PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED			
		49E084	B. WING _	B. WING		C 07/19/2023	
NAME OF PE	ROVIDER OR SUPPLIER		1	STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 077	10/2020
THE VIDG	INIA HOME			110	1 HAMPTON ST		
THE VING	INIA HOME			RIC	CHMOND, 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	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
E 000	Initial Comments		EC	000			
F 000	survey was conducted 07/19/2023. The facil compliance with 42 C Requirement for Long emergency preparedr investigated during the INITIAL COMMENTS.  An unannounced Me conducted 07/17/2023 Significant corrections.	lity was in substantial FR Part 483.73, p-Term Care Facilities. No ness complaints were e survey.  dicaid standard survey was 3 through 07/19/2023. s are required for	F(	000			
	Term Care Requirement (VA00057708- substant VA00057096-substant investigated during the Code survey/report with the census in this 13 126 at the time of the consisted of 29 current closed record reviews	ntiated with deficiency and tiated with deficiency), were e survey. The Life Safety ill follow.  O certified bed facility was survey. The survey sample at Resident reviews and two servers.					0 (0.4 (0.0
	self-determination, an access to persons an outside the facility, ince this section.  §483.10(a)(1) A facility	Rights.  Ship to a dignified existence, do communication with and do services inside and cluding those specified in the ship treat each resident	FE	550			8/31/23
ABOBATORY	promotes maintenand	ity and care for each and in an environment that se or enhancement of his or SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

**Electronically Signed** 08/08/2023 Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

Facility ID: VA0254

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		49E084	B. WING		C 07/19/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1101 HAMPTON ST  RICHMOND, VA 23220	1 01/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICAL DEFICIENCY)	D BE COMPLETION	
F 550	individuality. The far promote the rights of \$483.10(a)(2) The far access to quality car severity of condition must establish and appractices regarding provision of services residents regardless. \$483.10(b) Exercises The resident has the rights as a resident or resident of the Ur \$483.10(b)(1) The far resident can exercise interference, coercist from the facility. \$483.10(b)(2) The resident can exercise interference, reprisal from the facility. \$483.10(b)(2) The resident can exercise of interference, reprisal from the facility. This REQUIREMEN by:  Based on resident in clinical record review documentation, it was failed to promote an right to a dignified a three of 31 residents.	cognizing each resident's cility must protect and if the resident.  acility must provide equal re regardless of diagnosis, or payment source. A facility maintain identical policies and transfer, discharge, and the sunder the State plan for all sof payment source.  To f Rights.  To frights of the facility and as a citizen nited States.  Cacility must ensure that the lee his or her rights without fon, discrimination, or reprisal cesident has the right to be coercion, discrimination, and cility in exercising his or her ported by the facility in the er rights as required under this later is not met as evidenced ces as determined that the facility denhance each resident's and respected existence for in the survey sample,	F 5	FTag 550 resident Rights/Exercise Rights.  The three residents found to have b affected by the deficient practice we identified. Social Workers met with the second control of t	een re he	
	three of 31 residents Resident #60, #50 a The findings include	and #35.		identified. Social Workers met with t resident's weekly for a period of 2 m to provide support and active listenii Completed 4/21/23.	onths	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE	1 07	/ 19/2023
TVAIVIL OF T	TOVIDER OR GOLT EIER				HAMPTON ST		
THE VIRG	INIA HOME						
				RIC	HMOND, VA 23220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page	2	F 5	50			
	ensure the resident werespect. The resident by a staff member.  Resident #60 was ad 1/20/2005. A review of event dated 4/10/23 rallegation of abuse/member.  He stated that while go days ago, his CNA (comouth touched his performed an incident to the stated that while go days ago, his CNA (comouth touched his performed and the stated that while go days ago, his CNA (comouth touched his performed to the stated that while go days ago, his CNA (comouth touched his performed to the stated that while go days ago, his CNA (comouth touched his performed to the stated that while go days ago, his CNA (condended the resident as the BIMS (brief intervindicating the resident as for transfer and bathing bed mobility, dressing for eating / locomotion of the competition of the co	S (minimum data set) erly assessment, with an ference date) of 7/6/23, s scoring a 14 out of 15 on iew for mental status) score, t was cognitively intact. A ection G-functional status s requiring total dependence ng; extensive assistance for g, hygiene and independent			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 abarise it will be reported to the QAPI committee. Completed 4/13/23.  The Director of Social Services/Design 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/Design 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 we be investigated immediately per TVH Abuse Policy #707.4 and 707.5.	use ee /, ee ond	
	chaplain for support. decrease triggers: Re	efer to SW (social worker) or Resident-specific ways to esident requests to have ed nursing assistants). Staff					

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		49E084	B. WING	B. WING		C 07/19/2023	
	ROVIDER OR SUPPLIER		<u>. I</u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE  101 HAMPTON ST RICHMOND, VA 23220	<u> </u>	19/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	beforehand (changing daily living). Staff will by ensuring physical interpersonal interact safety. Staff will pron mutuality with resider sharing power and depromote trustworthine maintaining transpare maintaining trust with resident's empowerm supporting shared de goal setting. Staff will self-advocacy skills."  A review of the physic 4/10/23 at 3:33 PM, rincident regarding ab same story about the inappropriate contact allow me to examine no injuries and he was and he was very clea examined. He was up agreeable to follow-up therapy/counseling or visit."  A review of Resident dated 4/11/23, reveal trauma, briefly descriit reported on April 7th assigned CNA was children.	ell him what they want to do g clothes, all activities of ll ensure safety of resident setting is safe and ions promote a sense of note collaboration and at by partnering with him and ecision-making. Staff will ess and transparency by ency and building and resident. Staff will uphold ent and choice by cision-making, choice, and honor resident's  cian's progress note dated evealed, "Seen for recent use. Resident mentioned the aide having an with him; he refused to him as he said there were s in no pain. I asked again r that he did not wish to be eset at the incident and was p and get some in the next behavioral health  #60's "Trauma Assessment" ed, "Is there a history of the the event: Resident	F	550			
	resident's penis. Resi he did. Self-Reportin impact me at all 10=	dent asked him to stop and g Scale 0-10 (0= does not this impacts me a great eporting Scale, how much					

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		49E084	B. WING			C 07/19/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1101 HAMPTON ST  RICHMOND, VA 23220		7771372020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 550	said 10. What copin with thoughts of the unable to articulate like the opportunity counselor/therapist that may continue to told me no - that he needed. He told phy anything you would know? Want to be a Wants to sit outside and stepmother. Wo A review of the 4/11 note, revealed, "Readled his step-moth 10 minutes. Reside was his 1st time conwent to recreational therapy). He did not A review of the 4/17 coordination note, resident this mornin participating in the Naturday the 15th. 1st floor to socialize He had his tv on an game."	pact your daily life: Resident ng skills do you use to deal traumatic event? Resident is an answer to this. Would you to meet with a to discuss traumatic events impact your life? Resident would talk with staff as visician that he would. Is there like your social worker to like your social worker to like to talk with someone.  Wants to talk with his father ork with a female CNA only."  1/23 3:22 PM care coordination sident came to see me today. Out the incident that occurred ked to call his parents - we her and they talked for about and they talked for about the first floor today. He therapy and pt (physical tappear upset or frightened."	F 55	50		
	discussed the recer a staff person, relat incident and anxiety	nt incident of sexual abuse by ing preoccupation about the v about his future safety and rsonal relationships. He				

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		49E084	B. WING		C 07/19/2023		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1101 HAMPTON ST  RICHMOND, VA 23220	1 01110/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 550	long time and previor patient to develop plas and build ways to im  A review of the social at 3:56 PM, revealed office, requested to some with the social at 3:56 PM, revealed office, requested to some with the second office, requested to some strategies he uses to feelings. Resident excounseling support.  A review of the social at 10:49 AM, revealed SW (social worker) to the said he was feeling. A review of the social at 3:29 PM, revealed SW and asked to call her and resident said thinking about the tranking about the tranking about the tranking about the tranking about the was SW took resident to have talked. Resident several times and safether/step-mother work (May 6 or 7)."  An interview was core PM with Resident #60 stated, he was changing metouched his mouth to me and filed a report	e had been a resident for a usly felt safe there. Help an for coping with anxiety prove self-esteem."  I services note dated 4/20/23 d., "Resident came to writer's speak with writer in his room. The listening and therapeutic dent to recall several a self-soothe, validated theresed gratitude for staff support.  I services note dated 4/26/23 d., "Resident came to see oday for supportive listening.	F 55	50			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	102007		STREET ADDRESS, CITY, STATE, ZIP CO 1101 HAMPTON ST RICHMOND, VA 23220	DE	07/19/2023	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 550	and it happened. Evisame, I have been ta here. He (CNA #5) is the police and detect a bad situation. I felt was not good for me. now, Resident #60 st here and felt safe bed. An interview was conp. PM with LPN (license asked about the residerespect and dignity, Let being treated with being honored.  ASM #1, the administ of nursing and ASM # was made aware of to 7/19/23 at 9:05 AM.  According to the facility and Abuse Prohibition resident has a right to self-determination, an access to persons an outside the facility, in this section. A facility with respect and dignerical manner promotes maintenancher quality of life, recindividuality. The facil promote the rights of No further information.  2. For Resident #50,	er since then, I am not the lking with the staff working on there. I have talked with live a couple of times. It was bad. I told him to stop. It When asked how he felt ated, better now. I feel safe fore.  I ducted on 7/18/23 at 2:45 at practical nurse) #7. When dent being treated with LPN #7 stated, no, his rights dignity and respect were not strator, ASM #2, the director #3, the interim administrator he above concern on his reveals, "The oradignified existence, and communication with and and services inside and cluding those specified in a must treat each resident with and care for each and in an environment that the orange of the protect and lity must protect and lity must protect and	F	550			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		49E084	B. WING			C		
	ROVIDER OR SUPPLIER	1 10200		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HAMPTON ST RICHMOND, VA 23220	1	07/19/2023		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 550	respect. The resident by a staff member.  Resident #50 was ad 1/6/2004. A review of dated 4/14/23 revealed of abuse/mistreatmer an incident to the soc cared for his CNA (comouth touched him in the most recent MDS assessment, an annu (assessment reference the resident as scorin BIMS (brief interview indicating the resident impaired. A review of G-functional status correquiring extensive as total dependence for hygiene, bathing and A review of the comp 4/14/23 revealed, "PF history of trauma. He was sexually inappro APPROACHES/TASF offer counseling and services, if accepted Resident-specific way trigger occurs: He re local park/garden. En a trusted staff member to decrease triggers: will ensure safety of resetting is safe and integromote a sense of s	mitted to the facility on the facility synopsis of event ed "Incident Type: allegation nt. (Resident #50) reported cial worker, that while being ertified nursing assistant) nappropriately."  S (minimum data set) nal assessment, with an ARD ce date) of 5/18/23, coded ng a 12 out of 15 on the for mental status) score, nt was moderately cognitively the MDS Section oded the resident as esistance for bed mobility: transfer, dressing, eating, locomotion.  rehensive care plan dated ROBLEMS: Resident has a experite repriate with him. KS: Nursing will continue to will coordinate counseling	F 58	50				

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	ROVIDER OR SUPPLIER			1101 H	T ADDRESS, CITY, STATE, ZIP CODE  IAMPTON ST  MOND, VA 23220	<u> </u>	13/2020	
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F 550	decision-making. Stat trustworthiness and trustworthiness. Staff we empowerment and checision making, chowill honor resident's such at 12:58 PM, revealed my office and asked treported that while be person, he was touch mother, DON (director director and CEO (chenotified. The police are also notified."  A review of Resident dated 4/14/23, reveal trauma, briefly descrill expressed an allegati against a staff person Self-Reporting Scale me at all 10= this impa a Self-Reporting Scale trauma impact your define at all 10= this impa and trauma impact your defined to the traum in the proportion of the p	and sharing power and aff will promote ransparency by maintaining lding and maintaining trust will uphold resident's noice by supporting shared ice, and goal setting. Staff celf-advocacy skills."  services note dated 4/13/23 dd, "Today, resident came to ocall his mother. He had being taken care of by a staff cel inappropriately. His or of nursing), Medical ice executive officer) were not health department were were dependent to no feet a history of the event: Resident on of sexual misconduct on 3-11 shift.  O-10 (0= does not impact acts me a great deal). Using e, how much does this aily life: Resident said 0. you use to deal with attic event? He said "I go to amy mind off of it". Would the interest with a of discuss traumatic events impact your life? He services. Is there anything ocial worker to know? Want someone. Wants to sit	F	550				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1101 HAMPTON ST  RICHMOND, VA 23220	1 01110/2020	
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F 550	Continued From pa	ge 9	F 55	0		
	at 11:07 AM, reveal this morningHis fa weekend, and he end have office to socialize. In the social tands of the social tands and he social tands are weekend. A review of the social tands and he social tands are weekend he said he is don't to the park."  An interview was compared to the social tands and he social tands and he bent don't to my penis. I told the wanted to know any of this and show any of this and show any of this and show the social tands are weekend to the social tands and the social tands are the did this to. Policing report. He (CNA) is the detective. It did safe. I did not feel to when asked how he social tands are the	al services note dated 4/17/23 ed, "Resident came to see me amily came to visit over the njoyed their support."  al services note dated 4/24/23 ed, "Resident came to my lo concerns voiced."  al services note dated 5/2/23 ed, "Resident came to see bing fine and planning to [go]  anducted on 7/19/23 at 7:40 50. When asked if he could related to the sexual abuse, d, "He [CNA #5] was changing and he touched his mouth him to stop that I did not like it. if I was sure he did not want wed me his penis." Resident was another time when the hay room. I did not report this ed. There were several of us the talked to me and filed a the not here. I have talked with not make me feel good or good. I told him to stop." the was feeling now, Resident good now, there are no orking here anymore."				
	respect and dignity,	ident being treated with LPN #7 stated, no, his rights n dignity and respect were not				

` '		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	, ,	C C	
		49E084	B. WING			07/19/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HAMPTON ST RICHMOND, VA 23220		0//10/2020	
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F 550	Continued From particles being honored.	ge 10 istrator, ASM #2, the director	F 55	50			
	of nursing and ASM	#3, the interim administrator the above concern on					
	and Abuse Prohibiti resident has a right self-determination, a access to persons a outside the facility, it his section. A facili with respect and digresident in a manner promotes maintenather quality of life, re	cility's policy "Resident Rights on" which reveals, "The to a dignified existence, and communication with and and services inside and including those specified in the fity must treat each resident grity and care for each er and in an environment that the or enhancement of his or ecognizing each resident's cility must protect and of the resident."					
	3. For Resident #35 to treat the resident	on was provided prior to exit.  i (R35), the facility staff failed in a dignified manner. The sexually abused by a staff					
	assessment, a quar ARD (assessment r the resident scored (brief interview for n the resident modera decisions. In Sectio was coded as requi one or more staff m of daily living excep was independent af	MDS (minimum data set) terly assessment, with an reference date) of 5/25/2023, a 12 out of 15 on the BIMS mental status) score indicating ately impaired for making daily n G - Functional Status, R35 ring extensive assistance of embers for all of his activities t locomotion as the resident fer set up assistance was has a motorized wheelchair.					

` '		` '		(X3) DATE SURVEY COMPLETED	
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			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HAMPTON ST RICHMOND, VA 23220	•	
SUMMARY STATEMENT OF DEFICIENCIES  X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
Continued From pag	ge 11	F 5	50		
7/19/2023 at 9:17 a. (other staff member help in translating. I happened, R35 state pulled my pants dow some. Ewe. He put state of the put of t	m. accompanied by OSM ) #1, the social worker, to R35 was asked what ed, "He (expletive) me. He on and asked if I wanted something in my mouth. Ewe. did this to me. I asked him to or I would knock him out, on "OSM #1 clarified that eople accidentally, but he on purpose. When asked how 5 stated, "Bad." R35 was in his mouth, R35 stated, "His When asked if the CNA area, R35 stated yes, the on his penis. R35 was asked is happened, OSM #1 stated rviews with R35, throughout occurred in R35's room after R35 a shower. R35 stated, NA #5] not here anymore."  I of event dated, 4/14/2023, "Additional/Update to the Reported Incident: In as for the allegation made by esidents, (R50) and (R35) ainst [CNA - certified nursing ag assignments confirmed or the resident who made the ne of Investigation: rified by evidence collected rviews and assignment of				
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY S (EACH DEFICIEN REGULATORY OF REGULATORY OF REGULATORY OF REGULATORY)  Continued From page An interview was co 7/19/2023 at 9:17 a. (other staff member help in translating. If happened, R35 state pulled my pants dow some. Ewe. He put significant of the page out of my room of his face on purpose sometimes we hit per would have hit him of it made him feel, R3 asked what he put in (expletive - penis)." touched his private a CNA put his hands of when and where this that through the interesting that the investigation, it of CNA #5 had given For "That's why he's [CNA #5 had given For "That's why he'	ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	A BUILDIN B. WING	A BUILDING  49E084  STREET ADDRESS, CITY, STATE, ZIP CODITON HAMPTON ST RICHMOND, VA 23220  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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, R36 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 allegationsOutcome of Investigation: Allegations were verified by evidence collected including vicitim interviews and assignment of staffing schedules with the incident timeline Steps taken to investigate the	A BUILDING  49E084  49E084  B. WING  STREETADDRESS, CITY, STATE, ZIP CODE  1101 HAMPTON ST RICHMOND, VA 23220  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY) MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 11  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, "the (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, "H16 (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's atoed. "That's why he's [CNA #6] 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 (R80), 2 additional residents, (R50) and (R35) made complaints against [CNA - certified nursing assistant #5]. Staffing assignments confirmed that he was carriag 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 Eyes taken to investigate the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CON	(X3) DATE SURVEY COMPLETED		
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F 550	and law enforcement psychosocial distress the resident or notice staffConclusion: evidence collected all three victims by the Health Professional enforcement in whice consistent and the awith the time in whice a result of a verified physical, sexual, or counseling or other implemented to assemble and (R50) will receive determine if there a changes or negative. They will all receive assessments to det needed. If counseling arranged by the reseive resident's care plantincident (Name of and (R50). (R60) reto (Name of physician transmitted disease blood draw required (R35) and (R50) are documented, "Resident's care plantincident (Some of physician transmitted disease blood draw required (R35) and (R50) are documented, "Resident's care plantincident (Some of physician transmitted disease blood draw required (R35) and (R50) are documented, "Resident's care plantincident (Some of physician transmitted disease blood draw required (R35) and (R50) are documented, "Resident's care plantincident"	th Professions investigator int. No evidence of its or harm as expressed by its ded by care team or direct care. Allegations were verified by which included interviews with facility staff, Department of its investigators and law its chitching of abuse, such as mental abuse, identify interventions planned and its the resident. (R60), (R35). It is continued monitoring to re any physical or mental its outcomes of the abuse. It is trauma informed care in ermine if further counseling is ing is needed, it will be ident's care team. Each will be modified to include the if a physician) examined (R35) increase in the incident is continued in the include the incident is care team. It is a physician in the incident include the incident is a physician incident	F	550			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 550	penis) He also state unzipped his pants some of it. (R35) sa Investigation will be notified."  The physician note documented in part for allegations regal seen for recent incic panel ordered as a exposure. deferred injuries. Encourage	laying with his (expletive - d that the staff member and asked him if he would like	F 550			
	a.m., documented, completed trauma a Resident indicated I event. He reports he caregiver. He report no longer in his life. affect him daily, but He states he is oper comforted by talking able to identify any and MD (medical doto participate in course "Trauma Asses 11:29 a.m. documen 1. Is there a history traumatic event. Re abused by a CNA. Sidoes not impact me great deal. 2. Using	ssessment with resident. The experienced a traumatic erwas sexually abused by a state is glad this caregiver is the states the trauma doesn't talking with his SW helps The to counseling and is to someone. He was not triggers. SW notified nursing potor) that resident would like				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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F 550	Have you received to this trauma? If so, wo where and when? Not traumatic event does often do these mem distressed: Weekly, (not applicable). Coldoping skills do you the traumatic event? Counseling. 6. Would meet with a counsel traumatic events that life? Yes. Triggers a what makes you renand how you like to these memories. Not the event. I would like your social worked	ge 14 erapeutic Interventions. 3. herapeutic interventions for that service were received, to. Traumatic Event. 4. If the is not impact you daily, how ories cause you to feel Monthly, Little or Never. N/A ping Skills Identified. 5. What use to deal with thoughts of a Talking to my social worker. It do you like the opportunity to or/therapist to discuss at may continue to impact your and Coping. 7. Please identify member the traumatic event be comforted when you have on thing triggers memories of the to be comforted by talking the statement of the total worker to know? No."  "care plan dated, 4/13/2023, thas a history of trauma. He hally abused by a caregiver. Indocumented, "Nursing will unseling and will coordinate and the statement of the total worker to know? No."  "care plan dated, 4/13/2023, thas a history of trauma. He hally abused by a caregiver. Indocumented, "Nursing will unseling and will coordinate and the statement of the statement o	F 5	50		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 550	shared decision-making Staff will honor resident interview was con 7/18/2023 at 2:46 p.m tells them that a staff manner the resident of steps do you take, CN tell the charge nurse wasked if a resident to inappropriately touch manner, is that abuse When asked if that is dignity, CNA #6 states ASM #1, the executive aware of the above of being treated with dignam.	ent and choice by supporting ing, choice and goal setting. ent's self-advocacy skills."  ducted with CNA #6 on in. When asked if a resident member touched them in a did not like, sexually, what in it is not like, sexually, what in it is not like, sexually, what is not like, sexuall	F	550			
F 600 SS=G	Free from Abuse and CFR(s): 483.12(a)(1)  §483.12 Freedom from Exploitation The resident has the neglect, misappropriation and exploitation as desincludes but is not limic corporal punishment, any physical or chemic treat the resident's medians.	m Abuse, Neglect, and right to be free from abuse, stion of resident property, efined in this subpart. This sited to freedom from involuntary seclusion and ical restraint not required to edical symptoms.	F	600			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
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F 600	by: Based on staff intervand clinical record refacility staff failed to pin the survey sample #50 and #35), which past non-compliance.  The findings include:  1. The facility failed to sexual abuse from Classistant) #5.  A review of the facility 4/10/23 revealed "Incabuse/mistreatment. incident to the nursing while getting his brief CNA (certified nursing his penis for two second the resident as the BIMS (brief intervindicating the resident as the BIMS (brief intervindicating the resident as for transfer and bathin bed mobility, dressing for eating / locomotion.	is not met as evidenced iew, facility document review view, it was determined the protect three of 31 residents from abuse (Residents #60, resulted in harm cited at  protect Resident #60 from NA (certified nursing  resident #60 reported an g supervisor. He stated that changed two days ago, his g assistant) mouth touched onds."  6 (minimum data set) orly assessment, with an ference date) of 7/6/23, orly assessment, with an ference date, orly assessment, wit	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 A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 600	abused. APPROACH- continue to offer cour- counseling services, in Resident-specific way trigger occurs: Allow and validate them. Re- chaplain for support. decrease triggers: Re- female CNA's (certifiet to speak calmly and the beforehand (changing daily living). Staff will by ensuring physical sinterpersonal interact safety. Staff will pron- mutuality with resident sharing power and de- promote trustworthine maintaining transpare maintaining trust with resident's empowerm supporting shared de goal setting. Staff will self-advocacy skills."  A review of the physic 4/10/23 at 3:33 PM, re- incident regarding ab- same story about the inappropriate contact allow me to examine no injuries and he wa and he was very clea examined. He was up agreeable to follow-up	reports he was sexually HES/TASKS: Nursing will iseling and will coordinate of accepted by resident. It is to comfort resident if a resident to express feelings befer to SW (social worker) or Resident-specific ways to resident requests to have end nursing assistants). Staff will him what they want to do go clothes, all activities of all ensure safety of resident resetting is safe and resident setting is safe and resident setting is safe and resident. Staff will uphold resident. Staff will uphold rent and choice by cision-making, choice, and honor resident's	F	600			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		DNSTRUCTION	(X3) DATE COMP	SURVEY
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F 600	A review of Residen dated 4/11/23, reveat trauma, briefly descreported on April 7th assigned CNA was condended to resident's penis. Rechedid. Self-Reporti impact me at all 10-deal). Using a Self-Fedoes this trauma impact of the unable to articulate alike the opportunity to counselor/therapist that may continue to told me no - that he needed. He told phy anything you would know? Want to be a Wants to sit outside and stepmother. Wo	at #60's "Trauma Assessment" aled, "Is there a history of ribe the event: Resident a the 3-11 shift that his changing him on the bed. b put his mouth briefly on sident asked him to stop and ang Scale 0-10 (0= does not this impacts me a great Reporting Scale, how much pact your daily life: Resident ang skills do you use to deal traumatic event? Resident is an answer to this. Would you	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 600	called his stepmoth 10 minutes. Reside was his 1st time conwent to recreational therapy). He did not herapy). He did not herapy in the 4/17 coordination note, resident this mornin participating in the 4/18 Saturday the 15th. 1st floor to socialize He had his tv on an game."  A review of the 4/17 progress note, revediscussed the recera staff person, relatincident and anxiety worry about interperelated about how hong time and previous patient to develop pand build ways to in A review of the heptransmitted infection 4/19/23, revealed "Fivirus", RPR (rapid political functions), RPR (rapid political functions). The step is the second participation of the social functions are step in the second participation of the social functions and the second participation of th	ked to call his parents - we er and they talked for about int's mood was calm, he said it ming to the first floor today. He therapy and pt (physical tappear upset or frightened."  7/23 11:00 AM care evealed, "Checked on g. He said he enjoyed Walk-in-Roll event on He declined to come to the example and the declined to computer of the example and the said he didn't feel like it. It. It was playing a computer of the example and the example and the foliationships. He example a resident for a county felt safe there. Help alan for coping with anxiety in the prove self-esteem."  Tatitis and STI (sexually in the province of the example of the example of the province of the example of	F 6	,		
	office, requested to Writer provided acti	d, "Resident came to writer's speak with writer in his room. ve listening and therapeutic ident to recall several				

AND BLAN OF CORRECTION INTERPRETATION NUMBERS		` '	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
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F 600	feelings. Resident excounseling support,  A review of the 4/24/progress note, reveal individual therapy to depression. The includes a focus of treatr symptoms."  A review of the social at 10:49 AM, revealed SW (social worker) the said he was feeling the was smiling and mood."  A review of the social at 2:44 PM, revealed the was smiling and mood."  A review of the social at 3:29 PM, revealed SW and asked to can her and resident said thinking about the transport of the social at 3:29 PM, revealed SW and asked to can her and resident said thinking about the transport of the social thinking about the transport of the social thinking and said the was SW took resident to have talked. Resident several times and safether/stepmother with (May 6 or 7)."  A review of the social at 10:51 AM, revealed SW yesterday the 18 in a calm mood and	self-soothe, validated opersed gratitude for staff support.  23 psychological services aled, "Patient has had improve anxiety and ident of sexual abuse is now ment due to increased  al services note dated 4/26/23 and, "Resident came to see oday for supportive listening. In grine."  al services note dated 5/3/23 and, "SW spoke with resident. In reported he was in a good and services note dated 5/4/23 and, "Today, resident came to all his stepmother. We called a he was feeling sad from an aumatic event that occurred. Inted to talk with the chaplain. In see the chaplain and they are the	F6	500			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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F 600	at 2:21 PM, revealed He wanted to call his talk. Resident said he sleeping over the we know what was wron night."  A review of the socia at 5:04 PM, revealed resident in his room, case would occur. In have concrete inform some time. Resident that answer, then be music project and his	I services note dated 6/5/23 , "Resident came to see me. brother and they had a nice e had some problems ekend. He said he didn't g. He said he slept well last  I services note dated 6/12/23 , "Writer checked in with he asked when the court formed resident that I did not lation but that it would take expressed satisfaction with gan discussing his latest	Fé	600			
	resident in his room, Talked about his hau new friends, and the A review of the socia at 1:30 PM, revealed for 7/6/23. Resident sunable to tell me the scored 00 on the resmood concerns noted the first floor for certawatch tv and play vid been good. His fathemonth and he enjoys has no discharge pla Quarter goal to assis A review of CNA (cer	, "Writer checked in with he states he is feeling good. Inted house ideas, making TV show he was watching."  I services note dated 7/10/23 good. In the services note dated 7/10/23 good in the second 14 on the BIMS - current day of week. He ident Mood Interview - no door in programs. He likes to eo games. His mood has recomes to visit 1 -2 times a street the service of the servic					

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F 600	obtained and were The Virginia State I check was obtained identifiable records was obtained on 12 Department of Hea Lookup site. Certif additional public int According to the fa "On 3/23/23, a sen Virginia DHP reque After this request A member) #1, the ex the director of nurs performance record resident complaints other staff did not of CNA #5. Based on #1 and ASM #2 det doing his job well a residents." A revier lookup site on 7/18 aide certification was "The Board of Nurs CNA #5 is a substata and safety." In revier references, "he sex in his care". One refacility in another to located at this facility An interview was on PM with Resident # describe the events Resident #60 state remember, he was down and he touch	B. Reference checks were positive in describing CNA #5. Police Criminal background don 12/20/22 and found 'no ". His nurse aid certification 2/19/22 from the Virginia lth Professions (DHP) License ication was current and formation was listed as 'no'. collity's timeline of this incident, for investigator from the ested information on CNA #5. SM (administrative staff executive director and ASM #2, fing reviewed CNA #5's d. There were no other and the charge nurses and observe any problems with all available information, ASM elemined that CNA #5 was and giving good care to w of the Virginia DHP license //23 revealed, CNA #5's nurse as suspended 6/27/23 due to sing (BON) concluding that intial danger to public health lew of the BON actions, it sually assaulted four residents estation and the three residents	F	600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	IPLE CONSTRUCTION  IG	_	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	452004	] S. viiite	STREET ADDRESS, CITY, 1101 HAMPTON ST RICHMOND, VA 2322		07/19/2023	
(X4) ID PREFIX TAG			ID PREFI TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)	DATE.	
F 600	Friday (4/7/23), Good back from services a #60 stated, "Ever sin have been talking wit (CNA #5) is not here. police and detective bad situation. I felt b not good for me." W Resident #60 stated, and felt safe before."  An interview was cor PM with ASM #2, the	d Friday and I had just come and it happened." Resident ce then, I am not the same, I the staff working here. He I have talked with the a couple of times. It was a ad. I told him to stop. It was hen asked how he felt now, "Better now. I feel safe here aducted on 7/18/23 at 3:00 director of nursing. When	F	500			
	sexual abuse allegat #2 stated, "As soon a started the investigated while we investigated interviewed all male 4/10/23. We called t VDH-OLC (Virginia Dicensure Certification investigation we discussed also been sexually all (Department of Healt of the two residents a our investigation. Or arrived at facility. (Residue)	residents beginning on the police, informed Department of Health-Office on). On 4/11/23 during the overed (Resident #35) had					
	PM with RN (register to describe the event abuse allegation for I "It was reported to m morning. (Resident and She got me the CNA (#5) was	educted on 7/18/23 at 3:15 ed nurse) #1. When asked as regarding 4/10/23 sexual Resident #60, RN #1 stated, e by a CNA on Monday #60) said something to the to hear the issue. He told as taking care of him and enis and CNA #5 lifted his					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG		(X3) DATE COMP	SURVEY LETED
		49E084	B. WING _				C <b>19/2023</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1101 HAMPTON ST RICHMOND, VA 23220	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE
F 600	not want him to take or reported it to the DON COO/CEO (chief oper officer). I called the rephysician was notified.  An interview was comply with LPN (license asked to describe the sexual abuse allegatistated, "This was not not know that it happened to the sexual abuse allegatistated, "This was not not know that it happened beared CNA # stated, "Yes, I never I situation happened. Heager to help. Offere of the residents report An interview was con AM with CNA #4. Whevents regarding 4/10 for Resident #60, CN told me that a male Chim a couple of days resident's penis with nursing supervisor im ASM #1, the administ of nursing and ASM # was made aware of the facility will be treated to the facility	ed that (Resident #60) did care of him anymore. In and I met with the rating officer/chief executive esidents family. The did and saw the resident."  ducted on 7/18/23 at 3:20 and practical nurse) #9. When events regarding 4/10/23 and for Resident #60, LPN #9 known to me till later. I did ened." When asked if he did did to other CNA's. None atted to us real time."  ducted on 7/19/23 at 10:30 and asked to describe the color of the sexually assaulted earlier, that he touched the his mouth. I informed the simediately."  trator, ASM #2, the director for the above concern on the sexual expect at the color of the sexual expect at the distribution of the sexual expect and sexual expect at the distribution of the sexual expect and	F6				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		DATE SURVEY COMPLETED
		49E084	B. WING			C <b>07/19/2023</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HAMPTON ST RICHMOND, VA 23220	I	07/19/2023
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	tolerated. Abuse of contact. Administra which shall include abused resident, the discovering incident may have necessal may also require pleased and also reported as a referred to a psychosocial distresed as necessal referred to a psychosocial distresed as necessal referred to a psychosocial distresed as necessal referred to a psychosocial distresed as they mean the reviews completed according the potential threat investigation is in pleased as a social Services/ for monitoring residustress and ensuring will be reported according. The Director contact and according the potential according to the potential threat investigation is in pleased according to the potential threat investigation is in pleased according to the potential threat investigation is in pleased.	an consist of any sexual an consist of any sexual ator will direct investigation at a minimum: interviews with e alleged abuser, staff person t, witnesses and others who ry information. Investigation hysical/medical exam of the esident by nursing and/or seed and implemented a plan of contained the following 5 points:  Volved in the incident is no y the facility. Resident 1 Resident 2 (Resident #35) the physician. Resident 3 used the assessment. 3 were assessed for ss and care plans were ary. Residents have been cologist for evaluation and sents were interviewed by Social any have been affected. Seed of all residents on 4/13/23. See of abuse verbalized will be to the facility abuse policy and removed immediately while an	F 6			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	1, ,	ATE SURVEY OMPLETED
		49E084	B. WING _			C 07/19/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HAMPTON ST RICHMOND, VA 23220	· · · · · ·	3771372023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 600	requirements/removi immediately while an Staff inservicing was  4. Social Services waffected and provide period of two months  5. The Director of Someet with the resider each month to review Any allegations of abimmediately as per the Education and training an ongoing basis. The Services/designee watereds and/or pattern committee on at lease 6. Completion date 5. The credible evidence Correction, education audits and Quality Coand found to be in or were conducted with regarding abuse eduto reveal any concern residents failed to ide Past non-compliance 2. The facility failed the sexual abuse from Cassistant) #5.  A review of the facility 4/14/23 revealed "Incompliance of the sexual abuse of the facility 4/14/23 revealed" Incompliance of the facility failed the sexual abuse from Cassistant) #5.	ing a potential threat investigation is in process. completed on 4/21/23.  fill meet weekly with residents assistance as needed for a fill definite solutions assistance as needed for a fill definite solutions assistance as needed for a fill definite solutions assistance as ne	F6			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		OATE SURVEY OMPLETED
		49E084	B. WING _			C 07/19/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HAMPTON ST RICHMOND, VA 23220		01/19/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	cared for his CNA (comouth touched him)  The most recent ME assessment, an ann (assessment referenthe resident as scori BIMS (brief interview indicating the reside impaired. A review of G-functional status of requiring extensive atotal dependence for hygiene, bathing and A review of the compart of the com	I worker, that while being sertified nursing assistant) inappropriately."  In S (minimum data set) ual assessment, with an ARD ace date) of 5/18/23, coded and a 12 out of 15 on the value for mental status) score, and was moderately cognitively of the MDS Section coded the resident as assistance for bed mobility: a transfer, dressing, eating, and locomotion.  In the MDS Section coded the resident as a series as former care plan dated are reports a former caregiver opriate with him.  In the MDS Section coded the resident as a series a former caregiver opriate with him.  In the MDS Section code of the MDS Section code of the resident as a series of the MDS Section code of	F6			
	to decrease triggers will ensure safety of setting is safe and ir promote a sense of collaboration and management partnering with him a decision-making. Strustworthiness and transparency and but with resident. Staff empowerment and contract transparency and but the same of the same of the safe of the safe of the same of the safe	per. Resident-specific ways Resident stated none. Staff resident by ensuring physical atterpersonal interactions safety. Staff will promote utuality with resident by and sharing power and taff will promote transparency by maintaining uilding and maintaining trust will uphold resident's choice by supporting shared bice, and goal setting. Staff				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	i	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY
		49E084	B. WING _			1	C / <b>19/2023</b>
NAME OF PROVIDER OR SUR THE VIRGINIA HOME	PPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1101 HAMPTON ST  RICHMOND, VA 23220			13/2023
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
A review of the at 12:58 PM my office and reported that person, he was mother, DOI director and notified. The also notified also	he socia , reveale d asked t while be vas touch N (directe CEO (ch police a " he physi 155 PM, r tification ult allega titioned th e appear ng some rs renew Resident 23, revea fly descri n allegat aff persor ng Scale this imp rting Sca e this imp rting Scale the traum ark) to ge opportun erapist to ntinue to unseling s ke your s	I services note dated 4/13/23 d, "Today, resident came to to call his mother. He had eing taken care of by a staff ned inappropriately. His or of nursing), Medical hief executive officer) were not health department were cian progress note dated revealed, "Seen primarily for but also to discuss the tions. Resident was going nat he would discuss it red well. I mentioned testing as well. Will follow up	F	600			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		OATE SURVEY COMPLETED
		49E084	B. WING			C
	ROVIDER OR SUPPLIER	10230		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HAMPTON ST RICHMOND, VA 23220	I	07/19/2023
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	A review of the hep transmitted infection 4/14/23, revealed "virus), RPR (rapid proposed for the social states of	atitis and STI (sexually ns) lab profile obtained Hepatitis B, HCV (hepatitis C clasma regain) and HIV ficiency virus), chlamydia and reactive."  fial services note dated 4/17/23 led, "Resident came to see me amily came to visit over the njoyed their support."  fial services note dated 4/24/23 at no voiced concerns.  fial services note BIMS - e current year. Resident sident Mood Interview - no ced. Resident experienced a t included a staff person. expressed any negative note event. He gets up daily in and likes to ride to the park esident has a circle of peers. Resident has a circle of peers are supportive and ewed his advanced directives atisfied with his current plans. ands that he can make wants. We reviewed his e said he understands that he uest to move at any time.	F 60			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		49E084	B. WING			1	C <b>19/2023</b>
	ROVIDER OR SUPPLIER		1	110	REET ADDRESS, CITY, STATE, ZIP CODE  1 HAMPTON ST CHMOND, VA 23220	1 017	13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	∋ 30	F	600			
	at 4:33 PM, revealed his room for weekly o	services note dated 6/14/23 , "SW met with resident in heck-in. He states he feels ng alleged assailant is not g"					
	at 2:22 PM, revealed his room. SW asked he stated, "great!" He speak with the detect have his name or nur detective texted his n Resident gave permis his recent texts, but S	umber to the resident. ssion for SW to look through SW did not find a text from ssage for administrator					
	at 11:46 AM, revealed with me about a pers	services note dated 7/10/23 d, "Resident asked to talk onal matter. We discussed ras satisfied with our talk. He and sleeping fine."					
	PM with ASM #2, the asked to describe the abuse allegation for F stated, "On 4/13/23 E professions) investiga (Resident #50) stated abused him multiple for the same abused him multiple for the same as the same	ducted on 7/18/23 at 3:00 director of nursing. When events regarding the sexual Resident #50, ASM #2 DHP (department of health ators arrived at facility. If that (CNA #5) had sexually times on that day. He had sed to us that he had been					
	PM with RN (register	ducted on 7/18/23 at 3:15 ed nurse) #1. When asked s regarding 4/13/23 sexual					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			RIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		49E084	B. WING _			C <b>07/19/2023</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1101 HAMPTON ST RICHMOND, VA 23220	DDE	01/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		ON SHOULD BE IE APPROPRIAT	(X5) COMPLETION DATE	
F 600	abuse allegation for F this resident stated th oral sex on him multip in his room. He state watched pornographi room.  An interview was con PM with LPN (license asked to describe the abuse allegation for F "This was not known know that it happene observed (CNA #5) d stated, "Yes, I never I situation happened. Heager to help. Offere of the residents repor  An interview was con AM with Resident #50 describe the events r Resident #50 stated, me and he bent dowr to my penis. I told hin He wanted to know if any of this and showe another time when th room. I did not repor There were several o talked to me and filed here. I have talked w make me feel good o told him to stop. Whe now, Resident #50 st are no issues. He is	Resident #50, RN #1 stated, at CNA #5 had performed one times and had ejaculated at that CNA #5 had also a content with him in his ducted on 7/18/23 at 3:20 and practical nurse) #9. When a events regarding the sexual Resident #50, LPN #9 stated, to me till later. I did not d." When asked if he had uring the shift, LPN #9 had any complaints till this he was eager to be here and and aid to other CNA's. None ted to us real time."  ducted on 7/19/23 at 7:40 D. When asked if he could elated to the sexual abuse, he (CNA #5) was changing in and he touched his mouth in to stop that I did not like it. I was sure he did not want and me his penis. There was a considered in my to this when they first asked. If us he did this to. Police I a report. He (CNA) is not with the detective. It did not it is all good now, there not working here anymore. In additional control of the note, and occurred more than once, and occurred more than once,	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		49E084	B. WING			C 07/19/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HAMPTON ST RICHMOND, VA 23220		0771372023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	of nursing and ASM was made aware of 7/19/23 at 9:05 AM.  According to the fact and Abuse Prohibitic resident has a right self-determination, access to persons a outside the facility, it his section. A facility with respect and digresident in a manner promotes maintenancher quality of life, reindividuality. The fact promote the rights of the facility develops correction, which control of the facility develops correction and the facility develops correction.	strator, ASM #2, the director #3, the interim administrator the above concern on sility's policy "Resident Rights on" which reveals, "The to a dignified existence, and communication with and and services inside and including those specified in the ty must treat each resident guity and care for each or and in an environment that ince or enhancement of his or cognizing each resident's cility must protect and	F 60			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		49E084	B. WING _				C 1 <b>19/2023</b>
	ROVIDER OR SUPPLIER		1	1101 H	ET ADDRESS, CITY, STATE, ZIP CODE HAMPTON ST MOND, VA 23220		10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	for monitoring resided distress and ensuring will be reported accorpolicy. The Director has inserviced staff refacility abuse policy in requirements/removing immediately while an Staff inservicing was.  4. Social Services was affected and provide period of two months.  5. The Director of Someet with the resider each month to review Any allegations of abimmediately as per the Education and training an ongoing basis. The Services/designee with the residence on at leas.  6. Completion date 5. The credible evidence Correction, education and found to be in orwere conducted with	esignee will be responsible and for abuse/psychological gany allegations verbalized roing to the facility abuse of Social Services/designee egarding abuse and the including and a potential threat investigation is in process. completed on 4/21/23.  Ill meet weekly with residents assistance as needed for a completed on the second Tuesday of the facility abuse policy. In gwill be investigated are facility abuse policy. In gwill be provided to staff on the Director of Social ill identify and report any so to the quality assurance to a quarterly basis.  In service sign in sheets, buncil minutes were reviewed der. Random interviews staff on varying shifts cation and training and failed as. Review of current	F	600			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG	(X	3) DATE SURVEY COMPLETED
		49E084	B. WING			C
	ROVIDER OR SUPPLIER	102001		STREET ADDRESS, CITY, STATE, ZIP COI 1101 HAMPTON ST RICHMOND, VA 23220	DE	07/19/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	Past non-compliance No further informatio 3. For Resident #35 to protect the resider staff member CNA (c #5.  On the most recent N assessment, a quart ARD (assessment re the resident scored a (brief interview for m the resident moderat decisions. In Section was coded as requiri one or more staff me of daily living except was independent afte provided.  The facility synopsis documented in part, Information Related in the discovery proces (R60), 2 additional re made complaints aga assistant #5). Staffin	n was provided prior to exit. (R35), the facility staff failed at from sexual abuse from a certified nursing assistant)  MDS (minimum data set) erly assessment, with an ference date) of 5/25/2023, a 12 out of 15 on the BIMS ental status) score indicating ely impaired for making daily G - Functional Status, R35 ng extensive assistance of mbers for all of his activities locomotion as the resident er set up assistance was	F	500		
	allegationsOutcom Allegations were veri including victim inter- staffing schedules wi timelineSteps take allegation: Alleged v consistent in intervie Department of Health and law enforcement	e of Investigation: fied by evidence collected views and assignment of th the incident n to investigate the rictim's account were w with facility staff, n Professions investigator				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		ATE SURVEY DMPLETED
		49E084	B. WING _			C <b>07/19/2023</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1101 HAMPTON ST RICHMOND, VA 23220	•	01710/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 600	staffConclusion: evidence collected wall three victims by the Health Professional enforcement in whice consistent and the awith the time in whice a result of a verified physical, sexual, or counseling or other implemented to assend (R50) will receive determine if there a changes or negative. They will all receive assessments to determine if there a changes or negative. They will all receive assessments to determine if there a changes or negative. They will all receive assessments to determine if there a changes or negative. (Name of physician incident (Name of and (R50). (R60) re (Name of physician transmitted disease blood draw required (R35) and (R50) are the progress note of documented, "Residus worker) office. SW nursing) to meet wit meeting."  The progress note of documented, "Meet and myself. Reside staff member was penis) He also state.	Allegations were verified by which included interviews with facility staff, Department of is investigators and law is their accounts remained alignment of staff schedules in the incidents occurred As finding of abuse, such as mental abuse, identify interventions planned and ist the resident. (R60), (R35). We continued monitoring to re any physical or mental e outcomes of the abuse. It is trauma informed care ermine if further counseling is ing is needed, it will be ident's care team. Each will be modified to include the a physician) examined (R35) fused a physical exam.  I) ordered STD (sexually) testing. (R60) refused the lator the test. Results for	F	500		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING		COMF	(X3) DATE SURVEY COMPLETED				
		49E084	B. WING			C / <b>19/2023</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1101 HAMPTON ST  RICHMOND, VA 23220		07/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 600	notified."  The physician note documented in part for allegations regalseen for recent incipanel ordered as a exposure. deferred injuries. Encourage support and if need and counseling."  The progress note a.m., documented, completed trauma a Resident indicated event. He reports he caregiver. He reports he caregiver. He reports he caregiver in his life, affect him daily, but he states he is ope comforted by talking able to identify any and MD (medical deto participate in country in the "Trauma Asses 11:29 a.m. docume 1. Is there a history traumatic event. Reabused by a CNA.	aid he told him no. In done. (Name of doctor)  dated, 4/11/2023 at 2:11 p.m. In "CC (chief complaint) - seen rding a staff memberPlan: Ident regarding abuse. STD precaution, unsure of level of exam, (R35) mentioned no red to discuss with SW for red can get additional therapy  dated, 4/12/2023 at 11:38  "LATE ENTRY: SW assessment with resident. The experienced a traumatic the experienced a traumatic the was sexually abused by a rts he is glad this caregiver is the states the trauma doesn't totalking with his SW helps In to counseling and is to someone. He was not triggers. SW notified nursing toctor) that resident would like triggers. SW notified nursing	F 60	,			
	Resident indicated event. He reports h caregiver. He report no longer in his life. affect him daily, but He states he is ope comforted by talking able to identify any and MD (medical doto participate in court The "Trauma Asses 11:29 a.m. docume 1. Is there a history traumatic event. Reabused by a CNA. does not impact me great deal. 2. Using	the experienced a traumatic te was sexually abused by a rts he is glad this caregiver is. He states the trauma doesn't te talking with his SW helps In to counseling and is go to someone. He was not triggers. SW notified nursing foctor) that resident would like tenseling."  Sement" dated, 4/12/2023 at the intendin part, "Trauma History: of trauma, briefly describe tesident reports he was sexually self-Reporting Scale 0-10, 0 = te at all, 10 = this impacts me a in a Self-Reporting Scale, how					
	11:29 a.m. docume 1. Is there a history traumatic event. Re abused by a CNA. does not impact me great deal. 2. Using much does this trau (one). History of Th	onted in part, "Trauma History: of trauma, briefly describe esident reports he was sexually Self-Reporting Scale 0-10, 0 = e at all, 10 = this impacts me a					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		49E084	B. WING _			C 07/19/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 1101 HAMPTON ST RICHMOND, VA 23220		0771372023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	traumatic event doe often do these mem distressed: Weekly, (not applicable). Copcoping skills do you the traumatic event? Counseling. 6. Would meet with a counsel traumatic events that life? Yes. Triggers a what makes you ren and how you like to these memories. Not the event. I would lit to me. Social Worke would like your social traumatic events that life? Yes. Triggers a what makes you ren and how you like to these memories. Not the event. I would lit to me. Social Worke would like your social traumatic events was sexually the "Interventions" of continue to offer courounseling services. Resident-specific was	ge 37 o. Traumatic Event. 4. If the s not impact you daily, how ories cause you to feel Monthly, Little or Never. N/A bing Skills Identified. 5. What use to deal with thoughts of a Talking to my social worker. It you like the opportunity to or/therapist to discuss at may continue to impact your and Coping. 7. Please identify thember the traumatic event the comforted when you have thing triggers memories of the to be comforted by talking and worker to know? No."  care plan dated, 4/13/2023, has a history of trauma. He ally abused by a caregiver. Indocumented, "Nursing will inseling and will coordinate if accepted by resident. The ally to him. Resident specific	F	DEFICIENCY)			
	personal care. Staff buy ensuring physic interpersonal interact safety. Staff will promutuality with reside sharing power and corpromote trustworthir maintaining transpal maintaining trust wit resident' empowerm shared decision-mal	gers: 1) Ask before providing will ensure safety of resident al setting is safe and stions promote a sense of mote collaboration and ent by partnering with him and lecision-making. Staff will ness and transparency by rency and building and the resident. Staff will uphold ent and choice by supporting king, choice and goal setting. lent's self-advocacy skills."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUAND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		49E084	B. WING			C 07/19/2023	
	NAME OF PROVIDER OR SUPPLIER  THE VIRGINIA HOME			s 1	TREET ADDRESS, CITY, STATE, ZIP CODE  101 HAMPTON ST  RICHMOND, VA 23220	<u> </u>	19/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	7/18/2023 at 2:46 p.m tells them that a staff manner the resident of steps do you take, CN tell the charge nurse asked if a resident tol inappropriately touched manner, is that abuse.  An interview was compractical nurse) #8 or When asked if a residuched them inappround touched them inappround touched them inappround to manner.  ASM (administrative sexecutive vice president nursing, and ASM #3 were made aware of 7/19/2023 at 9:15 a.m.  An interview was com 7/19/2023 at 9:17 a.m (other staff member): help in translating. Rhappened that day to (expletive) me. He put asked if I wanted som in my mouth. Ewe. I come. I asked him to ge knock him out, on his clarified that sometim accidentally, but he we purpose. When asked	ducted with CNA #6 on  1. When asked if a resident member touched them in a did not like, sexually, what NA #6 stated she would go or supervisor. CNA #6 was d you a staff member ed them, in a sexual e? CNA #6 stated, yes.  ducted with LPN (licensed in 7/18/2023 at 2:53 p.m. Hent told you the night nurse opriately, what would you do, ould gather more information pervisor and the social  staff member) #1, the ent, ASM #2, the director of the interim administrator, the above concern on in.  ducted with R35 on in. accompanied by OSM #1, the social worker, to 35 was asked what him, R35 stated, "He lled my pants down and ine. Ewe. He put something lon't know why he did this to est out of my room or I would face on purpose." OSM #1 es we hit people	F	600			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49E084	B. WING			C <b>07/19/2023</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HAMPTON ST RICHMOND, VA 23220	I	07/19/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	When asked if the CR35 stated yes, the penis. R35 was aske happened, OSM #1 interviews with R35, it occurred in R35's R35 a shower. R35 #5) not here anymore. The facility develope correction, which cool of the facility developed correction of the facility developed correction.  2. All current resider services as they may allegations reported according to the potential threat repor	His (expletive - penis)." NA touched his private area, CNA put his hands on his ed when and where this stated that through the throughout the investigation, room after CNA #5 had given stated, "That's why he's (CNA e."  In d and implemented a plan of intained the following 5 points:  In olved in the incident is no the facility. Resident 1 Resident 2 (Resident #35) In ephysician. Resident 3 In ed the assessment. It were assessed for It is and care plans were It is were interviewed by Social	F6				

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49E084	B. WING			C	
NAME OF PROVIDER OR SUPPLIER  THE VIRGINIA HOME		402004	] 5: *******	1101	EET ADDRESS, CITY, STATE, ZIP CODE  HAMPTON ST  HMOND, VA 23220	<u> </u>	19/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	4. Social Services wi affected and provide a period of two months.  5. The Director of Social meet with the resident each month to review Any allegations of ability and training an ongoing basis. The Services/designee with trends and/or patterns committee on at least 6. Completion date 5/ The credible evidence Correction, education and found to be in ord were conducted with	investigation is in process. completed on 4/21/23.  Il meet weekly with residents assistance as needed for a  cial Services/designee will ts on the second Tuesday of resident rights and abuse. use will be investigated e facility abuse policy. g will be provided to staff on e Director of Social Il identify and report any is to the quality assurance a quarterly basis.  9/23.  e including the Plan of in-service sign in sheets, suncil minutes were reviewed der. Random interviews staff on varying shifts cation and training and failed in the service of current	Fe	600			
F 656 SS=D	Develop/Implement C CFR(s): 483.21(b)(1)( §483.21(b) Comprehe	n was provided prior to exit. comprehensive Care Plan (3)	F	856			8/31/23

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49E084	B. WING		C 07/19/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1101 HAMPTON ST  RICHMOND, VA 23220	1 01710/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
F 656	care plan for each re resident rights set for §483.10(c)(3), that in objectives and timef medical, nursing, an needs that are ident assessment. The condescribe the following (i) The services that or maintain the resident physical, mental, and required under §483 (ii) Any services that under §483.24, §483 provided due to the under §483.10, inclustreatment under §48 (iii) Any specialized rehabilitative services provide as a result of recommendations. It findings of the PASA rationale in the reside (iv) In consultation wore resident's representational (iv) The resident's profuture discharge. Fawhether the resident community was asset local contact agencial entities, for this purp (C) Discharge plans plan, as appropriate	chensive person-centered esident, consistent with the orth at §483.10(c)(2) and includes measurable rames to meet a resident's diffied in the comprehensive in more than and psychosocial ified in the comprehensive in more than are to be furnished to attain lent's highest practicable in the practicable in	F 65		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) A. BUILDING			(X3) DATE SURVEY COMPLETED				
		49E084	B. WING			C	
NAME OF PI	ROVIDER OR SUPPLIER	492004	B: Willia _	STREET ADDRESS, CITY, STATE, ZIP CODE	•	07/19/2023	
				1101 HAMPTON ST			
THE VIRG	INIA HOME			RICHMOND, VA 23220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	Continued From page	e 42	F 6	56			
F 656	§483.21(b)(3) The set by the facility, as outlooked care plan, must- (iii) Be culturally-com This REQUIREMENT by: Based on staff interview, the facility state comprehensive care in the survey sample.  The findings include: For Resident #38 (R3 implement the reside plan for anticoagulan R38's comprehensive documented, "(R38) therapyMonitor for effectiveness Q (eventage of R38's clir physician's order date milligrams by mouth pulmonary embolism (medication administ through July 2023 readministered Eliquis each day. Further re (including the MARs 2023 through July 20	rvices provided or arranged ined by the comprehensive petent and trauma-informed. Is not met as evidenced iew and clinical record off failed to implement the plan for one of 31 residents. Resident #38.  B8), the facility staff failed to int's comprehensive care to medication monitoring. It care plan dated 7/31/20 is on anticoagulant side effects and many)-SHIFT"	F 6	Tag 656 Develop/Implement Comprehensive Care Plan.  The resident found to have be by the deficient practice was a and an Anticoagulant monitori was added to their Medication Administration Record and Ca Completed 7/21/23.  All residents residing at TVH h potential to be affected by the practices. The facility audited medical records for residents anticoagulants. An anticoagula monitoring system will be added to their Medicati administration Record and Ca Completed 7/24/23.  The following procedures/syst changes will be implemented that the deficient practice does Anticoagulation monitoring will to all resident on Anticoagulation at the facility and on admission Anticoagulation Policy and Pro	addressed ng system are Plan.  have the deficient 100% of the on ation on are Plan.  demic to ensure s not recur. Il be added ats currently n.		
	On 7/19/23 at 9:03 a conducted with RN (r stated residents that	egistered nurse) #2. RN #2		be developed and in-serviced and RNs by the Staff Develop Coordinator.  The ADON will audit the Media	to all LPNs, ment		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49E084	B. WING		07/	D 19/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1101 HAMPTON ST  RICHMOND, VA 23220	1 011	19/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	every shift and the numonitoring form, but the R38. RN #2 stated the isto make sure the part their highest level of access to care plans implementing them.  On 7/19/23 at 9:11 a. staff member) #1 (the and ASM #2 (the dire aware of the above of the above of the above of the information regarding reference:  (1) "ELIQUIS is indicastroke and systemic of nonvalvular atrial fibric Risk: ELIQUIS increading can cause serious, por This information was https://www.eliquis.co.cid=sem_2167331&01aa9ec1836cd1510&Care Plan Timing and CFR(s): 483.21(b)(2) &\$483.21(b)(2) A complete (i) Developed within 7 the comprehensive as	irses utilize an anticoagulant he form was not in place for the purpose of the care plan atient is being taken care of of care and nurses have to ensure they are  Image: Market and the properties of the care and nurses have to ensure they are  Image: Market and the properties of care and nurses have to ensure they are  Image: Market and the properties of care and nurses have to ensure they are  Image: Market and the properties of care and nurses have to ensure they are  Image: Market and the properties of care and nurses have to ensure they are  Image: Market and the properties of care plan implementation.  In the properties of the pr	F 65	Administration Record and Care Plan weekly x4 weeks, monthly x4 for compliance. Results will be reported to the DON and QAPI Committee.		8/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		49E084	B. WING _		,	C 7/19/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HAMPTON ST RICHMOND, VA 23220		7713/2323
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	resident. (C) A nurse aide wit resident. (D) A member of food (E) To the extent professed the resident and the An explanation mus medical record if the and their resident renot practicable for the resident's care plans. (F) Other appropriate disciplines as determor as requested by the (iii) Reviewed and reteam after each assessments. This REQUIREMENT by:  Based on staff internand clinical record refacility staff failed to comprehensive care.	se with responsibility for the  th responsibility for the  ad and nutrition services staff. acticable, the participation of resident's representative(s). It be included in a resident's a participation of the resident presentative is determined the development of the  e staff or professionals in mined by the resident's needs the resident.  vised by the interdisciplinary the essment, including both the	F 6	· ·	ient nediate	
	review and revise the returned from the horizontal dischart 4/24/2023, documer Diagnoses/Plan: Coinfection) in the setti ureteral stone with h	R6), the facility staff failed to e care plan after the resident ospital with kidney stones.		All residents have the potential affected by the deficient practic was completed and revisions was necesary.  DON educated MDS Coordinat requirements of updating a care ensure a resident is receiving chighest level of their well being.	to be be. An audit were made tor on the e plan to care to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED			
		49E084	B. WING			C <b>07/19/2023</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1101 HAMPTON ST  RICHMOND, VA 23220		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	antibiotics, discharg cover both Citrobac will need outpatient definitive stone mare. The hospital discharge of the hospital or the hospital will hospit	ted total of 14 days of led on oral ciprofloxacin to ter and Enterococcus. Patient follow-up with urology for largement."  Inge summary dated, led in part, "Discharge losis due to urinary tract lemia. Nephrolithiasis: Patient letone, s/p (status post) stent letone, s/p (status post) stent letone, s/p (status post) stent letone, leto	F 65	<u>'</u>	on and any ion or each ers match care plan in and lit tool was g 10% of ardex.The this audit at monthly All findings mmediately	
	intake. Monitor and movements), offer F if no BM > (greater meds (medications) of UTI. Monitor skin Monitor/document for	encourage/assist with fluid document BMs (bowel PRN (as needed) interventions than) 3 days. Administer as ordered. Monitor for sings per protocol. or s/sx (signs and symptoms) blood-tinged urine, cloudiness,				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49E084	B. WING _				C <b>19/2023</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 1101 HAMPTON ST RICHMOND, VA 23220	)E	, <u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 657	pulse, increased tempered frequency, foul smellial altered mental status change in eating patt check and change. Stoilet and assist as necream after each in comprehensive care ureteral stones and uprocedures.  An interview was compractical nurse) #10 of When asked the purper #10 stated, it's to have care, such as what lift bathroom, their diet, asked who updates the stated they go over the she does some nursing resident has kidney surological surgery and twice for this concern on the care plan, LPN it should be care plan in place. R6's diagnowith LPN #10. LPN # a lot of sodas so we awater, has cups with stated they try to make water on his wheelch asked if these interver plan, LPN #10 stated then who updates the stated, she only addstated.	of urine color, increased to (temperature), urinary ng urine, fever, chills, change in behavior, erns. On toileting plan of taff prompt him to use the eeded. Apply Tena Protective ontinent episode."	F 6	57			

DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '			(X3) DATE SURVEY COMPLETED
	49E084	B. WING _			C <b>07/19/2023</b>
			STREET ADDRESS, CITY, STATE, ZIP 1101 HAMPTON ST RICHMOND, VA 23220	CODE	01/19/2023
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BI THE APPROPRIA	DATE
#10 made a call to the who told her, RN (requipalties to the care purposed in the care plan, should be. RN #2 was tent, history of stone urological procedure something related to plan, RN #2 stated, sunder UTI, but she replan.  The facility policy, "R System" documented the Interdisciplinary of reassess and revise throughout the quarte with their care."  ASM (administrative executive vice preside director of nursing, wabove concern on 7/  No further informatio	gistered nurse) #2 does the plan.  Inducted with RN #2, the MDS nurse on 7/18/2023 at 1:08 to updates the care plan, RN ly does but anyone can are plans are accessible by (interdisciplinary team). The N #10 spoke of were 2. When asked if they should RN #2 stated, yes, they as asked if the resident has a tes, sepsis twice and having a the end of July, shouldn't this be on the active care she had it on the care plan the esolved (deleted) that care desident Care Management are anytime there is a change staff member) #1, the dent, and ASM #2, the tere made aware of the 18/2023 at 4:15 p.m.  In was provided prior to exit.	F	357		
Resident #34 was ob	served in bed with upper				
	ROVIDER OR SUPPLIER  SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From pag #10 made a call to the who told her, RN (regupdates to the care p  An interview was core (minimum data set) report, when asked who will be a call to the composition of the care plan, should be a care plan a care	A9E084  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 47  #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. 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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.	ROUIDER OR SUPPLIER  INIA HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 47  #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. 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WIND  STREET ADDRESS, CITY, STATE, ZIP CODE  1101 HAMPTON ST RICHMOND, VA 23220  BUMMAPY STATEMENT OF DEPICIENCIES  (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 47  #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 was saked 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 UTT, but she resolved (deleted) that care plan.  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		49E084	B. WING _			C <b>07/19/2023</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HAMPTON ST RICHMOND, VA 23220	•	01110/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 657	bilateral side rails on 7/18/23 at 8:10 AM.  Resident #34 was at 10/24/22 with diagnoral not limited to: multiple the most recent MD assessment, a quart ARD (assessment recoded the resident at the BIMS (brief interindicating the resider impaired. A review of status coded the resider impaired. A review of status coded the resider impaired. A review of status coded the resider impaired. A review of the compatch o	7/17/23 at 3:05 PM and on  dmitted to the facility on usis that included but were e sclerosis and dementia.  S (minimum data set) erly assessment, with an eference date) of 7/6/23, s scoring a 09 out of 15 on view for mental status) score, nt was moderately cognitively f the Section G-functional ident as requiring total mobility, transfer, , eating, hygiene and  orehensive care plan dated OBLEMS: Resident is at risk ered mobility, disease psychotropics. KS: Has special bed. No side	F6	557			
	rails should be included stated, yes, they should	resident. When asked if bed led on the care plan, LPN #8 uld. When asked if the care le rails" and the resident had					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
	49E084	B. WING			l	D 19/2023
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(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	1				(X5) COMPLETION DATE
bilateral upper side rarevised; LPN #8 state what the resident had On 7/18/23 at approx (administrative staff in administrator and ASI was made aware of the facility policy revised 11/17, Interdisciplinary Care and revise a resident quarter anytime there. No further information Free of Accident Haza CFR(s): 483.25(d)(1) (1) (§483.25(d) (1) The resident facility must ensure street of accident had \$483.25(d)(2) (2) (3) (2) (3) (4) (4) (4) (5) (5) (6) (6) (7) (7) (7) (7) (7) (7) (7) (7) (7) (7	ails, had the care plan been ed, no, it was not correct to la, it has not been revised.  Imately 4:40 PM, ASM nember) #1, the M #2, the director of nursing ne findings.  It's "Resident Care Plan" reveals, "All members of the Plan Team must reassess is care plan throughout the is a change with their care."  In was provided prior to exit. ards/Supervision/Devices (2)  Inter that - sident environment remains interest as is possible; and sident receives adequate stance devices to prevent  It is not met as evidenced terview, staff interview, ew and clinical record iff failed to prevent accidents red bones for two of 31 y sample, Residents #43			Past noncompliance: no plan of correction required.		
The infairigs include.						
	Continued From page bilateral upper side rarevised; LPN #8 state what the resident had On 7/18/23 at approx (administrative staff in administrator and ASI was made aware of the A review of the facility policy revised 11/17, Interdisciplinary Care and revise a resident quarter anytime there. No further information Free of Accident Haza CFR(s): 483.25(d)(1)(1)(1)(1)(2)(1)(2)(2)(3)(3)(2)(3)(4)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	A9E084  ROVIDER OR SUPPLIER  INIA HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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. 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.	A BUILDI  A SOVIDER OR SUPPLIER  INIA HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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. 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)(2)Each 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.	A BUILDING B	A BUILDING  49E084  B. WIND  STREET ADDRESS, CITY, STATE, ZIP CODE  101 HAMPTON ST RICHMOND, VA 32220  PREVIOUS CROSS-REFERENCED TO THELL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 49  Bilateral upper side rails, had the care plan been revised; LPN 48 stated, no, it was not correct to what the resident had, it has not been revised.  CON 7/18/23 at approximately 4:40 PM, ASM (administrative staff member) #1, the administrative staff member) #1, 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. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  \$483.25(d) (1) The resident environment remains as free of accidents hazards as is possible; and \$483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and \$483.25(d)(1)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. 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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTR	RUCTION	(X3) DATE COMP	SURVEY LETED
		49E084	B. WING _				C <b>19/2023</b>
	ROVIDER OR SUPPLIER			1101 HAM	DDRESS, CITY, STATE, ZIP CODE IPTON ST ND, VA 23220	1 017	13/2323
(X4) ID PREFIX TAG			ID PREFI 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	e 50	F (	889			
	to transfer the reside lift, per the resident's in a fall and R43 sust R43's comprehensive documented, "(R43) (activities of daily livin (diagnoses): Cerebra Disorder. Approache MECHANICAL LIFT-R43's kardex dated 1 "Transferred using fur A review of R43's clir nurse's note dated 1/ "CNA (Certified Nurse (resident) fell to to [si was yelling before befeel comfortable with stand and pivot transbed. her shoe on right slipped and fell ontop CNA rolled her to her and transferred by hot three staff]. c/o (compshoulder, no signs of tylenol given. res said mother notified. vitals X-ray results dated 1 distal clavicle fracture.	Hoyer Lift for all transfers.  1/28/23 documented, Ill mechanical lift (Hoyer)."  Inical record revealed a 1/28/23 that documented, 1/28/23 that d					
	(R43) sustained a cla	turday January 28, 2023, avicle fracture after being wheelchair to the bed s interviewed on 2/3/23 by					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION  NG		(X3) DATE S COMPL	
		49E084	B. WING _			07/1	; 19/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1101 HAMPTON ST RICHMOND, VA 23220	ODE	, <b>.</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	(Director of Nursing) transfer on 1/28/23 w #1) if she knew what method was for (R43 was a Hoyer transfer (ASM #2) asked her stand pivot transfer in plan. (CNA #1) said doing it that way be cresident was noted to this shift 3PM to 11P fall incident by saying resident up from her right shoe came off. precipitated the fall error caused this incicare plan for transfer. CNA #1 was not avaisurvey. On 7/18/23 a was conducted with CNAs are made awa be transferred via a sresident's room door and in the computer transfers. CNA #2 staresident's care plan reasons.  On 7/18/23 at 4:33 p staff member) #1 (the and ASM #2 (the direaware of the above of the specific colors).	in regard to fall related with (R43). She asked (CNA the documented transfer st). (CNA #1) stated that it with two staff members. why she tried to execute a instead of following the care she felt more comfortable ause of her behaviors. The phave been yelling during M. (CNA #1) explained the gashe [sic] that she stood the power wheelchair and her. The change in balance then Unfortunately, humans [sic] ident by diverting from the tring the resident."  Italiable for interview during the fat 3:53 p.m., an interview CNA #2. CNA #2 stated the re of how a resident should sign on the back of the the resident's care plan, system when documenting the for transfers for safety  I.m., ASM (administrative executive vice president) ector of nursing) were made	F	589			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		49E084	B. WING _			l	C <b>19/2023</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 1101 HAMPTON ST RICHMOND, VA 23220	DE	1 011	13/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 689	person transfer only  A facility plan of corredocumented, "Staff mersident using stand player lift. Resident so C.N.A. Resident was Hoyer lift and 3 staff a complained of left shouses some of injury note and ice was applied for resident again complained of left disand ice was applied for resident again complained poctor) notified, and X-Ray showed left disand mother were notion orthopedic company) MD at (name of orthorest ordered. 2. All reincorrectly are at risk that did the incorrect stated that she knew Hoyer transfer and shouse trans	are to be used with a two ."  action dated 2/1/23 nember transferred the bivot instead of 2 person dipped and fell on top of a transferred to bed via assist. 1. Resident bulder pain after fall, upleted by Charge nurse with ed. (R43) received Tylenol or complaint of pain. 1/29 ained of pain. MD (Medical X-Ray was ordered. 1/30 stal clavicle fracture. MD fied. Referral to (name of . 1/31 resident was seen by pedic company), ice and esidents that are transferred of injury. 3. Staff member transfer was interviewed and the resident was a 2 person ne did a stand pivot instead. Iminated for not following taff Development te all nursing staff on the . 4. The Nursing on each shift will monitor taff compliance. 5. Dates of It this plan of correction was rvey.	F6	689			

AND DI AN OF CORRECTION IDENTIFICATION NUMBER			PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		49E084	B. WING_			C	
	ROVIDER OR SUPPLIER	432004		STREET ADDRESS, CITY, STATE, ZIP CODE  1101 HAMPTON ST  RICHMOND, VA 23220	<u> </u>	07/19/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPLICATION OF THE APPLICA	OULD BE	(X5) COMPLETION DATE	
F 689	and R71 sustained a R71's comprehensive documented, "(R71) to) altered mobility, or psychotropics. Appress to stand lift for all report dated 2/20/23 using the sit to stand kardex failed to docusing a sit to stand I A nurse's note dated "Assigned cna (certistransferring resident seat [sic] to stand lift knees landing on rigpain to right leg, uppordered."  A note signed by the documented a non-compared and the signed by the documented a non-compared in her row wheelchair. Initial resurray were negative, the resident complainexhibited swelling in x-rays revealed a frathe time of the fall, ([sic] the foot plates of t	g strap. This resulted in a fall a fractured right ankle.  e care plan dated 7/26/17 is at risk for falls r/t (related disease process and use of roaches/Tasks: Transfers-Use transfers" R71's kardex documented, "Transfer I lift only." The care plan and ument specific instructions for	F 6	89			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		49E084	B. WING _			C <b>07/19/2023</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 1101 HAMPTON ST RICHMOND, VA 23220	DE	07/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	Logically, the use of prevented this fallU mentioned in our distant did not use the lestabilize the resident incident was caused diverting from the carresident"  On the most recent of quarterly assessment reference date) of 4/2 15 on the BIMS (bried indicating the resident making daily decision.  On 7/18/23 at 8:33 and conducted with R71. Not refused leg strapthe sit to stand lift.  On 7/18/23 at 3:53 phonomorphisms of the leg strapth of the sit to stand lift.  On 7/18/23 and the resident stated not using the leg strapth and the CNAs are suffered by the sit of the sit o	the strap may have Unfortunately, as the C.N.A. cussion, she lost her focus ower leg strap to help during the transfer. This by human error and by re plan for transferring the  MDS (minimum data set), a at with an ARD (assessment 27/23, R71 scored 15 out of finterview for mental status), at was cognitively intact for as.  .m., an interview was The resident stated she has s while being transferred with  .m., an interview was #2. CNA #2 stated she did while transferring R71 on dent slid and fell. CNA #2 leg strap was her mistake apposed to make sure they it to stand lift transfers.  .m., ASM (administrative e executive vice president) ector of nursing) were made concern.  ed, "Sit to Stand Mechanical	F6	689			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE COMP	SURVEY LETED
		49E084	B. WING			C 07/19/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HAMPTON ST RICHMOND, VA 23220		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 689	or creased under the procedure with the other procedure with the other components of the procedure with the other components of the procedure with the other components of the procedure with the procedure of the	thigh. Repeat this her leg"  ction dated 2/23/23 tember transferred the tand lift. Resident moved and fell to her knees. C.N.A. to her legs before being a twas transferred to bed via the tand. It was the tand the tand the tand. It was the tand tand the	F 68	39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49E084	B. WING		C 07/19/2023
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  1101 HAMPTON ST  RICHMOND, VA 23220	1 07/13/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 689	Continued From pag		F 68	9	
	Past non-compliance				
F 695 SS=D	Respiratory/Tracheo CFR(s): 483.25(i)	stomy Care and Suctioning	F 69	5	8/31/23
	The facility must ensineeds respiratory calcare and tracheal sucare, consistent with practice, the compressore plan, the reside and 483.65 of this such that resident and that resident and that resident's nebulizer one of 31 residents in Resident #93.  The findings include  For Resident #93 (For Resident #93)  The findings include  For Resident #93 (For Resident #93)  Resident #93's most set), a quarterly asset (assessment reference coded Resident #93) the brief interview for	and tracheal suctioning. Sure that a resident who are, including tracheostomy actioning, is provided such a professional standards of thensive person-centered ants' goals and preferences, abpart. T is not met as evidenced acility document review, it facility staff failed to store a amask in a sanitary manner for an the survey sample,  active facility with diagnoses as not limited to wheezing.  The recent MDS (minimum data active date) of 07/06/2023, as scoring a 15 out of 15 on a mental status (BIMS) which and was cognitively intact for		Tag 0695 Respiratory/Tracheotomy and Sustioning.  For the resident found to have beer affected by the deficient practice, the facility took the following actions immediaely, the nursing staff covere nebulizer with a clean towel. Comple 7/19/23.  To identify other residents having the potential to be affected by the same deficient practice, the facility will take following actions: 1) an administrationarse will review all orders for all 13 residents and will identify those with respiratory orders and treatments. 2 nurse supervisor will check all the associated resident equipment and storage of said equipment. The sup will note the equipment as either in of compliance with our policy for said clean handling of repiratory equipment.	need the deted deted deted detected det

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		49E084	B. WING			1	C <b>19/2023</b>
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 0.7	10/2020
THE VIDO	INIA HOME			110	01 HAMPTON ST		
THE VING	INIA HOME			RIG	CHMOND, VA 23220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page	e 57	F 6	95			
	On 07/17/23 at appro	ximately 3:17 p.m., an			This measure that the facility will under	go	
		room revealed a nebulizer			usinf the Point Click Care eMar system		
	mask on R93's desk เ	uncovered.			and the quality assurance checklist too		
	On 07/18/23 at appro	ximately 8:21 a.m. and			will ensure that the deficient practice do not adversely affect additional resident		
		ons of R93's room revealed			not adversely affect additional resident	<i>5</i> .	
		R93's desk uncovered.			The following procedures/systemic		
					changes will be implemented to ensure		
	The physician's order				that the deficient practice does not recu		
		Albuterol Solution 0.5 - 2.5			1) The Licensed Practical Nurse will be	:	
		ally every 12 hours as 1). Order Date: 10/25/2021.			re-educated/in-serviced on respiratory care procedures with an emphasis on		
	Start Date: 10/26/202				proper handling and storage of equipm	ent	
					when not in use. The renewed emphas		
		proximately 12:45 p.m. an			on the procedures for safe handling of	the	
		room and interview were			equipment will be consistent with the		
		licensed practical nurse) #3.			professional standards of practice.	iloor	
		ibe the procedure for storing en it was not in use, she			Additionally, a Charge Nurse on each f will conduct a weekly audit for 8 weeks		
		e placed in a plastic bag to			the proper storage of respiratory	O1	
		PN #3 observed R93's			equipment. The documented audits wil	l be	
	nebulizer mask uncov	vered lying on top of the			submitted to the Director of Nursing for		
		he stated that it should be			compliance review and necesary		
	covered.				continuing education.		
		Respiratory Equipment Care" "BREATHING TREATMENT			The facility plans to monitor its performance to ensure solutions are		
	EQUIPMENT - NEBU				sustained by taking the following action	ıs:	
		ne mouthpiece on mask and			The DON will report the results of the		
		se under strong stream of			respiratory audits to the Quality Asuran	ce	
		off excess water and air dry.			Committee.		
	when completely dry mouthpiece in zip-loc	, reassemble and store					
	mounipiece in zip-ioc	r bay.					
	On 07/18/2023 at app	proximately 4:30 p.m., ASM					
	(administrative staff n	nember) #1, executive					
		SM #2, director of clinical					
	services, were made	aware of the above findings.					
			1				1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  3		TE SURVEY MPLETED
			7 50.125	<u></u>		С
		49E084	B. WING		o	7/19/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HAMPTON ST RICHMOND, VA 23220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 695	Reference:	e 58 n was provided prior to exit. th - known medically as	F 69	95		
F 756 SS=E	dyspnea - is often det tightening in the ches breathing, breathless suffocation. https://www.mayoclin of-breath/basics/defin	scribed as an intense t, air hunger, difficulty ness or a feeling of ic.org/symptoms/shortness- iition/sym-20050890 w, Report Irregular, Act On	F 7	56		8/31/23
	must be reviewed at I licensed pharmacist.	imen Review.  ug regimen of each resident  east once a month by a  view must include a review				
	of the resident's media §483.45(c)(4) The phirregularities to the at facility's medical direct and these reports mu (i) Irregularities including that meets the c (d) of this section for (ii) Any irregularities reduring this review mu separate, written report attending physician a director and director and director and the irregularity th (iii) The attending phyresident's medical recommendation of the irregularity the control of the irregularity the irre	armacist must report any tending physician and the ctor and director of nursing, st be acted upon. de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist st be documented on a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49E084	B. WING		C 07/19/2023
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/10/2020
TUE \#D0	INIIA LIONE			1101 HAMPTON ST	
THE VIRG	INIA HOME			RICHMOND, VA 23220	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	` '
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
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.		F 75	6	
	maintain policies and drug regimen review limited to, time frame the process and steps when he or she identifications requires urgent action. This REQUIREMENT	cility must develop and procedures for the monthly that include, but are not is for the different steps in is the pharmacist must take if it is an irregularity that in to protect the resident.			
	and clinical record rev facility staff failed to c for the monthly drug r frames for the differer including identifying a urgent actions to prot residents reviewed fo	iew, facility document review view, it was determined the completely develop a policy regimen reviews with times not steps in the process, an irregularity that requires ect the resident for five r medications, (Residents and #109), in the survey ts.		Tag F756 Drug Regimen Review.  The residents found to have been af by the deficient practice were address and a policy was revised for the modurug regime review with time frames different steps in the process, includidentifying irregularities that require action. Completed 8/7/23.  All resident residing at The Virginia H	ssed nthly s for ing urgent
	to include any docum timeframe that a phar required to be provide acted upon by the pharest regulatory requitime frames for the diand steps the pharms she identifies an irregaction to protect the resulting framest for the diand steps the pharms and steps the pharms action to protect the resulting framest fram	ant Pharmacist" policy failed entation regarding the macy recommendation is ed to the physician and ysician. The policy did not rements of specifying those fferent steps in the process acist must take when he or juliarity that requires urgent esident.		have the potential to be affected by to same deficient practices. The Consumpharmacist will review all current residents for any irregularities with medications that require urgent action will notify the attending Physician, modification and Director of Nursing. Complete by 8/14/23.  The following procedures/systemic changes will be implemented to ensumphat the deficient practice does not reach that the deficient practice does not reach the defic	the Iltant on and edical ure ecur.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49E084	B. WING		C 07/19/2023
NAME OF PROVIDER OR SUPPLIER  THE VIRGINIA HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HAMPTON ST RICHMOND, VA 23220	1 07/13/2023
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
F 756	drug regimen review records were reviewed. Resident #18's clinical unnecessary medical identified concerns with the resident was record. Resident #38's clinical unnecessary medical identified concerns with the resident was record.	ords were reviewed:  Pharmacy.F 8/7/23.  sident #18's clinical record was reviewed for necessary medications. There were no ntified concerns with the use of anticoagulation resident was receiving.  Pharmacy.F 8/7/23.  The Director recommend recommend Pharmacist		The Virginia Home and Family Care Pharmacy.Policy# 717.45. Comple	any tant
	unnecessary medica identified concerns w the resident was received. Resident #83's clinical unnecessary medical identified concerns w the resident was received.	al record was reviewed for tions. There were no vith the use of psychotropics			
	unnecessary medica identified concerns was resident was receiving A review of the facility regimen reviews and recommendations was "Consultant Pharmace "The clinical pharmace facility regularly review including data collect and data resulting from the resulting from the concerns the concern	tions. There were no with the use insulin the ag.  y policy regarding medication a pharmacy as conducted. The policy, cist" documented in part, cist recommends that the ews and analyzes data, and under the QAPI program om drug regimen reviews, data to make improvements			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			A. BUILDING			С	
		49E084	B. WING _			07/	19/2023
NAME OF PROVIDER OR SUPPLIER  THE VIRGINIA HOME			11	TREET ADDRESS, CITY, STATE, ZIP CODE  101 HAMPTON ST  ICHMOND, VA 23220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	stated that the facility review policy, was when pharmacy did not have #2 provided a revised meet guidelines.  ASM #1, the administ of nursing and ASM # was made aware of the 7/19/23 at 9:05 AM.  No further information Drug Regimen is Free CFR(s): 483.45(d)(1)-\$483.45(d) Unnecess Each resident's drug unnecessary drugs. Adrug when used-\$483.45(d)(1) In exceeduplicate drug therapy \$483.45(d)(2) For exceeduplicate drug therapy \$483.45(d)(3) Without \$483.45(d)(4) Without use; or	PM, an interview was (administrative staff ctor of nursing. ASM #2 Is pharmacy medication nat they had and the re a separate policy. ASM I policy, however it did not  arator, ASM #2, the director ready, the interim administrator ne above concern on  a was provided prior to exit. refrom Unnecessary Drugs re(6) regimen must be free from An unnecessary drug is any ressive dose (including y); or ressive duration; or t adequate monitoring; or t adequate indications for its  resence of adverse indicate the dose should be		756	DEFICIENCY		8/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				С		
49E084					07/19/2023	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE VIRG	INIA HOME			1101 HAMPTON ST		
THE VIICO	IIIIA IIOIIIE			RICHMOND, VA 23220		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 757	Continued From page	62	F 75	7		
	§483.45(d)(6) Any constated in paragraphs section.	mbinations of the reasons (d)(1) through (5) of this is not met as evidenced				
	Based on staff intervireview, the facility sta	ew and clinical record  ff failed to ensure one of 31  y sample was free from an  ion; Resident #38.		Tag 757 Drug Regime is free from Unnesessary Drugs.  The resident found to have been affect by the deficient practice was addresse		
	The findings include:			and an Anticoagulant Monitoring Syste was added to their Medication		
		8), the facility staff failed to or side effects (bleeding) t (blood thinning)		Administration record and Care Plan. Completed 7/21/23.		
	medication Eliquis (1)			All residents residing at The Virginia  Home have the potential to be affected	-	
	milligrams by mouth to pulmonary embolism. (medication administrathrough July 2023 rev	ed 11/3/20 for Eliquis five		the deficient practice. The facility Audit 100% of the residents on Anticoagulati Therapy. An Anticoagulation system wadded to their Medication Administratic System and Care Plan as needed. Completed 7/24/23.	on as	
	(including the MARs a 2023 through July 202	view of R38's clinical record and nurses' notes for May 23) failed to reveal the ed for side effects (bleeding)		The following procedures/systemic changes will be implemented to ensure that the deficient practice does not reconstructed Anticoagulation monitoring will be added to all present residents on Anticoagulants.	ur. ed	
	stated residents that a anticoagulants should every shift. RN #2 sta	egistered nurse) #2. RN #2		Anticoagulation Policy and Procedure of the developed and in-serviced to a Licensed Nursing staff by the Staff Development Coordinator.  The ADON will audit the Medication	will	
	On 7/19/23 at 9:11 a.ı	m., ASM (administrative		Administration Record and Care Plan weekly for 4 weeks, monthly for 4 mon	ths	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	<b>49E084</b> B. WING			C 07/19/2023			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP	CODE	0771972023	
				1101 HAMPTON ST			
THE VIRG	INIA HOME			RICHMOND, VA 23220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	( (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 757	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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=64c052d12700 1aa9ec1836cd1510884c&gclsrc=3p.ds&			ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SE			