STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495193	A. BUILDING _____ B. WING _____	C 05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENRICO HEALTH & REHABILITATION CENTER	561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 5/6/25 through 5/8/25 and 5/12/25 through 5/13/25.. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during the survey: VA00063842 - Substantiated with no deficiency VA00063869- Substantiated with two (2) deficiencies VA00064193 - Substantiated with two (2) deficiencies The census in this 120 certified bed facility was 107 at the time of the survey. The survey sample consisted of 5 resident reviews.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		6/11/25

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

Electronically Signed | 06/09/2025

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F 600	Continued From page 1 by: Based on resident interviews, staff interviews, and review of facility documents, the facility staff failed to protect a resident's right to be free of sexual abuse for 2 of 5 residents (Resident #1 and Resident #3) in the survey sample, which constituted harm. The findings included: Resident #1 was initially admitted to the facility on 11/21/23. The current diagnoses included other mechanical complications of the internal right hip prosthesis, muscle weakness, chronic kidney disease, other sickle-cell disorders without crisis, anxiety disorder, and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/15/25, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated that Resident #1's cognitive abilities for daily decision-making were intact. Resident #3 was no longer a resident of the facility; therefore, a closed record review was conducted. Resident #3 was admitted to the facility on 12/24/24, was discharged home on 4/25/25. The resident's diagnoses included metabolic encephalopathy, unspecified cirrhosis of the liver, muscle wasting and atrophy, and end-stage renal disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/28/25 coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This	F 600	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F600 Free from Abuse and Neglect 1. Resident #1 currently resides in the facility. Resident # 3 no longer resides in the facility. The identified staff member referenced in the allegation is no longer an employee in the facility. 2.Current residents in the facility have the potential to be affected, Interviews were conducted for residents that can be interviewed, with no concerns of sexual or other types of abuse identified. 3. The Administrator will provide all staff education regarding residents' rights to be free from sexual abuse or any other forms of abuse or neglect, to also include any staff identified in an abuse allegation suspended pending investigation immediately upon knowledge, to protect the resident or residents from potential abuse and/or emotional harm. 4. The RDCS Or designee will review service concerns to identify any type of allegations of abuse/neglect to ensure resident or residents were protected, the alleged staff member was immediately suspended pending investigation upon knowledge and the incident was reported to the appropriate representatives and	

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F 600	Continued From page 2 indicated that Resident #3's cognitive abilities for daily decision-making were intact. An interview was conducted on 5/6/25 at 4:55 PM with Resident #1. Resident #1 stated that in February 2025 (not sure of the exact date), the Receptionist said to him, "You are too stressed out. You need your dick sucked." Resident #1 also stated that a few days later, the same Receptionist displayed a picture on his phone to Resident #1 of him giving oral sex to another male. Resident #1 further stated that he informed the Activities Assistant regarding these two occurrences. During the interview, Resident #1 stated that at the end of March 2025 (not sure of the exact date), the Receptionist puckered his lips up, blew a kiss, and made smacking sounds directed towards him. Resident #1 also stated, "I felt humiliated and got angry." Resident #1 further stated that immediately after this incident occurred, he saw the Assistant Director of Nursing (ADON) in the hallway laughing and felt as if she was laughing at him. Resident #1 stated that he asked the ADON why she was laughing and said to her, "Everyone knows what that faggot did to me." On 5/6/25 at 5:55 PM, during the interview, Resident #1 became very emotional and began crying. Resident #1 stated, "I have not had the best life. I've seen a lot of things. It's been hard for me to get this out of my mind. Why did he target me? I'm someone that has health issues. He was trying to take advantage of me. I feel like people are laughing at me. Am I a video game? I'm not gay. It's about my dignity. It's embarrassing and humiliating, and I'm angry."	F 600	officials. Results Of the review Will be presented to the QAPI committee for and recommendation, Once the committee determines the problem no longer exists and is sustained, the review Will be conducted on a random basis. 5. Date of compliance: 6/11/2025	

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F 600	Continued From page 3	F 600		

An interview was conducted on 5/7/25 at 3:15 PM with Certified Nursing Assistant (CNA) #2. CNA #2 stated that on 3/29/25, a Transportation Driver approached him and stated that the receptionist was very inappropriate in a sexual manner with him. CNA #2 also stated that on this same day, the receptionist got very close to him as well and started making funny noises in his ear. CNA #2 further stated that he perceived the actions that the receptionist did were sexual and told the receptionist, "I don't go that way. Don't even try it." CNA #2 lastly stated that he did not tell the management team about these occurrences until the following week on 4/2/25 when he was asked questions by the Director of Nursing (DON) regarding the receptionist.

A review of a written statement dated 4/2/25 by the Transportation Driver read: On Saturday, March 29, 2025, I came to pick up a resident for dialysis. As I was walking to push the resident's wheelchair, the weekend ambassador stood in front of me and tried to grab my private area. I pushed his hand away. He tried to touch my private area again, so I left to get a witness. I grabbed a CNA, and he stopped trying to touch me. After that, I had no more incidents with him.

An interview was conducted on 5/7/25 at 5:35 PM with the Administrator. The Administrator stated that a Facility Reported Incident was initiated and investigated regarding the incidents that occurred over the weekend of 3/29/25-3/30/25. The Administrator also stated that the police were contacted on 4/3/25 to inform them of the sexual allegations, and a police report was filed. The Administrator further stated that the Receptionist was terminated and is not registered with any

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F 600	Continued From page 4	F 600		

licensing board. The Administrator lastly stated that sexual abuse was confirmed for four individuals (Resident #1, Resident #3, CNA #2, and the Transportation Driver), and the allegations of sexual abuse are substantiated.

An interview was conducted on 5/8/25 at 12:20 PM with the former ADON. The former ADON stated that on 3/31/25, Resident #1 told her that the receptionist puckered his lips up, blew him a kiss, and made a smacking sound. The former ADON also stated, Resident #1 was very agitated, upset, and visibly irritated.

An interview was conducted on 5/8/25 at 12:38 PM with the Discharge Planning Assistant. The Discharge Planning Assistant stated that she interviewed Resident #3 on 4/2/25 regarding interaction with the weekend receptionist. The Discharge Planning Assistant also stated that Resident #3 informed her that on one occasion the Receptionist came to his room to inform him that his ride was on the way and said to him, "I want to suck that dick." The Discharge Planning Assistant further stated that Resident #3 said he was unsure if he heard him correctly. However, the Receptionist repeated it again as they got closer to the double doors. The Discharge Planning Assistant lastly stated that Resident #3 said when he came back to the facility from his dialysis appointment, the receptionist was standing in the business office with the lights off and was beckoning him to come in, however he ignored him.

An interview was conducted on 5/8/25 at 2:10 PM with the Activities Assistant. The Activities Assistant stated that Resident #1 told her that the male receptionist said to him, "have you ever had

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F 600	Continued From page 5 your dick sucked?" The Activities Assistant also stated that Resident #1 said that the receptionist has videos of it on his phone. The Activities Assistant further stated, "I'm a mandated reporter, so I told the Social Worker Assistant and the Social Worker about this, and then the Administrator wanted to speak with me." The Facility's Abuse/Neglect/Misappropriation/Crime policy with an effective date of 10/17/23 read: Patients of the Center have the legal right to be free from verbal, sexual, mental, and physical abuse, corporal punishment, involuntary seclusion including abuse facilitated or enabled through the use of technology, and free from chemical and physical restraints except in an emergency and/or as authorized in writing by a physician. On 5/8/25 at approximately 5:00 PM, a final interview was conducted with the Administrator, Director of Nursing, and Regional Director of Clinical Services. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		6/11/25

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F 609	Continued From page 6 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of facility documents, the facility staff failed to ensure a violation involving abuse was reported to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services), within two hours of the violation occurring. The findings included: An interview was conducted on 5/7/25 at 2:50 PM with the Director of Nursing (DON). The DON stated that CNA #2 disclosed information on 4/2/25 during an interview regarding sexual allegations that occurred on 3/29/25. The DON stated that CNA #2 should have reported this to the Administrator, the Director of Nursing, or his immediate supervisor no later than two hours	F 609	F609 Reporting of Alleged Violations 1.Resident #1currently resides in the facility; resident #3 no longer resides in the facility. The staff member identified in the allegation is no longer an employee at the center. 2. Current residents in the facility have the potential to be affected. An audit of all service concerns and facility incident reports for the last 90 days has been reviewed to identify any potential allegations of abuse/neglect, with none identified. Interviews were conducted for residents that can be interviewed with no concerns of abuse or neglect identified. 3.The Administrator provided facility staff with education on timely reporting of abuse, to include reporting to the	

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F 609	Continued From page 7 after the incidents occurred. An interview was conducted on 5/7/25 at 3:15 PM with Certified Nursing Assistant (CNA) #2. CNA #2 stated that on 3/29/25 a transporting driver approached him and stated that the receptionist was very inappropriate in a sexual manner with him. CNA #2 also stated that on this same day the receptionist got very close to him as well and started making funny noises in his ear. CNA #2 further stated that he perceived the actions that the receptionist did was in a sexual manner and told the receptionist, "I don't go that way. Don't even try it." CNA #2 lastly stated that he did not tell the management team about these occurrences until the following week on 4/2/25 when he was asked questions by the Director of Nursing (DON) regarding the receptionist. A review of a written statement dated 4/2/25 by the Transportation Driver read: On Saturday March 29, 2025, I came to pick up a resident for dialysis. As I was walking to push the resident's wheelchair, the weekend ambassador stood in front of me and tried to grab my private area. I pushed his hand away. He tried to touch my private area again, so I left to get a witness. I grabbed a CNA, and he stopped trying to touch me. After that, I had no more incidents with him. An interview was conducted on 5/7/25 at 5:35 PM with Administrator. The Administrator stated that a Facility Reported Incident was initiated and investigated regarding the incidents that took place on the weekend of 3/29/25-3/30/25. The Administrator also stated that sexual abuse was confirmed for four individuals. The Administrator further stated that the allegation of sexual abuse is substantiated.	F 609	administrator, and other officials including the state survey agency and adult protective services within 2hours of the violation occurring. Any staff identified in an allegation of abuse will be suspended pending investigation immediately upon knowledge to protect the resident or other residents from potential abuse and/or emotional 4.The RDCS or VPO will review any FRIS (facility incident reports) to verify any allegations of abuse were appropriately reported. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists and is sustained, the review will be conducted on a random basis. 5. Date of compliance: 6/11/2025	

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F 609	Continued From page 8 Review of a reportable incident filed by the facility, documented the report was faxed to the Office of Licensure and Certification on 3/31/25 at 4:33 PM. The Facility's Abuse/Neglect/Misappropriation/Crime policy with an effective date of 10/17/23 read: All employees are responsible for immediately (no later than two hours after the allegation is made if the incident involves abuse or bodily injury, no later than 24 hours if the incident does not involve abuse or bodily injury) reporting to the Administrator, or in their absence, the Director of Nursing, or their immediate supervisor any and all suspected or witnessed incidents of patient abuse, neglect, theft, exploitation and/or mistreatment of a patient as well as any reasonable suspicion of a crime against a patient. On 5/8/25 at approximately 5:00 PM, a final interview was conducted with the Administrator, Director of Nursing, and Regional Director of Clinical Services. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.	F 609		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658		6/11/25

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F 658	Continued From page 9 Based on resident interview, staff interviews, clinical record review, and review of facility documents, the facility staff failed to follow the professional standards of quality regarding two trained staff members assisting with mechanical lifts and transfers for 1 of 5 residents (Resident # 5), in survey sample. The findings included: Resident #5 was originally admitted to the facility 11/22/22. The current diagnoses included chronic kidney disease, type 2 diabetes mellitus with other diabetic kidney complication, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and muscle weakness. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/5/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 09 out of a possible 15. This indicated Resident #5's cognitive abilities for daily decision making were moderately impaired. An interview was conducted on 5/12/25 at 3:30 PM with Resident #5. Resident #5 stated that she was hit in the head by the Hoyer lift bar when a Certified Nursing Assistant (CNA) was providing care for her. Resident #5 also stated that she told the CNA that she was hit in the head by the bar. Resident #5 further stated that there was only one CNA in the room when this incident occurred. An interview was conducted on 5/12/25 at 5:13 PM with the Director of Nursing (DON). The DON stated that it was an accident when the	F 658	F658 Services Provided Meet Professional Standards 1.Resident #5 currently resides in the facility 2. Current residents in the facility have the potential to be affected, an audit was conducted by the Director of Nursing on current residents requiring mechanical lifts for transfers 3. The SDC or designee will educate all CNA staff on ensuring two trained staff members are assisting with mechanical lifts and transfers. 4. The Unit Manager or designee will audit weekly x4 and then monthly, ensuring staff adhere to professional standards of quality regarding two trained staff members assisting with mechanical lifts and transfers. Results of the review" will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists and is sustained, the review will be conducted on a random basis. 5. Date of compliance: 6/11/2025	

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F 658	Continued From page 10	F 658		

Hoyer sling bar hit Resident #5 in the head. The DON also stated that due to this occurring, Resident #5 received a small hematoma on the head. The DON further stated that two trained staff members must assist with mechanical lifts and transfers.

An interview was conducted on 5/13/25 at 10:45 AM with CNA #3. CNA #3 stated that she began giving Resident #5 care, and called for help, but no one came. CNA #3 also stated that she was transferring Resident #5 with the Hoyer lift and the leg of the Hoyer lift got caught on the roommates bed and the Hoyer lift began to tip. CNA #3 further stated that she maneuvered Resident #5 in the sling, called for help, and when help arrived, they unhooked Resident #5. CNA #3 lastly stated that she never saw the Hoyer lift sling bar hit Resident #5 in the head. When asked if it is standard protocol for one (1) person to operate a mechanical lift alone? CNA #3 stated, "No it is not. It's standard to have two (2) individuals assisting with Hoyer lift transfers."

The facility's Mechanical Lift policy with an effective date of 1/29/24 read: Two trained staff must assist with mechanical lift and transfer.

According to the Office of People with Developmental Disabilities (State of New York): The number of staff required to perform a transfer is at the discretion of the practitioner who prescribed or recommended use of a mechanical lift device. However, it is always best practice to use mechanical lift equipment with a minimum of two staff. One staff member's primary role is the operation and movement of the lift equipment. The second staff is primarily responsible for the

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F 658	Continued From page 11 safe positioning of the individual in the sling or harness system during the transfer. Both staff should continually observe and communicate with each other and the individual throughout the transfer. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://opwdd.ny.gov/system/files/documents/2021/09/2021-use-of-mechanical-lifts.pdf On 5/13/25 at approximately 4:40 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional Director of Clinical Services, Regional Director of Operations, and Corporate Compliance Specialist. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.	F 658		
F 689 SS=D	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 interviews, clinical record review, and review of facility documents, the facility staff failed to provide two-person assistance while transferring Resident #5, which resulted in the resident being struck in the head by the Hoyer lift sling bar for 1 of 5 residents in the survey sample.	F 689	F689 Free of Accident Hazards/Supervision Devices 1.Resident #5 currently resides in the facility. 2.Current residents in the facility have the potential to be affected; an audit was conducted by the Director of Nursing on	6/11/25

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	495193	A. BUILDING _____ B. WING _____	C 05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENRICO HEALTH & REHABILITATION CENTER	561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075

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F 689	Continued From page 12 The findings included: Resident #5 was originally admitted to the facility 11/22/22. The current diagnoses included chronic kidney disease, type 2 diabetes mellitus with other diabetic kidney complication, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and muscle weakness. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/5/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 09 out of a possible 15. This indicated Resident #5's cognitive abilities for daily decision making were moderately impaired. An interview was conducted on 5/12/25 at 3:30 PM with Resident #5. Resident #5 stated that she was hit in the head by the Hoyer lift bar when a Certified Nursing Assistant (CNA) was providing care for her. Resident #5 also stated that she told the CNA that she was hit in the head by the bar. Resident #5 further stated that there was only one CNA in the room when this incident occurred. An interview was conducted on 5/12/25 at 5:13 PM with the Director of Nursing (DON). The DON stated that it was an accident when the Hoyer sling bar hit Resident #5 in the head. The DON also stated that due to this occurring, Resident #5 received a small hematoma on the head. The DON further stated that two trained staff members must assist with mechanical lifts and transfers.	F 689	current residents requiring mechanical lifts for transfers. 3.The SDC will educate all CNA staff regarding adequate supervision and assistance while using mechanical lifts during transfers to prevent accidents. 4.The unit Manager or designee will audit weekly and then monthly, ensuring the resident's environment is free of accident hazards as possible; and there is adequate supervision and assistance with devices to prevent accidents. Results of the review Will be presented to the QAPI committee for and recommendation. Once the committee determines the problem no longer exists and is sustained, the review will be conducted on a random basis. 5. Date of compliance: 6/11/2025	

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F 689	Continued From page 13	F 689		

An interview was conducted on 5/13/25 at 10:45 AM with CNA #3. CNA #3 stated that she began giving Resident #5 care, and called for help, but no one came. CNA #3 also stated that she was transferring Resident #5 with the Hoyer lift and the leg of the Hoyer lift got caught on the roommates bed and the Hoyer lift began to tip. CNA #3 further stated that she maneuvered Resident #5 in the sling, called for help, and when help arrived, they unhooked Resident #5. CNA #3 lastly stated that she never saw the Hoyer lift sling bar hit Resident #5 in the head. When asked if it is standard protocol for one (1) person to operate a mechanical lift alone? CNA #3 stated, "No it is not. It's standard to have two (2) individuals assisting with Hoyer lift transfers."

An interview was conducted on 5/13/25 at 12:10 PM with Licensed Practical Nurse (LPN) #2. LPN #2 stated she heard CNA #3 yelling for help and upon entering Resident #5's room, she saw Resident #5 in the chair, the Hoyer lift was tilted, and the CNA was holding the Hoyer. LPN #2 also stated that she assisted the CNA with unhooking the sling off the Hoyer Bar. LPN further stated that about 15 minutes later she was called to dining room and informed by Resident #5's son that the resident had a bruise on top of her head.

An interview was conducted on 5/13/25 at 1:24 PM with LPN #3. LPN #3 stated an assessment was completed immediately upon being notified of the Hoyer lift bar possibly hitting Resident #5 in the head. LPN #3 also stated that a raised area on top of Resident #5's head was observed. LPN #3 further stated that the CNA providing care for Resident #5 should not have been operating the Hoyer lift alone.

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F 689	Continued From page 14	F 689		

A review of the eInteract Change in Condition Evaluation form dated 5/8/25 at 12:19 PM read: Writer notes nurse reports that while resident was being transferred by hoyer lift, resident reported that the lift bar hit the resident in the top of her head. Skin Status Evaluation: Raised area on top of head.

A review of the Nursing Progress Note dated 5/8/25 at 1:58 PM read: Nursing observations, evaluation, and recommendations are: Writer notes nurse reports that while resident was being transferred by hoyer lift, resident reported that the lift bar hit the resident in the top of her head.

A review of the MEDICAL (MD,NP,PA) Progress Note dated 5/9/25 at 1:48 PM read: Head trauma from hoyer lift. Appears accidental injury, but APS filed by family for further investigation, Patient currently denied any pain at the site of injury, had ED visit 5/8/2025 where she had thorough trauma evaluation and no acute injuries noted. Small hematoma on crown region reported by nursing staff yesterday has now resolved Continue pain control with acetaminophen, may use lidocaine patch if convenient.

A review of the Emergency Department After Visit Summary dated 5/8/25 read: You were seen in the ER after hitting your head. Our trauma team evaluated you and found no significant injuries or reasons to be admitted to the hospital. You are cleared to go back to your facility.

The facility's Mechanical Lift policy with an effective date of 1/29/24 read: Two trained staff must assist with mechanical lift and transfer.

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F 689	Continued From page 15 On 5/13/25 at approximately 4:40 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional Director of Clinical Services, Regional Director of Operations, and Corporate Compliance Specialist. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.	F 689		