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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted onsite from April 8, 2025 through April 15, 2025. The facility was in substantial compliance with 42CFR Part 483.475, Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. No emergency preparedness complaints were investigated during this survey.	E 000		
W 000	INITIAL COMMENTS An unannounced re-certification survey was conducted from April 8, 2025 through April 15, 2025. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). No complaints were investigated during the survey. The census in this 75-bed certified facility was 66 at the time of survey. The survey sample consisted of 13 client reviews (Client #1 through #13).	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure clients were protected from abuse, which affected 9 (Clients #3, #6, #7, #8, #9, #10 #11, #12, and #13) of 9 clients reviewed for abuse. Specifically, on 05/27/2024, Psychiatric Care Technician (PCT) #17 pushed Client #12 against	W 122		

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

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a wall, causing a head injury.

On 07/30/2024, PCT #9 touched Client #11's genitalia inappropriately and made inappropriate comments.

On 08/26/2024, Lead Psychiatric Care Technician (LPCT) #14 huffed and aerosol can when he was on an outing with Clients #3, #6, #7, #8, and #9.

On 12/09/2024, PCT #8 hit Client #8, causing the client to have a bloody nose.

On 12/31/2024, LPCT #1 and LPCT #2 failed to follow Client #10's "Physical Management Plan," which resulted in a fall, the staff, including PCT #3, failed to immediately notify nursing staff, which caused a delay in treatment. Client #13's fall resulted in the client sustaining a C6-C7 cervical (vertebral bones of the neck) fracture.

Findings included:

1. An "Investigator's Summary," dated 05/27/2024, revealed that on 05/27/2024, Client #12 sustained a hematoma to the right side of their forehead. The summary indicated PCT #5 called the nursing department to have them assess Client #12. Per the summary, camera footage revealed PCT #17 pushed the client into a wall, which caused the head injury. The Investigator's Summary revealed the recommended findings indicated to substantiate the abuse.

2. An "Investigator's Summary," dated 08/23/2024, revealed that on 08/15/2024 at approximately 5:10 PM, the Facility Director (FD) received a statement that alleged PCT #9 had

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inappropriately touched Client #11's genitalia on 07/30/2024. The Investigator's Summary also revealed that PCT #9 had made inappropriate comments in the presence of Client #11. The summary indicated that the investigator recommended the allegation of abuse and neglect be substantiated.

3. An "Investigator's Summary," dated 08/26/2024, revealed that on 08/26/2024, LPCT #13 called Assistant Director of Residential (ADR) #16 to report that LPCT #14 was witnessed inhaling the contents of an aerosol can and appeared to be disoriented while on duty with Client #6 and four other clients. Per the investigation, the recommended findings were that neglect occurred.

4. An "Investigator's Summary," dated 12/09/2024, indicated that Client #13 was attempting to enter another client's bedroom where PCT #6 was assisting another client. The summary indicated that Client #13 entered the room and PCT #6 asked Client #13 to leave. The summary indicated PCT #8 entered the area and requested Client #13 leave the room. Per the summary, PCT #8 and Client #13 were then heard yelling at each other, and both were seen grabbing and hitting each other. The summary indicated Client #13 had a bloody nose after the altercation with PCT #8. The summary revealed the investigator recommended the allegation of abuse be substantiated.

5. An "Investigator's Summary," dated 01/02/2025, revealed that on 12/31/2024, staff assisted Client #10 up the stairs of a facility-owned van and while they assisted Client #10, Client #10 fell backwards and struck the

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W 122	Continued From page 3 ground. The document indicated that staff failed to adhere to the established fall protocols and continued with their planned outing. Per the summary, the allegation of neglect was substantiated. Refer to W127	W 122		
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure clients were not subjected to abuse, which affected 9 (Clients #3, #6, #7, #8, #9, #10 #11, #12, and #13) of 9 clients reviewed for abuse. Specifically, Psychiatric Care Technician (PCT) #17 pushed Client #12 against a wall, causing a head injury; PCT #9 touched Client #11's genitalia inappropriately and made inappropriate comments; PCT #8 hit Client #13, causing the client to have a bloody nose; Lead Psychiatric Care Technician (LPCT) #14 huffed an aerosol can when he was on an outing with Clients #3, #6, #7, #8, and #9; and LPCT #1 and LPCT #2 failed to follow Client #10's "Physical Management Plan," which resulted in a fall, the staff, including PCT #3, failed to immediately notify nursing staff, which caused a delay in treatment. Client #13's fall resulted in the client sustaining a C6-C7 cervical (vertebral bones of the neck) fracture. Findings included:	W 127		

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W 127	Continued From page 4 A facility policy titled, "Policy on Abuse and Neglect of Individuals," dated 11/09/2021, revealed, "All employees and other service providers, including volunteers of [Facility Name], will adhere to the policies, procedures, and responsibilities prescribed in DBHDS [Department of Behavioral Health and Developmental Services] DI [Departmental Instruction] 201 (RTS)03." The "Department Instruction 201 (RTS)03 Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities," revealed the section titled, "Definitions," included "Abuse Code of Virginia §37.2-100 The means any act or failure to act by any employee or other person responsible for the care of an individual in a Department facility that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury or death to a person receiving care or treatment for mental illness, mental retardation or substance abuse." The policy revealed, "Neglect Code of Virginia §37.2-200 This means the failure by a person, program, or facility operated, licensed, or funded by the department, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of a person receiving care or treatment for mental illness, mental retardation or substance abuse." 1. A "Face Sheet" revealed the facility admitted Client #12 on 06/06/2006. According to the Face Sheet, the client had a medical history that included a diagnosis of intellectual disability.	W 127		

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An "Investigator's Summary," dated 05/27/2024, revealed that on 05/27/2024, Client #12 sustained a hematoma to the right side of their forehead. The summary indicated PCT #5 called the nursing department to have them assess Client #12. Per the summary, camera footage revealed PCT #17 pushed the client into a wall, which caused the head injury. The Investigator's Summary revealed the recommended findings indicated to substantiate the abuse. The Investigator's Summary indicated PCT #17 was interviewed and stated Client #12 had been upset, then after breakfast, the client got out of their wheelchair, walked into the staff office, and began yelling, calling staff names, and banging on the counter. The summary indicated PCT #17 stated he instructed Client #12 to go back into their wheelchair, but the client refused and sat on the counter. The summary indicated PCT #17 then stated that Client #12 started walking towards the door, tripped on something that was on the floor, and fell into the wall.

A timeline of events, attached as part of the investigation, dated 05/27/2024, revealed that closed circuit footage of the event was reviewed and revealed the following:
- At 9:49:15 AM, Client #12 tried to take papers off a desk and PCT #17 grabbed the papers from the client.
- At 9:49:37 AM, Client #12 tried to take papers again from off the desk.
- At 9:49:43 AM, Client #12 leaned towards PCT #17, at which time PCT #17 stood up and grabbed Client #12's left arm with both hands and pushed Client #12 toward the wall.
- At 9:49:47 AM, PCT #17 pushed Client #12 down on the counter, holding Client #12's left arm

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and the middle of the client's back.
- At 9:49:48 AM, PCT #17 had Client #12 off the counter and then proceeded to push the upper right side of Client #12's body toward the wall, causing Client #12's head to strike the wall "extremely hard."
- At 9:50 AM, PCT #17 pulled Client #12 back from the wall, and Client #12 continued leaning on the counter.
- At 9:50:04 AM, PCT #17 let go of Client #12 while standing behind them.
- At 9:51:08 AM, PCT #5 walked into the staff office.
- At 9:51:41 AM, Client #12 sat up, and a large hematoma on the right side of their forehead was visible.
- At 9:51:41 AM, PCT #5 called nursing staff.

During an interview on 04/14/2025 at 2:30 PM, the Facility Director (FD) stated that the investigation had substantiated the abuse allegation, and that staff should not have pushed Client #12's head into the wall. The FD stated that PCT #17 had resigned from his position before the investigation was completed.

2. A "Face Sheet" revealed the facility admitted Client #11 on 07/02/1984. According to the Face Sheet, the client had a medical history that included a diagnosis of intellectual developmental disorder.

An "Investigator's Summary," dated 08/23/2024, revealed that on 08/15/2024 at approximately 5:10 PM, the Facility Director (FD) received a statement that alleged PCT #9 had inappropriately touched Client #11's genitalia on 07/30/2024. The Investigator's Summary also revealed that PCT #9 had made inappropriate

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comments in the presence of Client #11. The summary indicated that the investigator recommended the allegation of abuse and neglect be substantiated. The summary revealed that PCT #3 reported that PCT #9 had previously made several inappropriate remarks about Client #11's genitalia during previous bathing sessions.

During an interview on 04/14/2025 at 2:30 PM, the FD stated that the investigation regarding PCT #9 was substantiated for abuse. The FD stated staff should never abuse a client.

3. A "Face Sheet" revealed the facility admitted Client #13 on 12/28/1995. According to the Face Sheet, the client had a medical history that included a diagnosis of intellectual disability.

An "Investigator's Summary," dated 12/09/2024, indicated that Client #13 was attempting to enter another client's bedroom where PCT #6 was assisting another client. The summary indicated that Client #13 entered the room and PCT #6 asked Client #13 to leave. The summary indicated PCT #8 entered the area and requested Client #13 leave the room. Per the summary, PCT #8 and Client #13 were then heard yelling at each other, and both were seen grabbing and hitting each other. The summary indicated Client #13 had a bloody nose after the altercation with PCT #8. The summary revealed the investigator recommended the allegation of abuse be substantiated.

The "Investigator's Summary" indicated PCT #6 was interviewed and stated that Client #13 swung at PCT #8, and PCT #8 swung back. The summary indicated PCT #8 noticed the client's nose was bleeding.

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The "Investigator's Summary" indicated that PCT #8 was interviewed and stated Client #13 "smacked" her in the face. The summary indicated that PCT #8 stated she hit Client #13 back "in an attempt to get [Client #13] to not hurt [her]."

During an interview on 04/14/2025 at 2:30 PM, the Facility Director (FD) stated that the investigation involving PCT #8 was substantiated. The FD stated staff should never abuse a client.

4. A "Face Sheet" revealed the facility admitted Client #3 on 01/25/2005. According to the Face Sheet, the client had a medical history that included a diagnosis of intellectual developmental disorder.

A "Face Sheet" revealed the facility admitted Client #6 on 03/23/2004. According to the Face Sheet, the client and a medical history that included a diagnosis of intellectual developmental disorder.

A "Face Sheet" revealed the facility admitted Client #7 on 02/27/2020. According to the Face Sheet, the client and a medical history that included a diagnosis of intellectual developmental disorder.

A "Face Sheet" revealed the facility admitted Client #8 on 04/30/2015. According to the Face Sheet, the client and a medical history that included a diagnosis of intellectual developmental disorder.

A "Face Sheet" revealed the facility admitted Client #9 on 02/05/2020. According to the Face

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Sheet, the client and a medical history that included a diagnosis of intellectual developmental disorder.

An "Investigator's Summary," dated 08/26/2024, revealed that on 08/26/2024, LPCT #13 called Assistant Director of Residential (ADR) #16 to report that LPCT #14 was witnessed inhaling the contents of an aerosol can and appeared to be disoriented while on duty with Client #6 and four other clients. Per the investigation, the recommended findings were that neglect occurred.

The "Investigator's Summary," dated 08/26/2024, revealed that PCT #12 was interviewed and stated that during a community outing, LPCT #14 was the van driver. The summary indicated that the group stopped at a store for snacks, where LPCT #14 also made a purchase. The summary indicated that, while at a park, LPCT #14 started "snorting" something and his behavior was "erratic." The summary indicated that LPCT #14 had difficulty turning on the van and attempting to put the van in park and turning it off. The summary indicated that staff had to que him to turn the van on to drive it. The summary indicated that due to LPCT #14 "being fallen over," PCT #12 thought it could be a medical concern. Per the summary, in between "snorting," LPCT #14 became "loud and obnoxious." The summary indicated PCT #12 immediately took the keys away from LPCT #14. The summary indicated that LPCT #14 also had urinated on himself during the outing. Per the summary, LPCT 14's thought process was not safe to drive the van and staff immediately called ADR #16 to the scene and asked if he would bring another administrator with him. The summary indicated ADR #15 was

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the investigator.

The "Investigator's Summary," dated 08/26/2024, revealed LPCT #13 was interviewed and indicated that LPCT #14 drove the staff and clients to a store in the community, he went inside the store and came out with two bags. The summary indicated he put a can of a type of cleaner in the cup holder of the van. The summary indicated LPCT #13 stated that he heard the sound of something spraying, and when he looked up, he saw LPCT #14 putting the can down. The summary indicated that LPCT #14 drove the van to a baseball field and when LPCT #14 took three clients to the bathroom, LPCT #13 noticed LPCT #14 had urinated on himself. Per the summary, after getting back on the van, LPCT #14 drove the van a little further in the parking lot and turned it off, then staff saw him with the can, heard him spray the can, and heard inhaling. The summary indicated that LPCT #14 put his head down then he was acting like he was talking to someone on the phone and tried to put the van in park when the van was off. The summary indicated he tried several times to shift the gears when the van was off. Per the summary, LPCT #14 then turned the van on and off, then he got off the van and laid his head on the hood with his eyes closed and mouth open for about three minutes. Per the summary, LPCT #14 then got back on the van and sprayed the can and inhaled it again and was "really out of it." The summary indicated that the staff kept asking if he was all right and he did not respond. The summary indicated that PCT #12 took the van keys out of the ignition and LPTCT #13 called ADR #16.

The "Investigator's Summary," dated 08/26/2024,

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revealed LPCT #14 was interviewed and stated that he bought a can of "computer" cleaner at a store, and when he used it to clean food material from his mouth, he got a "head rush," then inhaled it fully. The summary indicated that he inhaled a couple more times in the parking lot of the store, waited for his head to clear before driving away to a softball field. The summary indicated that after letting three clients use a portable bathroom, he drove to a shaded lot and inhaled "a couple more times." The summary indicated that LPCT #14 admitted to inhaling electronics cleaner while at work.

During an interview on 04/14/2025 at 12:39 PM, ADR #15 stated he was the one assigned to investigate the allegation of neglect on 08/26/2024. ADR #15 stated that when he interviewed PCT #12 and LPCT #13, they stated that they did not see LPCT #14 inhale from the aerosol can prior to driving the van that day. ADR #15 stated that when the staff did notice LPCT #14 inhaling from the aerosol can and acting erratic, they took the keys to the van away from him and called ADR #16 and the Persons Centered Supports Director (PSD). ADR #15 stated he concluded that LPCT #14 had neglected Clients #3, #6, #7, #8, and #9 by using drugs while he transported them in the facility's van.

During an interview on 04/14/2025 at 2:30 PM, the Facility Director (FD) stated that staff who used drugs while caring for clients was considered neglectful. The FD stated that LPCT #14's employment was terminated at the conclusion of the investigation.

5. A facility policy titled, "Falls Management,"

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dated 08/01/2022, revealed the section titled, "4. Procedures," included, "E. Reporting, Responding and Documenting All Falls: Following all falls, staff will notify Nursing immediately after all falls for assessment."

Client #10's "[Facility Name] Individual Support Plan," revealed the client was admitted to the facility on 06/25/1985. The support plan revealed the client had a medical history that included diagnoses of falls, severe intellectual disability, autistic disorder, quadriceps weakness, weakness, and difficulty walking.

Client #10's "Physical Management Plan," dated 07/03/2024, revealed that Client #10 was no longer safe to ascend or descend the van steps, even with assistance. The plan indicated that a wheelchair must be used for boarding and exiting the van.

An "Investigator's Summary," dated 01/02/2025, revealed that on 12/31/2024 at approximately 9:15 AM, Client #10 was being assisted up the steps of the facility-owned bus in preparation for an outing; Client #10 fell backwards and struck the ground. The Investigator's Summary revealed staff failed to adhere to established fall protocols and proceeded with the planned outing despite the incident. The Investigator's Summary revealed LPCT #1 and LPCT #2 violated Client #10's PMP by removing them from their wheelchair and having them walk up the steps of the van. The Investigator's Summary revealed the facility substantiated the allegation of neglect against LPCT #1 and LPCT #2. Further review of the Investigator's Summary indicated that during the outing, staff observed swelling to the back of Client #10's head and returned to the client's

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SOUTHEASTERN VIRGINIA TRAINING	2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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house. The summary indicated that once the staff returned to the house, the nursing staff was contacted and Client #10 was sent out to the hospital, where they were diagnosed with a C6-C7 cervical fracture. The results of the investigation indicated LPCT #2 and LPCT #1 failed to follow Client #10's individualized service plan, failed to ensure the client received immediate and appropriate medical attention, and failed to report physical injuries "without reasonable justification."

During an interview on 04/14/2025 at 9:52 AM, PCT #3 stated she was working on 12/31/2024. PCT #3 stated she was helping get her client onto the van using the wheelchair lift and did not see the whole incident with Client #10. PCT #3 stated that after she got her client onto the van, she assisted LPCT #1 and LPCT #2 with getting Client #10 off the ground and onto the van. PCT #3 stated they drove around with the clients and did not get out of the van during the outing. PCT #3 stated that when LPCT #1 and LPCT #2 noticed that Client #10's head was swelling, they went back to the house and notified the nurse.

During an interview on 04/14/2025 at 11:45 AM, the Security Supervisor (SS) stated that during his investigation, the interviews from LPCT #1 and LPCT #2 did not match up with PCT #3's interview. The SS stated that because there was a discrepancy, he reviewed camera footage and saw that Client #10 fell getting on the bus and that LPCT #1 and LPCT #2 got the client up and into the bus, then left for the outing. He stated that once he determined that the staff lied about what happened, he interviewed LPCT #1 and LPCT #2 a second time, and that was when they stated they were scared to report it once they

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W 127	Continued From page 14 realized the seriousness of the injury. The SS stated that at the conclusion of his investigation, the allegation of neglect involving LPCT #1 and LPCT #2 was substantiated. During an interview on 04/14/2024 at 2:30 PM, the Facility Director (FD) stated that staff failing to report a fall according to the Falls Management Policy was considered neglectful. The FD stated that LPCT #1 and LPCT #2 should have immediately reported the fall before they left on the outing. The FD stated that LPCT #1's and LPCT #2's employments were terminated at the conclusion of the investigation.	W 127		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure staff notified the Facility Director immediately of allegations of abuse and neglect for 2 (Client #10 and Client #11) of 9 clients reviewed for abuse. Findings included: A facility policy titled, "Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities," revised 08/31/2009, revealed the section titled, "Procedures - Reporting," included, "Any	W 153		

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workforce member who has any knowledge or reason to believe that an individual residing in a state facility may have been abused or neglected, or both, shall immediately report this information directly to the facility director, or designee, as appropriate."

1. A facility policy titled, "Falls Management," dated 08/01/2022, revealed the section titled, "4. Procedures," included, "E. Reporting, Responding and Documenting All Falls: Following all falls, staff will notify Nursing immediately after all falls for assessment."

Client #10's "[Facility Name] Individual Support Plan" revealed the client was admitted to the facility on 06/25/1985. The support plan revealed the client had a medical history that included diagnoses of falls, severe intellectual disability, autistic disorder, quadriceps weakness, weakness, and difficulty walking.

Client #10's "Physical Management Plan [PMP]," dated 07/03/2024, revealed the client was no longer safe to ascend or descend van steps even with assistance. The PMP revealed that a wheelchair should be utilized for transfers on and off the van.

An "Investigator's Summary," dated 01/02/2025, revealed that on 12/31/2024 at approximately 9:15 AM, Client #10 was being assisted up the steps of the facility-owned bus in preparation for an outing; Client #10 fell backwards and struck the ground. The Investigator's Summary revealed staff failed to adhere to established fall protocols and proceeded with the planned outing despite the incident. The Investigator's Summary revealed Lead Psychiatric Care Technician

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(LPCT) #1 and LPCT #2 violated Client #10's PMP by removing them from their wheelchair and having them walk up the steps of the van. The Investigator's Summary revealed the facility substantiated the allegation of neglect against LPCT #1 and LPCT #2. The Investigator's Summary revealed that the incident was reported by Psychiatric Care Technician (PCT) #3 on 01/02/2025.

During an interview on 04/14/2025 at 9:52 AM, PCT #3 stated she had been working on the day of 12/31/2024. PCT #3 stated she had been pulled from her normal house to the house where Client #10 lived. PCT #3 stated she was helping get her client onto the van using the wheelchair lift and did not see the whole incident with Client #10. PCT #3 stated that after she got her client onto the van, she assisted LPCT #1 and LPCT #2 in getting Client #10 up off the ground and onto the van. PCT #3 stated they drove around with the clients and did not get out of the van during the outing. PCT #3 stated that when LPCT #1 and LPCT #2 noticed that Client #10's head was swelling, they went back to the house and notified the nurse. PCT #3 stated she was a new staff member, and she trusted the other staff members, who had worked at the facility for a while, that they were following the proper policy and procedure for falls at the time of Client #10's fall.

During an interview on 04/14/2025 at 2:30 PM, the Facility Director stated that staff failing to report a fall according to the Falls Management Policy was considered neglectful. The Facility Director stated that LPCT #1 and LPCT #2 should have immediately reported the fall before they left on the outing.

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2. A "Face Sheet" revealed the facility admitted Client #11 on 07/02/1984. According to the Face Sheet, the client had a medical history that included a diagnosis of intellectual developmental disorder.

An "Investigator's Summary," dated 08/23/2024, revealed that on 08/15/2024 at approximately 5:10 PM, the Facility Director received a statement that alleged Psychiatric Care Technician (PCT) #9 had inappropriately touched Client #11's genitalia on 07/30/2024. The Investigator's Summary also revealed that PCT #9 had made inappropriate comments in the presence of Client #11. The Investigator's Summary revealed the incident was reported by PCT #3 and PCT #10 to the Facility Director on 08/15/2024.

During an interview on 04/14/2025 at 9:52 AM, PCT #3 stated that she was not paying attention to what PCT #9 was saying and talking about until the investigation was started, and she tried to recall what was said during the incident. PCT #3 stated PCT #9 had a crude way of talking "all of the time." PCT #3 said most of what PCT #9 talked about was inappropriate. PCT #3 said she did not report it because she never paid attention to what PCT #9 said.

During an interview on 04/14/2025 at 2:30 PM, the Facility Director stated that staff should follow policy and procedure and report any allegations of abuse and neglect immediately to her. The Facility Director stated that PCT #3 and PCT #10 had failed to report the allegations of abuse immediately to her.

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W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review, interview, and document review, the facility failed to complete a thorough investigation by failing to interview staff on different shifts to determine if there was systemic abuse and/or neglect for 9 (Clients #3, #6, #7, #8, #9, #10, #11, #12, and #13) of 9 clients reviewed for abuse. Findings included: 1. A "Face Sheet" revealed the facility admitted Client #12 on 06/06/2006. According to the Face Sheet, the client had a medical history that included a diagnosis of intellectual disability. An "Investigator's Summary," dated 05/27/2024, revealed that, on 05/27/2024, Client #12 sustained a hematoma to the right side of their forehead. Per the document, Psychiatric Care Technician (PCT) #5 called a licensed practical nurse (LPN) to assess Client #12. On 05/28/2024 at approximately 10:00 AM, the Environment of Care Director (ECD) reviewed a video of the event leading to the injury, which showed PCT #17 pushed Client #12's head into a wall. The ECD contacted the acting Facility Director, who then initiated an investigation. The review revealed that only staff involved in the 05/27/2024 incident were interviewed as part of the investigation. The investigation lacked evidence that other staff from different shifts were interviewed to ensure there were not systemic issues regarding abuse or neglect.	W 154		

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2. A "Face Sheet" revealed the facility admitted Client #11 on 07/02/1984. According to the Face Sheet, the client had a medical history that included a diagnosis of intellectual developmental disorder.

An "Investigator's Summary," dated 08/23/2024, revealed that, on 08/15/2024, Psychiatric Care Technician (PCT) #3 and PCT #10 submitted formal statements to their manager concerning an incident they alleged they witnessed on 07/30/2024 in a particular house. The incident involved PCT #9, who allegedly engaged in both verbal and physical abuse toward Client #11 while addressing the client's leaking colostomy bag. Per the allegation, PCT #9 made inappropriate comparisons between Client #11's erect penis and that of another individual from a different residence, followed by physically grabbing Client #11's erect penis in a non-therapeutic manner, all in the presence of three other staff members. The review revealed that only staff involved in the 07/30/2024 incident were interviewed as part of the investigation. The investigation lacked evidence that other staff from different shifts were interviewed to ensure there were not systemic issues regarding abuse or neglect.

3. A "Face Sheet" revealed the facility admitted Client #3 on 01/25/2005. According to the Face Sheet, the client had a medical history that included a diagnosis of intellectual developmental disorder.

A "Face Sheet" reveled the facility admitted Client #6 on 03/23/2004. According to the Face Sheet, the client and a medical history that included a diagnosis of intellectual developmental disorder.

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A "Face Sheet" revealed the facility admitted Client #7 on 02/27/2020. According to the Face Sheet, the client and a medical history that included a diagnosis of intellectual developmental disorder.

A "Face Sheet" revealed the facility admitted Client #8 on 04/30/2015. According to the Face Sheet, the client and a medical history that included a diagnosis of intellectual developmental disorder.

A "Face Sheet" revealed the facility admitted Client #9 on 02/05/2020. According to the Face Sheet, the client and a medical history that included a diagnosis of intellectual developmental disorder.

An "Investigator's Summary," dated 08/26/2024, revealed that, on 08/26/2024, Lead Psychiatric Care Technician (LPCT) #13 called the Assistant Director of Residential to allege that LPCT #14 was witnessed inhaling the contents of an aerosol can, and that LPCT #14 appeared to be disoriented while they provided care to Clients #3, #6, #7, #8, and #9. The allegation of neglect was substantiated after completion of the investigation. The review revealed that only staff involved in the 08/26/2024 incident were interviewed as part of the investigation. The investigation lacked evidence that other staff from different shifts were interviewed to ensure there were not systemic issues regarding abuse or neglect.

4. A "Face Sheet" revealed the facility admitted Client #13 on 12/28/1995. According to the Face Sheet, the client had a medical history that

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included a diagnosis of intellectual disability.

An "Investigator's Summary," dated 12/09/2024, indicated Client #13 was attempting to enter another individual's bedroom, where PCT #6 was assisting another client with changing. Per the document, Client #13 entered the room and PCT #6 asked Client #13 to leave. Per the document, PCT #8 entered the area and also requested that Client #13) leave the room. PCT #8 and Client #13 were then heard yelling at each other. Both PCT #8 and Client #13 were seen grabbing and hitting each other. Further review revealed that Client #13 had a nose bleed after the interaction with PCT #8. The document noted that PCT #6 summoned a nurse to assess Client #13 approximately 40 minutes after the altercation. The review revealed that only staff involved in the 12/09/2024 incident were interviewed as part of the investigation. The investigation lacked evidence that other staff from different shifts were interviewed to ensure there were not systemic issues regarding abuse or neglect.

5. A "Face Sheet" revealed the facility admitted Client #10 on 06/25/1985. According to Client #10's "[Facility initialism] Individual Support Plan," the client had a medical history that included diagnoses of falls, severe intellectual disability, autistic disorder, quadriceps weakness, weakness, and difficulty walking.

An "Investigator's Summary," dated 01/02/2025, revealed that, on 12/31/2024, staff assisted Client #10 up the stairs of a facility-owned van. While they assisted Client #10, Client #10 began to fall backward and struck the ground. Staff assisted Client #10 off the ground and then continued with their planned outing. The review revealed that

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W 154	Continued From page 22 only staff involved in the 12/31/2024 incident were interviewed as part of the investigation. The investigation lacked evidence that other staff from different shifts were interviewed to ensure there were not systemic issues regarding abuse or neglect. During an interview on 04/14/2025 at 11:45 AM, the Security Supervisor (SS) stated he only interviewed staff involved in the 05/27/2024, 07/31/2024, and 12/31/2024 incidents and did not interview any staff from other shifts to ensure there were not any systemic issues that involved abuse and/or neglect. The SS indicated he was only concerned with the incident at hand and not systemic issues. The SS noted he investigated the allegations that occurred on 05/27/2024, 07/30/2024, and 12/31/2024 only. During an interview on 04/14/2025 at 12:39 PM, Assistant Director of Residential (ADR) #15 stated he only interviewed staff involved in the 08/26/2024 and 12/09/2024 incidents and did not interview any additional staff from other shifts to ensure there were not any systemic issues that involved abuse and/or neglect. ADR #15 noted he investigated the allegations that occurred on 08/26/2024 and 12/09/2024. During an interview on 04/14/2024 at 2:30 PM, the Facility Director stated investigators should complete a thorough investigation by interviewing additional staff from other shifts to ensure that a systemic failure was not present.	W 154		
W 156	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) The results of all investigations must be reported	W 156		

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W 156	Continued From page 23 to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure abuse investigation results were reported to the Facility Director within five working days for 1 (Client #11) of 9 clients reviewed for abuse. Findings included: A facility policy titled, "Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities," revised 08/31/2009, revealed a table titled, "Roles and Responsibilities," that indicated the role of "The Investigator," included, "Complete the investigation within the required timeframes -Within 5 working days for cases that are reported to the Department of Health or when an employee has been suspended." The policy revealed, "Submit a summary report of findings, documentary evidence and preliminary determination with signature and date. Forward a copy of the summary report to the facility director and human rights advocate. Brief the facility director and facility advocate regarding case findings." A "Face Sheet" revealed the facility admitted Client #11 on 07/02/1984. According to the Face Sheet, the client had a medical history that included a diagnosis of intellectual developmental disorder. An "Investigator's Summary," dated 08/23/2024, revealed that on 08/15/2024 at approximately	W 156		

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W 156	Continued From page 24 5:10 PM, the Facility Director received a statement that alleged Psychiatric Care Technician (PCT) #9 had inappropriately touched Client #11's genitalia on 07/30/2024. The Investigator's Summary also revealed that PCT #9 had made inappropriate comments in the presence of Client #11. An attached "Memorandum," dated 08/23/2024, revealed the Security Supervisor had attached the investigative report of findings to the Memorandum and submitted it to the Acting Facility Director. During an interview on 04/14/2025 at 2:30 PM, the Facility Director indicated that completed investigations should be submitted to her within five working days of the incident. The Facility Director indicated that she had not received the completed investigation within five working days for the incident involving Client #11 (that occurred on 07/30/2024).	W 156		
W 157	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure staff were retrained on immediate reporting of an allegation of neglect for 1 (Client #10) of 9 clients reviewed for abuse. Findings included: A facility policy titled, "Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities," revised	W 157		

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08/31/2009, revealed the section titled, "Procedures - Reporting," included, "Any workforce member who has any knowledge or reason to believe that an individual residing in a state facility may have been abused or neglected, or both, shall immediately report this information directly to the facility director, or designee, as appropriate."

A facility policy titled, "Falls Management," dated 08/01/2022, revealed the section titled, "4. Procedures," included, "E. Reporting, Responding and Documenting All Falls: Following all falls, staff will notify Nursing immediately after all falls for assessment."

Client #10's "[Facility Name] Individual Support Plan," revealed the client was admitted to the facility on 06/25/1985. The support plan revealed the client had a medical history that included diagnoses of falls, severe intellectual disability, autistic disorder, quadriceps weakness, weakness, and difficulty walking.

Client #10's "Physical Management Plan [PMP]," dated 07/03/2024, revealed the client was no longer safe to ascend or descend van steps even with assistance. The PMP revealed that a wheelchair should be utilized for transfers on and off the van.

An "Investigator's Summary," dated 01/02/2025, revealed that on 12/31/2024 at approximately 9:15 AM, Client #10 was being assisted up the steps of the facility-owned bus in preparation for an outing; Client #10 fell backwards and struck the ground. The Investigator's Summary revealed staff failed to adhere to established fall protocols and proceeded with the planned outing despite

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G005	A. BUILDING _____ B. WING _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHEASTERN VIRGINIA TRAINING	2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 157	Continued From page 26	W 157		

the incident. The Investigator's Summary revealed Lead Psychiatric Care Technician (LPCT) #1 and LPCT #2 violated Client #10's PMP by removing them from their wheelchair and having them walk up the steps of the van. The Investigator's Summary revealed the facility substantiated the allegation of neglect against LPCT #1 and LPCT #2.

During an interview on 04/14/2025 at 9:52 AM, Psychiatric Care Technician (PCT) #3 stated she had been working on the day of 12/31/2024. PCT #3 stated she had been pulled from her normal house to the house where Client #10 lived. PCT #3 stated she was helping get her client onto the van using the wheelchair lift and did not see the whole incident with Client #10. PCT #3 stated that after she got her client onto the van, she assisted LPCT #1 and LPCT #2 in getting Client #10 up off the ground and onto the van. PCT #3 stated they drove around with the clients and did not get out of the van during the outing. PCT #3 stated that when LPCT #1 and LPCT #2 noticed that Client #10's head was swelling, they went back to the house and notified the nurse.

PCT #3's personnel record did not indicate they had been retrained on the Falls Management Plan after the 12/31/2024 incident.

During an interview on 04/14/2025 at 2:30 PM, the Facility Director stated PCT #3 should have been retrained on the Falls Management Policy after the 12/31/2024 event but was not retrained.