resident expressed an allegation of sexual misconduct against a staff person on 3-11 shift.
Self-Reporting Scale 0-10 (0= does not impact me at all 10= this impacts me a great deal). Using a Self-Reporting Scale, how much does this trauma impact your daily life: Resident said 0.
What coping skills do you use to deal with thoughts of the traumatic event? He said "I go to [Name of Park] to get my mind off of it". Would you like the opportunity to meet with a counselor/therapist to discuss traumatic events that may continue to impact your life? He declined counseling services. Is there anything you would like your social worker to know? Want to be able to talk with someone. Wants to sit outside. Wants to talk with his father and stepmother. Work with a female CNA only."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 9	F 550		

A review of the social services note dated 4/17/23 at 11:07 AM, revealed, "Resident came to see me this morning...His family came to visit over the weekend, and he enjoyed their support."

A review of the social services note dated 4/24/23 at 11:01 AM, revealed, "Resident came to my office to socialize. No concerns voiced."

A review of the social services note dated 5/2/23 at 11:20 AM, revealed, "Resident came to see me. He said he is doing fine and planning to [go] out to the park."

An interview was conducted on 7/19/23 at 7:40 AM with Resident #50. When asked if he could describe the events related to the sexual abuse, Resident #50 stated, "He [CNA #5] was changing me and he bent down and he touched his mouth to my penis. I told him to stop that I did not like it. He wanted to know if I was sure he did not want any of this and showed me his penis." Resident #50 stated, "There was another time when the CNA ejaculated in my room. I did not report this when they first asked. There were several of us he did this to. Police talked to me and filed a report. He (CNA) is not here. I have talked with the detective. It did not make me feel good or safe. I did not feel good. I told him to stop." When asked how he was feeling now, Resident #50 stated, "It is all good now, there are no issues. He is not working here anymore."

An interview was conducted on 4/18/23 at 2:45 PM with LPN (licensed practical nurse) #7. When asked about the resident being treated with respect and dignity, LPN #7 stated, no, his rights to being treated with dignity and respect were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 10	F 550		

being honored.

ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the interim administrator was made aware of the above concern on 7/19/23 at 9:05 AM.

According to the facility's policy "Resident Rights and Abuse Prohibition" which reveals, "The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident."

No further information was provided prior to exit.
3. For Resident #35 (R35), the facility staff failed to treat the resident in a dignified manner. The resident had been sexually abused by a staff member.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/25/2023, the resident scored a 12 out of 15 on the BIMS (brief interview for mental status) score indicating the resident moderately impaired for making daily decisions. In Section G - Functional Status, R35 was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living except locomotion as the resident was independent after set up assistance was provided. Resident has a motorized wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 11	F 550		

An interview was conducted with R35 on 7/19/2023 at 9:17 a.m. accompanied by OSM (other staff member) #1, the social worker, to help in translating. R35 was asked what happened, R35 stated, "He (expletive) me. He pulled my pants down and asked if I wanted some. Ewe. He put something in my mouth. Ewe. I don't know why he did this to me. I asked him to get out of my room or I would knock him out, on his face on purpose." OSM #1 clarified that sometimes we hit people accidentally, but he would have hit him on purpose. When asked how it made him feel, R35 stated, "Bad." R35 was asked what he put in his mouth, R35 stated, "His (expletive - penis)." When asked if the CNA touched his private area, R35 stated yes, the CNA put his hands on his penis. R35 was asked when and where this happened, OSM #1 stated that through the interviews with R35, throughout the investigation, it occurred in R35's room after CNA #5 had given R35 a shower. R35 stated, "That's why he's [CNA #5] not here anymore."

The facility synopsis of event dated, 4/14/2023, documented in part, "Additional/Update Information Related to the Reported Incident: In the discovery process for the allegation made by (R60), 2 additional residents, (R50) and (R35) made complaints against [CNA - certified nursing assistant #5]. Staffing assignments confirmed that he was caring for the resident who made the allegations...Outcome of Investigation: Allegations were verified by evidence collected including victim interviews and assignment of staffing schedules with the incident timeline...Steps taken to investigate the allegation: Alleged victim's account were consistent in interview with facility staff,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 12	F 550		

Department of Health Professions investigator and law enforcement. No evidence of psychosocial distress or harm as expressed by the resident or noticed by care team or direct care staff....Conclusion: Allegations were verified by evidence collected which included interviews with all three victims by facility staff, Department of Health Professionals investigators and law enforcement in which their accounts remained consistent and the alignment of staff schedules with the time in which the incidents occurred...As a result of a verified finding of abuse, such as physical, sexual, or mental abuse, identify counseling or other interventions planned and implemented to assist the resident. (R60), (R35). and (R50) will receive continued monitoring to determine if there are any physical or mental changes or negative outcomes of the abuse. They will all receive trauma informed care assessments to determine if further counseling is needed. If counseling is needed, it will be arranged by the resident's care team. Each resident's care plan will be modified to include the incident... (Name of a physician) examined (R35) and (R50). (R60) refused a physical exam. (Name of physician) ordered STD (sexually transmitted disease) testing. (R60) refused the blood draw required for the test. Results for (R35) and (R50) are pending."

The progress note dated, 4/11/2023 at 1:39 p.m. documented, "Resident came to SW (social worker) office. SW invited DON (director of nursing) to meet with resident and she joined meeting."

The progress note dated, 4/11/2023 at 1:40 p.m., documented, "Meeting with social worker, (R35) and myself. Resident stated that last Tuesday a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 13	F 550		

staff member was playing with his (expletive - penis) He also stated that the staff member unzipped his pants and asked him if he would like some of it. (R35) said he told him no. Investigation will be done. (Name of doctor) notified."

The physician note dated, 4/11/2023 at 2:11 p.m. documented in part, "CC (chief complaint) - seen for allegations regarding a staff member...Plan: seen for recent incident regarding abuse. STD panel ordered as a precaution, unsure of level of exposure. deferred exam, (R35) mentioned no injuries. Encouraged to discuss with SW for support and if needed can get additional therapy and counseling."

The progress note dated, 4/12/2023 at 11:38 a.m., documented, "LATE ENTRY: SW completed trauma assessment with resident. Resident indicated he experienced a traumatic event. He reports he was sexually abused by a caregiver. He reports he is glad this caregiver is no longer in his life. He states the trauma doesn't affect him daily, but talking with his SW helps... He states he is open to counseling and is comforted by talking to someone. He was not able to identify any triggers. SW notified nursing and MD (medical doctor) that resident would like to participate in counseling."

The "Trauma Assessment" dated, 4/12/2023 at 11:29 a.m. documented in part, "Trauma History: 1. Is there a history of trauma, briefly describe traumatic event. Resident reports he was sexually abused by a CNA. Self-Reporting Scale 0-10, 0 = does not impact me at all, 10 = this impacts me a great deal. 2. Using a Self-Reporting Scale, how much does this trauma impact your daily life. 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 14	F 550		

(one). History of Therapeutic Interventions. 3. Have you received therapeutic interventions for this trauma? If so, what service were received, where and when? No. Traumatic Event. 4. If the traumatic event does not impact you daily, how often do these memories cause you to feel distressed: Weekly, Monthly, Little or Never. N/A (not applicable). Coping Skills Identified. 5. What coping skills do you use to deal with thoughts of the traumatic event? Talking to my social worker. Counseling. 6.Would you like the opportunity to meet with a counselor/therapist to discuss traumatic events that may continue to impact your life? Yes. Triggers and Coping. 7. Please identify what makes you remember the traumatic event and how you like to be comforted when you have these memories. Nothing triggers memories of the event. I would like to be comforted by talking to me. Social Worker. 8 Is there anything you would like your social worker to know? No."

The comprehensive care plan dated, 4/13/2023, documented, "(R35) has a history of trauma. He reports he was sexually abused by a caregiver. The "Interventions" documented, "Nursing will continue to offer counseling and will coordinate counseling services, if accepted by resident. Resident-specific ways to comfort resident if a trigger occurs: 1) Talk to him. Resident specific way to decrease triggers: 1) Ask before providing personal care. Staff will ensure safety of resident buy ensuring physical setting is safe and interpersonal interactions promote a sense of safety. Staff will promote collaboration and mutuality with resident by partnering with him and sharing power and decision-making. Staff will promote trustworthiness and transparency by maintaining transparency and building and maintaining trust with resident. Staff will uphold

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 15 resident' empowerment and choice by supporting shared decision-making, choice and goal setting. Staff will honor resident's self-advocacy skills." An interview was conducted with CNA #6 on 7/18/2023 at 2:46 p.m. When asked if a resident tells them that a staff member touched them in a manner the resident did not like, sexually, what steps do you take, CNA #6 stated she would go tell the charge nurse or supervisor. CNA #6 was asked if a resident told you a staff member inappropriately touched them, in a sexual manner, is that abuse? CNA #6 stated, yes. When asked if that is treating a resident with dignity, CNA #6 stated, no. ASM #1, the executive vice president, was made aware of the above concern for the resident not being treated with dignity on 7/19/2023 at 10:15 a.m. No further information was provided prior to exit.	F 550		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 16 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to protect three of 31 residents in the survey sample from abuse (Residents #60, #50 and #35), which resulted in harm cited at past non-compliance. The findings include: 1. The facility failed to protect Resident #60 from sexual abuse from CNA (certified nursing assistant) #5. A review of the facility synopsis of event dated 4/10/23 revealed "Incident Type: allegation of abuse/mistreatment. Resident #60 reported an incident to the nursing supervisor. He stated that while getting his brief changed two days ago, his CNA (certified nursing assistant) mouth touched his penis for two seconds." The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 7/6/23, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring total dependence for transfer and bathing; extensive assistance for bed mobility, dressing, hygiene and independent for eating / locomotion. A review of the comprehensive care plan dated 4/12/23 revealed, "PROBLEMS: Resident has a	F 600	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17	F 600		

history of trauma. He reports he was sexually abused. APPROACHES/TASKS: Nursing will continue to offer counseling and will coordinate counseling services, if accepted by resident. Resident-specific ways to comfort resident if a trigger occurs: Allow resident to express feelings and validate them. Refer to SW (social worker) or chaplain for support. Resident-specific ways to decrease triggers: Resident requests to have female CNA's (certified nursing assistants). Staff to speak calmly and tell him what they want to do beforehand (changing clothes, all activities of daily living). Staff will ensure safety of resident by ensuring physical setting is safe and interpersonal interactions promote a sense of safety. Staff will promote collaboration and mutuality with resident by partnering with him and sharing power and decision-making. Staff will promote trustworthiness and transparency by maintaining transparency and building and maintaining trust with resident. Staff will uphold resident's empowerment and choice by supporting shared decision-making, choice, and goal setting. Staff will honor resident's self-advocacy skills."

A review of the physician's progress note dated 4/10/23 at 3:33 PM, revealed, "Seen for recent incident regarding abuse. Resident mentioned the same story about the aide having an inappropriate contact with him; he refused to allow me to examine him as he said there were no injuries and he was in no pain. I asked again and he was very clear that he did not wish to be examined. He was upset at the incident and was agreeable to follow-up and get some therapy/counseling on the next behavioral health visit."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 18	F 600		

A review of Resident #60's "Trauma Assessment" dated 4/11/23, revealed, "Is there a history of trauma, briefly describe the event: Resident reported on April 7th the 3-11 shift that his assigned CNA was changing him on the bed. CNA was reported to put his mouth briefly on resident's penis. Resident asked him to stop and he did. Self-Reporting Scale 0-10 (0= does not impact me at all 10= this impacts me a great deal). Using a Self-Reporting Scale, how much does this trauma impact your daily life: Resident said 10. What coping skills do you use to deal with thoughts of the traumatic event? Resident is unable to articulate an answer to this. Would you like the opportunity to meet with a counselor/therapist to discuss traumatic events that may continue to impact your life? Resident told me no - that he would talk with staff as needed. He told physician that he would. Is there anything you would like your social worker to know? Want to be able to talk with someone. Wants to sit outside. Wants to talk with his father and stepmother. Work with a female CNA only."

A review of the director of nursing (DON) note dated 4/10/23 at 9:29 AM, revealed, "Meeting with resident, social worker and myself. Resident is reporting an incident that happened on Friday night with his assigned CNA. Resident stated that when the aid was providing peri care his aide momentarily put his mouth on his penis. Resident stated he told him to stop and he did, closed his brief and left the room. Resident said that it was the first time having the CNA and he has not had him since."

A review of the 4/11/23 3:22 PM care coordination note, revealed, "Resident came to see me today. He talked a little about the incident that occurred

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 19	F 600		

on 4/7. Resident asked to call his parents - we called his stepmother and they talked for about 10 minutes. Resident's mood was calm, he said it was his 1st time coming to the first floor today. He went to recreational therapy and pt (physical therapy). He did not appear upset or frightened."

A review of the 4/17/23 11:00 AM care coordination note, revealed, "Checked on resident this morning. He said he enjoyed participating in the Walk-in-Roll event on Saturday the 15th. He declined to come to the 1st floor to socialize. He said he didn't feel like it. He had his tv on and was playing a computer game."

A review of the 4/17/23 psychological services progress note, revealed, "Patient readily discussed the recent incident of sexual abuse by a staff person, relating preoccupation about the incident and anxiety about his future safety and worry about interpersonal relationships. He related about how he had been a resident for a long time and previously felt safe there. Help patient to develop plan for coping with anxiety and build ways to improve self-esteem."

A review of the hepatitis and STI (sexually transmitted infections) lab profile obtained 4/19/23, revealed "Hepatitis B, HCV (hepatitis C virus), RPR (rapid plasma regain) and HIV (human immunodeficiency virus) all non-reactive."

A review of the social services note dated 4/20/23 at 3:56 PM, revealed, "Resident came to writer's office, requested to speak with writer in his room. Writer provided active listening and therapeutic support. Helped resident to recall several

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 20	F 600		

strategies he uses to self-soothe, validated feelings. Resident expressed gratitude for counseling support, staff support.

A review of the 4/24/23 psychological services progress note, revealed, "Patient has had individual therapy to improve anxiety and depression. The incident of sexual abuse is now also a focus of treatment due to increased symptoms."

A review of the social services note dated 4/26/23 at 10:49 AM, revealed, "Resident came to see SW (social worker) today for supportive listening. He said he was feeling fine."

A review of the social services note dated 5/3/23 at 2:44 PM, revealed, "SW spoke with resident. He was smiling and reported he was in a good mood."

A review of the social services note dated 5/4/23 at 3:29 PM, revealed, "Today, resident came to SW and asked to call his stepmother. We called her and resident said he was feeling sad from thinking about the traumatic event that occurred. Resident said he wanted to talk with the chaplain. SW took resident to see the chaplain and they have talked. Resident has come to see SW several times and said he was doing okay. His father/stepmother will come to visit this week (May 6 or 7)."

A review of the social services note dated 5/16/23 at 10:51 AM, revealed, "Resident came to see SW yesterday the 15th and today the 16th. He is in a calm mood and said he feels better. Resident saw his father the previous weekend and said they had a nice visit."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 21	F 600		

A review of the social services note dated 6/5/23 at 2:21 PM, revealed, "Resident came to see me. He wanted to call his brother and they had a nice talk. Resident said he had some problems sleeping over the weekend. He said he didn't know what was wrong. He said he slept well last night."

A review of the social services note dated 6/12/23 at 5:04 PM, revealed, "Writer checked in with resident in his room, he asked when the court case would occur. Informed resident that I did not have concrete information but that it would take some time. Resident expressed satisfaction with that answer, then began discussing his latest music project and his visit with his dad."

A review of the social services note dated 6/23/23 at 3:56 PM, revealed, "Writer checked in with resident in his room, he states he is feeling good. Talked about his haunted house ideas, making new friends, and the TV show he was watching."

A review of the social services note dated 7/10/23 at 1:30 PM, revealed, "Quarterly assessment note for 7/6/23. Resident scored 14 on the BIMS - unable to tell me the current day of week. He scored 00 on the resident Mood Interview - no mood concerns noted. Resident likes to come to the first floor for certain programs. He likes to watch tv and play video games. His mood has been good. His father comes to visit 1 -2 times a month and he enjoys these visits very much. He has no discharge plans. He has a legal guardian. Quarter goal to assist as requested."

A review of CNA (certified nursing assistant) #5's employee record, revealed the following. CNA #5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 22	F 600		

was hired on 1/9/23. Reference checks were obtained and were positive in describing CNA #5. The Virginia State Police Criminal background check was obtained on 12/20/22 and found 'no identifiable records". His nurse aid certification was obtained on 12/19/22 from the Virginia Department of Health Professions (DHP) License Lookup site. Certification was current and additional public information was listed as 'no'. According to the facility's timeline of this incident, "On 3/23/23, a senior investigator from the Virginia DHP requested information on CNA #5. After this request ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing reviewed CNA #5's performance record. There were no other resident complaints, and the charge nurses and other staff did not observe any problems with CNA #5. Based on all available information, ASM #1 and ASM #2 determined that CNA #5 was doing his job well and giving good care to residents." A review of the Virginia DHP license lookup site on 7/18/23 revealed, CNA #5's nurse aide certification was suspended 6/27/23 due to "The Board of Nursing (BON) concluding that CNA #5 is a substantial danger to public health and safety." In review of the BON actions, it references, "he sexually assaulted four residents in his care". One resident was located in another facility in another location and the three residents located at this facility.

An interview was conducted on 7/18/23 at 2:00 PM with Resident #60. When asked if he could describe the events related to the sexual abuse, Resident #60 stated, "From what I can remember, he was changing me and he bent down and he touched his mouth to my penis. Police talked to me and filed a report. It was a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 23	F 600		

Friday (4/7/23), Good Friday and I had just come back from services and it happened." Resident #60 stated, "Ever since then, I am not the same, I have been talking with the staff working here. He (CNA #5) is not here. I have talked with the police and detective a couple of times. It was a bad situation. I felt bad. I told him to stop. It was not good for me." When asked how he felt now, Resident #60 stated, "Better now. I feel safe here and felt safe before."

An interview was conducted on 7/18/23 at 3:00 PM with ASM #2, the director of nursing. When asked to describe the events regarding 4/10/23 sexual abuse allegation for Resident #60, ASM #2 stated, "As soon as we knew about it, we started the investigation. We suspended the CNA while we investigated. We assessed and interviewed all male residents beginning on 4/10/23. We called the police, informed VDH-OLC (Virginia Department of Health-Office Licensure Certification). On 4/11/23 during the investigation we discovered (Resident #35) had also been sexually abused. Virginia DHP (Department of Health Professions) was informed of the two residents alleging sexual abuse and our investigation. On 4/13/23 DHP investigators arrived at facility. (Resident #50) also stated that CNA #5 had sexually abused him multiple times."

An interview was conducted on 7/18/23 at 3:15 PM with RN (registered nurse) #1. When asked to describe the events regarding 4/10/23 sexual abuse allegation for Resident #60, RN #1 stated, "It was reported to me by a CNA on Monday morning. (Resident #60) said something to the CNA and she got me to hear the issue. He told me the CNA (#5) was taking care of him and mouth touched his penis and CNA #5 lifted his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 24	F 600		

head up." RN #1 stated that (Resident #60) did not want him to take care of him anymore. I reported it to the DON and I met with the COO/CEO (chief operating officer/chief executive officer). I called the residents family. The physician was notified and saw the resident."

An interview was conducted on 7/18/23 at 3:20 PM with LPN (licensed practical nurse) #9. When asked to describe the events regarding 4/10/23 sexual abuse allegation for Resident #60, LPN #9 stated, "This was not known to me till later. I did not know that it happened." When asked if he had observed CNA #5 during the shift, LPN #9 stated, "Yes, I never had any complaints till this situation happened. He was eager to be here and eager to help. Offered aid to other CNA's. None of the residents reported to us real time."

An interview was conducted on 7/19/23 at 10:30 AM with CNA #4. When asked to describe the events regarding 4/10/23 sexual abuse allegation for Resident #60, CNA #4 stated, "The resident told me that a male CNA had sexually assaulted him a couple of days earlier, that he touched the resident's penis with his mouth. I informed the nursing supervisor immediately."

ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the interim administrator was made aware of the above concern on 7/19/23 at 9:05 AM.

According to the facility's policy "Abuse Prohibition" which reveals in part, "All residents at the facility will be treated with dignity and respect for their individuality. Abusive or neglectful acts towards residents by employees, visitors, relatives or others, in any form, will not be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 25	F 600		

tolerated. Abuse can consist of any sexual contact. Administrator will direct investigation which shall include at a minimum: interviews with abused resident, the alleged abuser, staff person discovering incident, witnesses and others who may have necessary information. Investigation may also require physical/medical exam of the allegedly abused resident by nursing and/or medical staff."

The facility developed and implemented a plan of correction, which contained the following 5 points:

1. The employee involved in the incident is no longer employed by the facility. Resident 1 (Resident #60) and Resident 2 (Resident #35) were assessed by the physician. Resident 3 (Resident #50) refused the assessment. Residents 1, 2 and 3 were assessed for psychosocial distress and care plans were revised as necessary. Residents have been referred to a psychologist for evaluation and treatment.

2. All current residents were interviewed by Social Services as they may have been affected. Interviews completed of all residents on 4/13/23. Any new allegations of abuse verbalized will be reported according to the facility abuse policy and the potential threat removed immediately while an investigation is in process.

3. Social Services/designee will be responsible for monitoring residents for abuse/psychological distress and ensuring any allegations verbalized will be reported according to the facility abuse policy. The Director of Social Services/designee has inserviced staff regarding abuse and the facility abuse policy including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 26	F 600		

requirements/removing a potential threat immediately while an investigation is in process. Staff inservicing was completed on 4/21/23.

4. Social Services will meet weekly with residents affected and provide assistance as needed for a period of two months.

5. The Director of Social Services/designee will meet with the residents on the second Tuesday of each month to review resident rights and abuse. Any allegations of abuse will be investigated immediately as per the facility abuse policy. Education and training will be provided to staff on an ongoing basis. The Director of Social Services/designee will identify and report any trends and/or patterns to the quality assurance committee on at least a quarterly basis.

6. Completion date 5/9/23.

The credible evidence including the Plan of Correction, education, in-service sign in sheets, audits and Quality Council minutes were reviewed and found to be in order. Random interviews were conducted with staff on varying shifts regarding abuse education and training and failed to reveal any concerns. Review of current residents failed to identify any concerns.

Past non-compliance.

2. The facility failed to protect Resident #50 from sexual abuse from CNA (certified nursing assistant) #5.

A review of the facility synopsis of event dated 4/14/23 revealed "Incident Type: allegation of abuse/mistreatment. Resident #50 reported an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 27	F 600		

incident to the social worker, that while being cared for his CNA (certified nursing assistant) mouth touched him inappropriately."

The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 5/18/23, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility: total dependence for transfer, dressing, eating, hygiene, bathing and locomotion.

A review of the comprehensive care plan dated 4/14/23 revealed, "PROBLEMS: Resident has a history of trauma. He reports a former caregiver was sexually inappropriate with him. APPROACHES/TASKS: Nursing will continue to offer counseling and will coordinate counseling services, if accepted by resident. Resident-specific ways to comfort resident if a trigger occurs: He reports he enjoys going to a local park/garden. Encourage him to speak with a trusted staff member. Resident-specific ways to decrease triggers: Resident stated none. Staff will ensure safety of resident by ensuring physical setting is safe and interpersonal interactions promote a sense of safety. Staff will promote collaboration and mutuality with resident by partnering with him and sharing power and decision-making. Staff will promote trustworthiness and transparency by maintaining transparency and building and maintaining trust with resident. Staff will uphold resident's empowerment and choice by supporting shared decision making, choice, and goal setting. Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 28	F 600		

will honor resident's self-advocacy skills."

A review of the social services note dated 4/13/23 at 12:58 PM, revealed, "Today, resident came to my office and asked to call his mother. He had reported that while being taken care of by a staff person, he was touched inappropriately. His mother, DON (director of nursing), Medical director and CEO (chief executive officer) were notified. The police and health department were also notified."

A review of the physician progress note dated 4/13/23 at 1:55 PM, revealed, "Seen primarily for recert (recertification) but also to discuss the recent assault allegations. Resident was going out and mentioned that he would discuss it tomorrow. He appeared well. I mentioned possibly doing some testing as well. Will follow up in am. Orders renewed."

A review of Resident #50's "Trauma Assessment" dated 4/14/23, revealed, "Is there a history of trauma, briefly describe the event: Resident expressed an allegation of sexual misconduct against a staff person on 3-11 shift.
Self-Reporting Scale 0-10 (0= does not impact me at all 10= this impacts me a great deal). Using a Self-Reporting Scale, how much does this trauma impact your daily life: Resident said 0.
What coping skills do you use to deal with thoughts of the traumatic event? He said, "I go to (Name of Park) to get my mind off of it". Would you like the opportunity to meet with a counselor/therapist to discuss traumatic events that may continue to impact your life? He declined counseling services. Is there anything you would like your social worker to know? Want to be able to talk with someone. Wants to sit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 29	F 600		

outside. Wants to talk with his father and stepmother. Work with a female CNA only."

A review of the hepatitis and STI (sexually transmitted infections) lab profile obtained 4/14/23, revealed "Hepatitis B, HCV (hepatitis C virus), RPR (rapid plasma regain) and HIV (human immunodeficiency virus), chlamydia and gonococcus all non-reactive."

A review of the social services note dated 4/17/23 at 11:07 AM, revealed, "Resident came to see me this morning...His family came to visit over the weekend, and he enjoyed their support."

A review of the social services note dated 4/24/23 at 11:01 AM, 5/2/23 at 11:20 AM, and 5/16/23 at 10:54 AM revealed no voiced concerns.

A review of the social services note dated 5/24/23 at 2:14 PM, revealed, "Annual assessment note for 5/18/23. Resident scored 12 on the BIMS - unable to tell me the current year. Resident scored 00 on the resident Mood Interview - no mood concerns voiced. Resident experienced a traumatic event that included a staff person. Resident has not expressed any negative consequences from the event. He gets up daily in his w/c (wheelchair) and likes to ride to the park or to sit outside. Resident has a circle of peers he likes to talk with. Resident has a cell phone to call his family. His parents are supportive and visit often. We reviewed his advanced directives and he said he is satisfied with his current plans. He said he understands that he can make changes when he wants. We reviewed his discharge plans. He said he understands that he has the right to request to move at any time. Quarter goal to assist as requested."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 30	F 600		

A review of the social services note dated 6/14/23 at 4:33 PM, revealed, "SW met with resident in his room for weekly check-in. He states he feels "fine" and safe knowing alleged assailant is not allowed in the building..."

A review of the social services note dated 6/22/23 at 2:22 PM, revealed, "SW met with resident in his room. SW asked how he's been feeling and he stated, "great!" He states he would like to speak with the detective in his case but doesn't have his name or number. He states the detective texted his number to the resident. Resident gave permission for SW to look through his recent texts, but SW did not find a text from detective. SW left message for administrator requesting information."

A review of the social services note dated 7/10/23 at 11:46 AM, revealed, "Resident asked to talk with me about a personal matter. We discussed his concern and he was satisfied with our talk. He said he is doing well and sleeping fine."

An interview was conducted on 7/18/23 at 3:00 PM with ASM #2, the director of nursing. When asked to describe the events regarding the sexual abuse allegation for Resident #50, ASM #2 stated, "On 4/13/23 DHP (department of health professions) investigators arrived at facility. (Resident #50) stated that (CNA #5) had sexually abused him multiple times on that day. He had not previously disclosed to us that he had been assaulted."

An interview was conducted on 7/18/23 at 3:15 PM with RN (registered nurse) #1. When asked to describe the events regarding 4/13/23 sexual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 31	F 600		

abuse allegation for Resident #50, RN #1 stated, this resident stated that CNA #5 had performed oral sex on him multiple times and had ejaculated in his room. He stated that CNA #5 had also watched pornographic content with him in his room.

An interview was conducted on 7/18/23 at 3:20 PM with LPN (licensed practical nurse) #9. When asked to describe the events regarding the sexual abuse allegation for Resident #50, LPN #9 stated, "This was not known to me till later. I did not know that it happened." When asked if he had observed (CNA #5) during the shift, LPN #9 stated, "Yes, I never had any complaints till this situation happened. He was eager to be here and eager to help. Offered aid to other CNA's. None of the residents reported to us real time."

An interview was conducted on 7/19/23 at 7:40 AM with Resident #50. When asked if he could describe the events related to the sexual abuse, Resident #50 stated, he (CNA #5) was changing me and he bent down and he touched his mouth to my penis. I told him to stop that I did not like it. He wanted to know if I was sure he did not want any of this and showed me his penis. There was another time when the CNA ejaculated in my room. I did not report this when they first asked. There were several of us he did this to. Police talked to me and filed a report. He (CNA) is not here. I have talked with the detective. It did not make me feel good or safe. I did not feel good. I told him to stop. When asked how he was feeling now, Resident #50 stated, it is all good now, there are no issues. He is not working here anymore. When asked if this had occurred more than once, Resident #50 stated, no.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 32	F 600		

ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the interim administrator was made aware of the above concern on 7/19/23 at 9:05 AM.

According to the facility's policy "Resident Rights and Abuse Prohibition" which reveals, "The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident."

The facility developed and implemented a plan of correction, which contained the following 5 points:

1. The employee involved in the incident is no longer employed by the facility. Resident 1 (Resident #60) and Resident 2 (Resident #35) were assessed by the physician. Resident 3 (Resident #50) refused the assessment. Residents 1, 2 and 3 were assessed for psychosocial distress and care plans were revised as necessary. Residents have been referred to a psychologist for evaluation and treatment.

2. All current residents were interviewed by Social Services as they may have been affected. Interviews completed of all residents on 4/13/23. Any new allegations of abuse verbalized will be reported according to the facility abuse policy and the potential threat removed immediately while an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 33	F 600		

investigation is in process.

3. Social Services/designee will be responsible for monitoring residents for abuse/psychological distress and ensuring any allegations verbalized will be reported according to the facility abuse policy. The Director of Social Services/designee has inserviced staff regarding abuse and the facility abuse policy including requirements/removing a potential threat immediately while an investigation is in process. Staff inservicing was completed on 4/21/23.

4. Social Services will meet weekly with residents affected and provide assistance as needed for a period of two months.

5. The Director of Social Services/designee will meet with the residents on the second Tuesday of each month to review resident rights and abuse. Any allegations of abuse will be investigated immediately as per the facility abuse policy. Education and training will be provided to staff on an ongoing basis. The Director of Social Services/designee will identify and report any trends and/or patterns to the quality assurance committee on at least a quarterly basis.

6. Completion date 5/9/23.

The credible evidence including the Plan of Correction, education, in-service sign in sheets, audits and Quality Council minutes were reviewed and found to be in order. Random interviews were conducted with staff on varying shifts regarding abuse education and training and failed to reveal any concerns. Review of current residents failed to identify any concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 34	F 600		

Past non-compliance.

No further information was provided prior to exit.
3. For Resident #35 (R35), the facility staff failed to protect the resident from sexual abuse from a staff member CNA (certified nursing assistant) #5.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/25/2023, the resident scored a 12 out of 15 on the BIMS (brief interview for mental status) score indicating the resident moderately impaired for making daily decisions. In Section G - Functional Status, R35 was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living except locomotion as the resident was independent after set up assistance was provided.

The facility synopsis of event dated, 4/14/2023, documented in part, "Additional/Update Information Related to the Reported Incident: In the discovery process for the allegation made by (R60), 2 additional residents, (R50) and (R35) made complaints against (CNA - certified nursing assistant #5). Staffing assignments confirmed that he was caring for the resident who made the allegations...Outcome of Investigation: Allegations were verified by evidence collected including victim interviews and assignment of staffing schedules with the incident timeline...Steps taken to investigate the allegation: Alleged victim's account were consistent in interview with facility staff, Department of Health Professions investigator and law enforcement. No evidence of psychosocial distress or harm as expressed by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 35	F 600		

the resident or noticed by care team or direct care staff....Conclusion: Allegations were verified by evidence collected which included interviews with all three victims by facility staff, Department of Health Professionals investigators and law enforcement in which their accounts remained consistent and the alignment of staff schedules with the time in which the incidents occurred...As a result of a verified finding of abuse, such as physical, sexual, or mental abuse, identify counseling or other interventions planned and implemented to assist the resident. (R60), (R35). and (R50) will receive continued monitoring to determine if there are any physical or mental changes or negative outcomes of the abuse. They will all receive trauma informed care assessments to determine if further counseling is needed. If counseling is needed, it will be arranged by the resident's care team. Each resident's care plan will be modified to include the incident... (Name of a physician) examined (R35) and (R50). (R60) refused a physical exam. (Name of physician) ordered STD (sexually transmitted disease) testing. (R60) refused the blood draw required for the test. Results for (R35) and (R50) are pending."

The progress note dated, 4/11/2023 at 1:39 p.m. documented, "Resident came to SW (social worker) office. SW invited DON (director of nursing) to meet with resident and she joined meeting."

The progress note dated, 4/11/2023 at 1:40 p.m., documented, "Meeting with social worker, (R35) and myself. Resident stated that last Tuesday a staff member was playing with his (expletive - penis) He also stated that the staff member unzipped his pants and asked him if he would like

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 36	F 600		

some of it. (R35) said he told him no. Investigation will be done. (Name of doctor) notified."

The physician note dated, 4/11/2023 at 2:11 p.m. documented in part, "CC (chief complaint) - seen for allegations regarding a staff member...Plan: seen for recent incident regarding abuse. STD panel ordered as a precaution, unsure of level of exposure. deferred exam, (R35) mentioned no injuries. Encouraged to discuss with SW for support and if needed can get additional therapy and counseling."

The progress note dated, 4/12/2023 at 11:38 a.m., documented, "LATE ENTRY: SW completed trauma assessment with resident. Resident indicated he experienced a traumatic event. He reports he was sexually abused by a caregiver. He reports he is glad this caregiver is no longer in his life. He states the trauma doesn't affect him daily, but talking with his SW helps... He states he is open to counseling and is comforted by talking to someone. He was not able to identify any triggers. SW notified nursing and MD (medical doctor) that resident would like to participate in counseling."

The "Trauma Assessment" dated, 4/12/2023 at 11:29 a.m. documented in part, "Trauma History: 1. Is there a history of trauma, briefly describe traumatic event. Resident reports he was sexually abused by a CNA. Self-Reporting Scale 0-10, 0 = does not impact me at all, 10 = this impacts me a great deal. 2. Using a Self-Reporting Scale, how much does this trauma impact your daily life. 1 (one). History of Therapeutic Interventions. 3. Have you received therapeutic interventions for this trauma? If so, what service were received,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 37	F 600		

where and when? No. Traumatic Event. 4. If the traumatic event does not impact you daily, how often do these memories cause you to feel distressed: Weekly, Monthly, Little or Never. N/A (not applicable). Coping Skills Identified. 5. What coping skills do you use to deal with thoughts of the traumatic event? Talking to my social worker. Counseling. 6.Would you like the opportunity to meet with a counselor/therapist to discuss traumatic events that may continue to impact your life? Yes. Triggers and Coping. 7. Please identify what makes you remember the traumatic event and how you like to be comforted when you have these memories. Nothing triggers memories of the event. I would like to be comforted by talking to me. Social Worker. 8 Is there anything you would like your social worker to know? No."

The comprehensive care plan dated, 4/13/2023, documented, "(R35) has a history of trauma. He reports he was sexually abused by a caregiver. The "Interventions" documented, "Nursing will continue to offer counseling and will coordinate counseling services, if accepted by resident. Resident-specific ways to comfort resident if a trigger occurs: 1) Talk to him. Resident specific way to decrease triggers: 1) Ask before providing personal care. Staff will ensure safety of resident buy ensuring physical setting is safe and interpersonal interactions promote a sense of safety. Staff will promote collaboration and mutuality with resident by partnering with him and sharing power and decision-making. Staff will promote trustworthiness and transparency by maintaining transparency and building and maintaining trust with resident. Staff will uphold resident' empowerment and choice by supporting shared decision-making, choice and goal setting. Staff will honor resident's self-advocacy skills."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 38	F 600		

An interview was conducted with CNA #6 on 7/18/2023 at 2:46 p.m. When asked if a resident tells them that a staff member touched them in a manner the resident did not like, sexually, what steps do you take, CNA #6 stated she would go tell the charge nurse or supervisor. CNA #6 was asked if a resident told you a staff member inappropriately touched them, in a sexual manner, is that abuse? CNA #6 stated, yes.

An interview was conducted with LPN (licensed practical nurse) #8 on 7/18/2023 at 2:53 p.m. When asked if a resident told you the night nurse touched them inappropriately, what would you do, LPN #8 stated she would gather more information and report it to my supervisor and the social worker.

ASM (administrative staff member) #1, the executive vice president, ASM #2, the director of nursing, and ASM #3 the interim administrator, were made aware of the above concern on 7/19/2023 at 9:15 a.m.

An interview was conducted with R35 on 7/19/2023 at 9:17 a.m. accompanied by OSM (other staff member) #1, the social worker, to help in translating. R35 was asked what happened that day to him, R35 stated, "He (expletive) me. He pulled my pants down and asked if I wanted some. Ewe. He put something in my mouth. Ewe. I don't know why he did this to me. I asked him to get out of my room or I would knock him out, on his face on purpose." OSM #1 clarified that sometimes we hit people accidentally, but he would have hit him on purpose. When asked how it made him feel, R35 stated, "Bad." R35 was asked what he put in his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 39	F 600		

mouth, R35 stated, "His (expletive - penis)." When asked if the CNA touched his private area, R35 stated yes, the CNA put his hands on his penis. R35 was asked when and where this happened, OSM #1 stated that through the interviews with R35, throughout the investigation, it occurred in R35's room after CNA #5 had given R35 a shower. R35 stated, "That's why he's (CNA #5) not here anymore."

The facility developed and implemented a plan of correction, which contained the following 5 points:

1. The employee involved in the incident is no longer employed by the facility. Resident 1 (Resident #60) and Resident 2 (Resident #35) were assessed by the physician. Resident 3 (Resident #50) refused the assessment. Residents 1, 2 and 3 were assessed for psychosocial distress and care plans were revised as necessary. Residents have been referred to a psychologist for evaluation and treatment.

2. All current residents were interviewed by Social Services as they may have been affected. Interviews completed of all residents on 4/13/23. Any new allegations of abuse verbalized will be reported according to the facility abuse policy and the potential threat removed immediately while an investigation is in process.

3. Social Services/designee will be responsible for monitoring residents for abuse/psychological distress and ensuring any allegations verbalized will be reported according to the facility abuse policy. The Director of Social Services/designee has inserviced staff regarding abuse and the facility abuse policy including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 40 requirements/removing a potential threat immediately while an investigation is in process. Staff inservicing was completed on 4/21/23. 4. Social Services will meet weekly with residents affected and provide assistance as needed for a period of two months. 5. The Director of Social Services/designee will meet with the residents on the second Tuesday of each month to review resident rights and abuse. Any allegations of abuse will be investigated immediately as per the facility abuse policy. Education and training will be provided to staff on an ongoing basis. The Director of Social Services/designee will identify and report any trends and/or patterns to the quality assurance committee on at least a quarterly basis. 6. Completion date 5/9/23. The credible evidence including the Plan of Correction, education, in-service sign in sheets, audits and Quality Council minutes were reviewed and found to be in order. Random interviews were conducted with staff on varying shifts regarding abuse education and training and failed to reveal any concerns. Review of current residents failed to identify any concerns. Past non-compliance. No further information was provided prior to exit.	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		8/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 41	F 656		

implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 42 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to implement the comprehensive care plan for one of 31 residents in the survey sample, Resident #38. The findings include: For Resident #38 (R38), the facility staff failed to implement the resident's comprehensive care plan for anticoagulant medication monitoring. R38's comprehensive care plan dated 7/31/20 documented, "(R38) is on anticoagulant therapy...Monitor for side effects and effectiveness Q (every)-SHIFT..." A review of R38's clinical record revealed a physician's order dated 11/3/20 for Eliquis (1) five milligrams by mouth two times a day for pulmonary embolism. A review of R38's MARs (medication administration records) for May 2023 through July 2023 revealed the resident was administered Eliquis five milligrams two times each day. Further review of R38's clinical record (including the MARs and nurses' notes for May 2023 through July 2023) failed to reveal the resident was monitored for side effects (bleeding) from Eliquis. On 7/19/23 at 9:03 a.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated residents that are administered anticoagulants should be monitored for bleeding	F 656	Tag 656 Develop/Implement Comprehensive Care Plan. The resident found to have been affected by the deficient practice was addressed and an Anticoagulant monitoring system was added to their Medication Administration Record and Care Plan. Completed 7/21/23. All residents residing at TVH have the potential to be affected by the deficient practices. The facility audited 100% of the medical records for residents on anticoagulants. An anticoagulation monitoring system will be added to their Medication administration Record and Care Plan. Completed 7/24/23. The following procedures/systemic changes will be implemented to ensure that the deficient practice does not recur. Anticoagulation monitoring will be added to all resident on Anticoagulants currently at the facility and on admission. Anticoagulation Policy and Procedure will be developed and in-serviced to all LPNs, and RNs by the Staff Development Coordinator. The ADON will audit the Medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 43 every shift and the nurses utilize an anticoagulant monitoring form, but the form was not in place for R38. RN #2 stated the purpose of the care plan is to make sure the patient is being taken care of at their highest level of care and nurses have access to care plans to ensure they are implementing them. On 7/19/23 at 9:11 a.m., ASM (administrative staff member) #1 (the executive vice president) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Resident Care Management System" failed to document specific information regarding care plan implementation. Reference: (1) "ELIQUIS is indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation (NVAF)...Bleeding Risk: ELIQUIS increases the risk of bleeding and can cause serious, potentially fatal, bleeding." This information was obtained from the website: https://www.eliquis.com/eliquis/hcp/wellcareform?cid=sem_2167331&ovl=isi&gclid=64c052d127001aa9ec1836cd1510884c&gclsrc=3p.ds&	F 656	Administration Record and Care Plan weekly x4 weeks, monthly x4 for compliance. Results will be reported to the DON and QAPI Committee.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		8/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 44 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plan for two of 31 residents in the survey sample, Residents #6 and #34. The findings include: 1. For Resident #6 (R6), the facility staff failed to review and revise the care plan after the resident returned from the hospital with kidney stones. The hospital discharge summary dated, 4/24/2023, documented in part, "Discharge Diagnoses/Plan: Complicated UTI (urinary tract infection) in the setting of right-sided obstructive ureteral stone with hydronephrosis treated with cystoscopy and stent and IV (intravenous)	F 657	F657 Care Plan timing and revision. Residents affected by the deficient practice were identified. An immediate review was completed on resident care plans and updated appropriately. All residents have the potential to be affected by the deficient practice. An audit was completed and revisions were made as necesary. DON educated MDS Coordinator on the requirements of updating a care plan to ensure a resident is receiving care to the highest level of their well being. The IDT will ensure the care plan is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 45 antibiotics. Completed total of 14 days of antibiotics, discharged on oral ciprofloxacin to cover both Citrobacter and Enterococcus. Patient will need outpatient follow-up with urology for definitive stone management." The hospital discharge summary dated, 5/19/2023, documented in part, "Discharge Diagnosis/Plan: Sepsis due to urinary tract infection and bacteremia. Nephrolithiasis: Patient with right proximal stone, s/p (status post) stent placement on 4/21/2023. Urology evaluating, timing for stone treatment to be determined. Needs outpatient follow-up." The physician orders dated, 7/17/2023, documented, "Res (resident) has a schedule Urology Procedure appt (appointment) on July 24, 2023, at 6:00 a.m. with (name of urologist) at (initials of hospital with address) Outpatient Registration. Nothing to eat or drink after (12:01 a.m.) in prep for urology procedure." Review of the comprehensive care plan revised on 8/28/2019, documented, "Problem: (R6) has a history of bowel and bladder incontinence with urosepsis r/t (related to) TBI (traumatic brain injury)." The "Interventions" documented, "Apply moisture barrier to skin as ordered. Check and change toileting schedule. Resident will at time decline to return to the unit to be change. Maintain hydration, encourage/assist with fluid intake. Monitor and document BMs (bowel movements), offer PRN (as needed) interventions if no BM > (greater than) 3 days. Administer meds (medications) as ordered. Monitor for sings of UTI. Monitor skin per protocol. Monitor/document for s/sx (signs and symptoms) UTI: pain, burning, blood-tinged urine, cloudiness,	F 657	reviewed and updated following readmission after hospitalization and any changes on a residents condition or service needs. The IDT will at each quarterly meeting that MD orders match the care plan. At this time the care plan in its entirety has been reviewed and updated as necessary. An audit tool was developed, it includes checking 10% of the residents care plan and Kardex.The MDS Coordinator will conduct this audit at random weekly x4, then twice monthly x2mths and then monthly x1. All findings of concern will be addressed immediately and reported to the QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 46	F 657		

no output, deepening of urine color, increased pulse, increased temp (temperature), urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. On toileting plan of check and change. Staff prompt him to use the toilet and assist as needed. Apply Tena Protective cream after each in continent episode."

There was no documentation in the comprehensive care plan related to the resident's ureteral stones and upcoming urological procedures.

An interview was conducted with LPN (licensed practical nurse) #10 on 7/18/2023 at 12:59 p.m. When asked the purpose of the care plan, LPN #10 stated, it's to have guidelines to the resident's care, such as what lift to use, how they use the bathroom, their diet, and behaviors. LPN #10 was asked who updates the care plans, LPN #10 stated they go over them quarterly, she stated she does some nursing updates. When asked if a resident has kidney stones and is scheduled for urological surgery and has been in the hospital twice for this concern, should that be addressed on the care plan, LPN #10 stated, if it's an issue, it should be care planned and have interventions in place. R6's diagnoses and care plan reviewed with LPN #10. LPN #10 stated, (R6) used to drink a lot of sodas so we are now giving him flavored water, has cups with his name on them. LPN #10 stated they try to make sure he has a cup of water on his wheelchair with his long straw. When asked if these interventions should be on his care plan, LPN #10 stated, yes. LPN #1 was asked then who updates the care plans, LPN #10 stated, she only adds minor things to the care plan, but didn't know who updates them. LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 47	F 657		

#10 made a call to the DON (director of nursing) who told her, RN (registered nurse) #2 does the updates to the care plan.

An interview was conducted with RN #2, the MDS (minimum data set) nurse on 7/18/2023 at 1:08 p.m. When asked who updates the care plan, RN #2 stated she typically does but anyone can update them. The care plans are accessible by everyone on the IDT (interdisciplinary team). The interventions that LPN #10 spoke of were discussed with RN #2. When asked if they should be on the care plan, RN #2 stated, yes, they should be. RN #2 was asked if the resident has a stent, history of stones, sepsis twice and having a urological procedure the end of July, shouldn't something related to this be on the active care plan, RN #2 stated, she had it on the care plan under UTI, but she resolved (deleted) that care plan.

The facility policy, "Resident Care Management System" documented in part, "10. All members of the Interdisciplinary Care Plan Team must reassess and revise a resident's care plan throughout the quarter anytime there is a change with their care."

ASM (administrative staff member) #1, the executive vice president, and ASM #2, the director of nursing, were made aware of the above concern on 7/18/2023 at 4:15 p.m.

No further information was provided prior to exit.

2. For Resident #34, the facility failed to revise the comprehensive care plan to include bed rails.

Resident #34 was observed in bed with upper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 48	F 657		

bilateral side rails on 7/17/23 at 3:05 PM and on 7/18/23 at 8:10 AM.

Resident #34 was admitted to the facility on 10/24/22 with diagnosis that included but were not limited to: multiple sclerosis and dementia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 7/6/23, coded the resident as scoring a 09 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the Section G-functional status coded the resident as requiring total dependence for bed mobility, transfer, locomotion, dressing, eating, hygiene and bathing.

A review of the comprehensive care plan dated 6/4/19 revealed, "PROBLEMS: Resident is at risk for falls related to altered mobility, disease process, and use of psychotropics. APPROACHES/TASKS: Has special bed. No side rails."

A review of the bed rail assessments for 1/7/22 and 1/4/23 revealed, "Are bed rails indicated-YES. Two bed rails are indicated-self positioning."

An interview was conducted on 7/18/23 at 1:30 PM with LPN (licensed practical nurse) #8. When asked the purpose of the care plan, LPN #8 stated, to provide direction for the care and interventions for the resident. When asked if bed rails should be included on the care plan, LPN #8 stated, yes, they should. When asked if the care plan revealed "no side rails" and the resident had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 49 bilateral upper side rails, had the care plan been revised; LPN #8 stated, no, it was not correct to what the resident had, it has not been revised. On 7/18/23 at approximately 4:40 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. A review of the facility's "Resident Care Plan" policy revised 11/17, reveals, "All members of the Interdisciplinary Care Plan Team must reassess and revise a resident's care plan throughout the quarter anytime there is a change with their care." No further information was provided prior to exit.	F 657		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to prevent accidents that resulted in fractured bones for two of 31 residents in the survey sample, Residents #43 and #71. This was cited at harm past non-compliance. The findings include:	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 50	F 689		

1. For Resident #43 (R43), the facility staff failed to transfer the resident with a Hoyer mechanical lift, per the resident's plan of care. This resulted in a fall and R43 sustained a fractured clavicle.

R43's comprehensive care plan dated 7/31/17 documented, "(R43) requires assistance with ADL (activities of daily living) tasks r/t (related to) Dx (diagnoses): Cerebral Palsy, Spasticity and Mood Disorder. Approaches/Tasks: FULL MECHANICAL LIFT-Hoyer Lift for all transfers. R43's kardex dated 1/28/23 documented, "Transferred using full mechanical lift (Hoyer)."

A review of R43's clinical record revealed a nurse's note dated 1/28/23 that documented, "CNA (Certified Nursing Assistant) reported res (resident) fell to to [sic] floor during transfer. res was yelling before bed, CNA says she didn't [sic] feel comfortable with hoyer transfer so she did stand and pivot transfer from w/c (wheelchair) to bed. her shoe on right foot not on all the way, res slipped and fell ontop [sic] of CNA on the floor. CNA rolled her to her back to get help. assessed and transferred by hoyer to the bed x3 [times three staff]. c/o (complained of) pain to left shoulder, no signs of injury. ice applied and tylenol given. res said she did not hit her head. mother notified. vitals normal."

X-ray results dated 1/30/23 documented an acute distal clavicle fracture.

A facility synopsis of events dated 2/3/23 documented, "On Saturday January 28, 2023, (R43) sustained a clavicle fracture after being transferred from her wheelchair to the bed... (CNA #1) C.N.A. was interviewed on 2/3/23 by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 51	F 689		

(ASM [administrative staff member] #2), DON (Director of Nursing) in regard to fall related transfer on 1/28/23 with (R43). She asked (CNA #1) if she knew what the documented transfer method was for (R43). (CNA #1) stated that it was a Hoyer transfer with two staff members. (ASM #2) asked her why she tried to execute a stand pivot transfer instead of following the care plan. (CNA #1) said she felt more comfortable doing it that way because of her behaviors. The resident was noted to have been yelling during this shift 3PM to 11PM. (CNA #1) explained the fall incident by saying she [sic] that she stood the resident up from her power wheelchair and her right shoe came off. The change in balance then precipitated the fall...Unfortunately, humans [sic] error caused this incident by diverting from the care plan for transferring the resident."

CNA #1 was not available for interview during the survey. On 7/18/23 at 3:53 p.m., an interview was conducted with CNA #2. CNA #2 stated the CNAs are made aware of how a resident should be transferred via a sign on the back of the resident's room door, the resident's care plan, and in the computer system when documenting transfers. CNA #2 stated it is important to follow a resident's care plan for transfers for safety reasons.

On 7/18/23 at 4:33 p.m., ASM (administrative staff member) #1 (the executive vice president) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Mechanical Lifts and Transfers" documented, "Residents who need assistance to transfer to bed or chair will have their Care Plan reflect the proper method...Full

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 52	F 689		

body mechanical lifts are to be used with a two person transfer only..."

A facility plan of correction dated 2/1/23 documented, "Staff member transferred the resident using stand pivot instead of 2 person Hoyer lift. Resident slipped and fell on top of C.N.A. Resident was transferred to bed via Hoyer lift and 3 staff assist. 1. Resident complained of left shoulder pain after fall, assessment was completed by Charge nurse with no signs of injury noted. (R43) received Tylenol and ice was applied for complaint of pain. 1/29 resident again complained of pain. MD (Medical Doctor) notified, and X-Ray was ordered. 1/30 X-Ray showed left distal clavicle fracture. MD and mother were notified. Referral to (name of orthopedic company). 1/31 resident was seen by MD at (name of orthopedic company), ice and rest ordered. 2. All residents that are transferred incorrectly are at risk of injury. 3. Staff member that did the incorrect transfer was interviewed and stated that she knew the resident was a 2 person Hoyer transfer and she did a stand pivot instead. Staff member was terminated for not following correct procedure. Staff Development Coordinator to educate all nursing staff on the Mechanical lift Policy. 4. The Nursing Supervisor/Manager on each shift will monitor weekly for 4 weeks staff compliance. 5. Dates of Completion: 4/4/23."

Credible evidence for this plan of correction was verified during the survey.

Past non-compliance.

2. For Resident #71 (R71), the facility staff failed to properly transfer the resident with a sit to stand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 53	F 689		

lift by utilizing the leg strap. This resulted in a fall and R71 sustained a fractured right ankle.

R71's comprehensive care plan dated 7/26/17 documented, "(R71) is at risk for falls r/t (related to) altered mobility, disease process and use of psychotropics. Approaches/Tasks: Transfers-Use sit to stand lift for all transfers..." R71's kardex report dated 2/20/23 documented, "Transfer using the sit to stand lift only." The care plan and kardex failed to document specific instructions for using a sit to stand lift.

A nurse's note dated 2/20/23 documented, "Assigned cna (certified nursing assistant) was transferring resident from shower chair using a seat [sic] to stand lift, Res. (Resident) fell on her knees landing on right leg. c/o (Complained of) pain to right leg, upper and lower leg X-ray ordered."

A note signed by the orthopedist on 2/21/23 documented a non-displaced right ankle fracture.

A facility synopsis of events dated 3/1/23 documented, "On Monday February 20, 2023, (R71) sustained a ground level fall while being transferred in her room from shower chair to her wheelchair. Initial reports of right leg pain and x-ray were negative. The following day, however, the resident complained of right ankle pain and exhibited swelling in the right ankle. Additional x-rays revealed a fracture in the right ankle...At the time of the fall, (R71) separated her feet of [sic] the foot plates of the sit-to-stand lift and from there tilted forward and slid to the ground from her position in the shower chair. (CNA #2) confirmed there was no lower leg strap used during the transfer which was her omission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 54	F 689		

Logically, the use of the strap may have prevented this fall...Unfortunately, as the C.N.A. mentioned in our discussion, she lost her focus and did not use the lower leg strap to help stabilize the resident during the transfer. This incident was caused by human error and by diverting from the care plan for transferring the resident..."

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/27/23, R71 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

On 7/18/23 at 8:33 a.m., an interview was conducted with R71. The resident stated she has not refused leg straps while being transferred with the sit to stand lift.

On 7/18/23 at 3:53 p.m., an interview was conducted with CNA #2. CNA #2 stated she did not use the leg strap while transferring R71 on 2/20/23 and the resident slid and fell. CNA #2 stated not using the leg strap was her mistake and the CNAs are supposed to make sure they use leg straps with sit to stand lift transfers.

On 7/18/23 at 4:33 p.m., ASM (administrative staff member) #1 (the executive vice president) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Sit to Stand Mechanical Lift" documented, "Residents who need assistance to transfer to bed or chair will have their Care Plan reflect the proper method...Raise the resident's leg and feed the strap under and up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 55	F 689		

between the legs. Ensure the sling is not twisted or creased under the thigh. Repeat this procedure with the other leg..."

A facility plan of correction dated 2/23/23 documented, "Staff member transferred the resident using sit to stand lift. Resident moved her feet off platform and fell to her knees. C.N.A. did not attach straps to her legs before being transferred. Resident was transferred to bed via Hoyer lift and 3 staff assist. 1. Resident complained of right knee pain. Knee was noted to be swollen with bruising. MD (Medical Doctor) was notified and Xray's were ordered. Results showed no fracture of knee or tibia/fibula. Resident then complained of right ankle pain. Sent to (name of orthopedic company) 2/21/23 and was diagnosed with fracture of the right BiMalleolar, and was placed in a walking boot. 2. All residents that are transferred incorrectly using a sit to stand lift are at risk of injury. 3. Staff member that did the incorrect transfer was interviewed and stated that the resident will not let her put leg straps on when using the sit to stand lift. Staff member was put on a 3 day suspension and will have training when she returns. The staff development coordinator will in-service the nursing staff on the proper transfer using the sit to stand lift. Residents that use the sit to stand for transfer will also be instructed on the proper technique for using the sit to stand lift and there will be no deviations. 4. The Nursing Supervisor/Manager will monitor for 4 weeks staff compliance. 5. Dates of Completion: 4/7/23. Credible evidence for this plan of correction was verified during the survey and no further deficiencies regarding safety and accidents were cited.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 56 Past non-compliance.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to store a resident's nebulizer mask in a sanitary manner for one of 31 residents in the survey sample, Resident #93. The findings include: For Resident # 93 (R93) the facility staff failed to cover the nebulizer mask when it was not in use. R93 was admitted to the facility with diagnoses that included but was not limited to wheezing. Resident #93's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/06/2023, coded Resident #93 as scoring a 15 out of 15 on the brief interview for mental status (BIMS) which indicated the resident was cognitively intact for making daily decisions.	F 695	Tag 0695 Respiratory/Tracheotomy Care and Sustioning. For the resident found to have been affected by the deficient practice, the facility took the following actions immediaely, the nursing staff covered the nebulizer with a clean towel. Completed 7/19/23. To identify other residents having the potential to be affected by the same deficient practice, the facility will take the following actions: 1) an administrative nurse will review all orders for all 130 residents and will identify those with respiratory orders and treatments. 2) A nurse supervisor will check all the associated resident equipment and the storage of said equipment. The supervisor will note the equipment as either in or out of compliance with our policy for safe and clean handling of repiratory equipment.	8/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 57 On 07/17/23 at approximately 3:17 p.m., an observation of R93's room revealed a nebulizer mask on R93's desk uncovered. On 07/18/23 at approximately 8:21 a.m. and 12:35 p.m., observations of R93's room revealed a nebulizer mask on R93's desk uncovered. The physician's order for Resident # 93 documented in part, "Albuterol Solution 0.5 - 2.5 (3) MG/3ML inhale orally every 12 hours as needed for dyspnea (1). Order Date: 10/25/2021. Start Date: 10/26/2021." On 07/18/2023 at approximately 12:45 p.m. an observation of R93's room and interview were conducted with LPN (licensed practical nurse) #3. When asked to describe the procedure for storing a nebulizer mask when it was not in use, she stated that it should be placed in a plastic bag to keep it clean. After LPN #3 observed R93's nebulizer mask uncovered lying on top of the desk in R93's room she stated that it should be covered. The facility's policy "Respiratory Equipment Care" it documented in part "BREATHING TREATMENT EQUIPMENT - NEBULIZER. After each treatment: Remove the mouthpiece on mask and medication cup. Rinse under strong stream of hot tap water, shake off excess water and air dry. When completely dry, reassemble and store mouthpiece in zip-lock bag." On 07/18/2023 at approximately 4:30 p.m., ASM (administrative staff member) #1, executive vice-president, and ASM #2, director of clinical services, were made aware of the above findings.	F 695	This measure that the facility will undergo usinf the Point Click Care eMar system and the quality assurance checklist tool will ensure that the deficient practice does not adversely affect additional residents. The following procedures/systemic changes will be implemented to ensure that the deficient practice does not recur: 1) The Licensed Practical Nurse will be re-educated/in-serviced on respiratory care procedures with an emphasis on proper handling and storage of equipment when not in use. The renewed emphasis on the procedures for safe handling of the equipment will be consistent with the professional standards of practice. Additionally, a Charge Nurse on each floor will conduct a weekly audit for 8 weeks of the proper storage of respiratory equipment. The documented audits will be submitted to the Director of Nursing for compliance review and necesary continuing education. The facility plans to monitor its performance to ensure solutions are sustained by taking the following actions: The DON will report the results of the respiratory audits to the Quality Asurance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 58 No further information was provided prior to exit. Reference: (1) Shortness of breath - known medically as dyspnea - is often described as an intense tightening in the chest, air hunger, difficulty breathing, breathlessness or a feeling of suffocation. https://www.mayoclinic.org/symptoms/shortness-of-breath/basics/definition/sym-20050890	F 695		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 756		8/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 59 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to completely develop a policy for the monthly drug regimen reviews with times frames for the different steps in the process, including identifying an irregularity that requires urgent actions to protect the resident for five residents reviewed for medications, (Residents #18, #38, #43, #83 and #109), in the survey sample of 31 residents. The findings include: The facility, "Consultant Pharmacist" policy failed to include any documentation regarding the timeframe that a pharmacy recommendation is required to be provided to the physician and acted upon by the physician. The policy did not meet regulatory requirements of specifying those time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. During the unnecessary medication review and	F 756	Tag F756 Drug Regimen Review. The residents found to have been affected by the deficient practice were addressed and a policy was revised for the monthly drug regime review with time frames for different steps in the process, including identifying irregularities that require urgent action. Completed 8/7/23. All resident residing at The Virginia Home have the potential to be affected by the same deficient practices. The Consultant Pharmacist will review all current residents for any irregularities with medications that require urgent action and will notify the attending Physician, medical Director and Director of Nursing. Complete by 8/14/23. The following procedures/systemic changes will be implemented to ensure that the deficient practice does not recur. The updated policy on Medication Regimen Review will be put into effect by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 60 drug regimen review, the following resident records were reviewed: Resident #18's clinical record was reviewed for unnecessary medications. There were no identified concerns with the use of anticoagulation the resident was receiving. Resident #38's clinical record was reviewed for unnecessary medications. There were no identified concerns with the use of anticoagulation the resident was receiving. Resident #43's clinical record was reviewed for unnecessary medications. There were no identified concerns with the use of antidepressant the resident was receiving. Resident #83's clinical record was reviewed for unnecessary medications. There were no identified concerns with the use of psychotropics the resident was receiving. Resident #108's clinical record was reviewed for unnecessary medications. There were no identified concerns with the use insulin the resident was receiving. A review of the facility policy regarding medication regimen reviews and pharmacy recommendations was conducted. The policy, "Consultant Pharmacist" documented in part, "The clinical pharmacist recommends that the facility regularly reviews and analyzes data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements within 30 days of receipt".	F 756	The Virginia Home and Family Care Pharmacy.Policy# 717.45. Completed 8/7/23. The Director of Nursing will include any recommendations from the Consultant Pharmacist that required immediate action to The QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 61 On 07/18/23 at 1:15 PM, an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that the facility's pharmacy medication review policy, was what they had and the pharmacy did not have a separate policy. ASM #2 provided a revised policy, however it did not meet guidelines. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the interim administrator was made aware of the above concern on 7/19/23 at 9:05 AM. No further information was provided prior to exit.	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757		8/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 62 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure one of 31 residents in the survey sample was free from an unnecessary medication; Resident #38. The findings include: For Resident #38 (R38), the facility staff failed to monitor the resident for side effects (bleeding) from the anticoagulant (blood thinning) medication Eliquis (1). A review of R38's clinical record revealed a physician's order dated 11/3/20 for Eliquis five milligrams by mouth two times a day for pulmonary embolism. A review of R38's MARs (medication administration records) for May 2023 through July 2023 revealed the resident was administered Eliquis five milligrams two times each day. Further review of R38's clinical record (including the MARs and nurses' notes for May 2023 through July 2023) failed to reveal the resident was monitored for side effects (bleeding) from Eliquis. On 7/19/23 at 9:03 a.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated residents that are administered anticoagulants should be monitored for bleeding every shift. RN #2 stated the nurses utilize an anticoagulant monitoring form, but the form was not in place for R38. On 7/19/23 at 9:11 a.m., ASM (administrative	F 757	Tag 757 Drug Regime is free from Unnesessary Drugs. The resident found to have been affected by the deficient practice was addressed and an Anticoagulant Monitoring System was added to their Medication Administration record and Care Plan. Completed 7/21/23. All residents residing at The Virginia Home have the potential to be affected by the deficient practice. The facility Audited 100% of the residents on Anticoagulation Therapy. An Anticoagulation system was added to their Medication Administration System and Care Plan as needed. Completed 7/24/23. The following procedures/systemic changes will be implemented to ensure that the deficient practice does not recur. Anticoagulation monitoring will be added to all present residents on Anticoagulants, admitted or started on Anticoagulants. Anticoagulation Policy and Procedure will be developed and in-serviced to a Licensed Nursing staff by the Staff Development Coordinator. The ADON will audit the Medication Administration Record and Care Plan weekly for 4 weeks, monthly for 4 months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 63 staff member) #1 (the executive vice president) and ASM #2 (the director of nursing) were made aware of the above concern. The facility did not have a policy regarding anticoagulant medication monitoring. Reference: (1) "ELIQUIS is indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation (NVAF)...Bleeding Risk: ELIQUIS increases the risk of bleeding and can cause serious, potentially fatal, bleeding." This information was obtained from the website: https://www.eliquis.com/eliquis/hcp/wellcareform?cid=sem_2167331&ovl=isi&gclid=64c052d127001aa9ec1836cd1510884c&gclsrc=3p.ds&	F 757	and report the finding to the DON and QAPI Committee.	