STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Lifelong H & R Warwick Forest	1000 Old Denbeigh Boulevard Newport News, VA 23602

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, family interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to notify the resident's family representative of two pressure ulcers identified on 7/09/25 for 1 of 17 residents (Resident #15), in the survey sample. Resident #15 was initially admitted to the facility on [DATE] and readmitted on [DATE] from the community. The current diagnoses included cerebral vascular Disease. The admission, significant change, annual quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/15/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This indicated Resident #15 cognitive abilities for daily decision making were severely intact.In sectionGG(Functional Abilities) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, eating, toileting, personal hygiene. In section M (Skin Conditions) Number of stage 2 pressure ulcers =1. Number of unstageable with slough/eschar =1. The care plan dated 7/24/25 read: the resident has pressure injuries and the potential for pressure injury development r/t Hx of ulcers, Immobility, incontinence, and end-of-life process. Unstageable to sacrum and Stage 2 to sacrum (resolved 7/24/25). The Goals for the resident included: Pressure ulcer will show signs of healing and remain free from infection through review date. The Interventions for the resident included: Inform the resident/family/caregivers of any new area of skin breakdown and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate.A review of an incident dated 7/09/25, Late Entry at 10:30 am, read: Resident was found on the floor of her room on the fall mat. Family has been contacted and notified as well as providers. Will continue to monitor. The timeline revealed the following: 1.7/09/25-Resident had a fall around 10:30 am. Family was notified of the fall. (According to the incident note. The family was notified of a fall that occurred on 7/09/25, but wasn't notified of an advanced-stage pressure ulcer nor a stage 2 pressure ulcer on the resident's sacrum and buttocks, which was identified hours after the resident's fall.2.7/09/25- Unstageable wound to the sacral area and stage 2 wound to the buttocks identified at 7:11 am. A review of a Skin/Wound Note Effective Date: 07/09/2025 at 7:11 pm., read: The resident presents with an unstageable wound to the sacral area and stage 2 wound to the buttock from shearing. Treatment order applied to prevent deterioration; however, hospice was notified. Awaiting a call back to verify or change the wound treatment order.According to the medical records, Resident #15's daughter was not notified on 7/09/25 concerning the staff identifying the two pressure ulcers that were later found in the evening around 7:11 pm. According to the medical records, the resident's daughter was notified of the resident having a fall on the morning of 7/09/25 at 10:30 am.On 8/21/25 at approximately 12:22 pm., a phone call was made to Resident #15's daughter (Resident Representative) concerning her wounds. She said that she was informed that her mother had a bedsore about three weeks ago. On 8/21/25 at approximately 4:40 pm., an interview was conducted with LPN #6. LPN #6 said that the unstageable sacral wound was first identified on 7/09/25, as well as the stage 2 wound on the resident's buttocks. LPN #6 also said that she was not working on 7/09/25 and had assumed the resident's daughter had been notified of the wounds, but after conducting a chart audit, she did not see that the daughter had been contacted initially, but she notified her on 7/21/25. LPN #6 also mentioned that the Director of Nursing (DON) notified hospice on 7/09/25. LPN #6 also said that it's not acceptable to first identify a wound as unstageable.On 8/22/25 at approximately 4:40 pm., an interview was conducted with the Director of Nursing (DON). The DON said that on 7/09/25, Resident #15's sacral area had yellow slough, and the buttocks had a sheared area. The DON also mentioned that she had called Hospice, not the resident's daughter.On 8/25/25, a pre-exit interview was conducted at approximately 11:40 am. The above findings were shared with the Administrator, Director of Nursing, and Corporate Consultant. They had no comments and voiced no further concerns regarding the above information

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews and review of facility documentation the facility staff failed to ensure resident care and services were provided in accordance with accepted standards of clinical practice for medication administration for 1of 17 residents. Resident #11.Findings included: For Resident #11, the facility staff failed to administer her scheduled Gabapentin (a seizure medication commonly used for neuropathic pain) on 2/17/24 at 8:00 PM, 2/18/24 at 8:00 AM, midday and 8:00 PM, 2/19/24 at 8:00 AM and midday as ordered by the physician.Resident #11 was originally admitted to the facility on [DATE] with diagnoses including but not limited to: hypertension, major depressive disorder, chronic pain, insomnia, muscle spasms, reduced mobility, anxiety, treatment for malignant neoplasm right kidney, cardiomegaly, polyneuropathy, chronic pulmonary disease, morbid (severe) obesity due to excessive calories, osteoporosis, atrial fibrillation and peripheral vascular disease. On the most recent MDS (Minimum Data Set) a Quarterly Assessment with ARD (assessment reference date) of 5/13/25, Section C: Cognitive Patterns was coded as 15 out of 15, as cognitively intact. This indicates Resident #11 cognitive ability for daily decision making is intact. On 8/19/25 approximately 1:00 PM an interview was conducted with Resident #11 to review incident of her scheduled Gabapentin not administered on 2/17/24 through 2/19/24. During the interview Resident #11 initially stated she had never missed any medications. I shared with her the report from the Ombudsmen where the resident had left her a message on 2/19/24 stating she had not received her Gabapentin on evening of 2/17/24 through 2/19/24. She replied, Oh, yes, I call her all the time about lots of things. I remember now, that was a long time ago. Yes, I didn't get them for a few days. When asked about any pain she experienced as a result of the missing Gabapentin she stated, No, not that I remember, my pain is always about the same. I have arthritis. When asked why she was still in bed at 1:00 PM in the afternoon she replied, Oh, they usually get me up in the mornings, but I fell asleep again after breakfast, so they let me sleep in. I have problems with insomnia, so they let me sleep a little longer in the mornings sometimes. I asked her how her pain was today, and she replied, Oh it's ok today. Further interview about if she had any other incidents about missing her Gabapentin and she replied, Oh, they are late sometimes with my morning Gabapentin but that about it. I asked her why she was prescribed Gabapentin, and she replied, I have nerve pain. On 8/19/25 at 1:30 PM a control drug count was completed on 2 of the medication carts on the Rehab Unit with LPN#2 and LPN# 3 to verify medications were available. A review of physician orders revealed Resident #11 had an order for Gabapentin 300 MG Give 1 capsule by mouth three times a day for Neuropathy Start Date 2/2/24. A review of the medication administration record for 2/17/24 through 2/19/24 revealed: 2/17/24 at 8:00 PM coded as 9 [Code 9 means See nurses Notes] 2/18/24 at 8:00 AM, midday and 8:00 PM coded as 9 2/19/24 at 8:00 AM - blank/hole in the medication administration record, midday dose coded 9A review of the progress notes for code 9 revealed:2/17/24 at 8:43 PM, the nurse documented that she re-ordered the Gabapentin 2/18/24 at 8:00 AM, no explanation of code 9 2/18/24 at 2:01 PM, no explanation of code 9 2/18/24 at 10:02 PM the nurse documented new script needed 2/19/24 at 8:25 AM the nurse documented MD (physician) was notified about resident's missing Gabapentin. There is a current order with 90 refills remaining signed on 2/2/24 by the MD (physician), however, [name redacted] pharmacy provider is stating she does not have an active order. 2/19/24 at 1:36 PM, (midday dose) medication order noted, no explanation of code 9 2/19/24 at 6:36 PM, nurse documented Received a one-time pull code to administer Gabapentin 300mg. Spoke with (name redacted) physician and he stated to give the resident her scheduled Gabapentin 300mg at HS. On-coming nurse made aware.A review of the Medication Administration Record for assessment of Resident #11's pain revealed:2/17/24 No pain 2/18/24 No pain 2/19/24 No pain until night shift, and nurse assessed as a 5 out of 10 for pain in the right lower backOn 8/20/25 at approximately 12:45 PM, an interview was conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on what code 9 meant on the Medication Administration Record, and the DON replied, the nurse is to document an explanation in the progress notes. A request for the Medication Administration and When Medications are not Available Policies. At 3:27 PM, the Assistant Director of Nursing provided a copy of the facility's Medication Administration Policy #6562. On page 1 of 5 pages, the policy revealed Medications will be administered in accordance with regulatory guidelines, infection control, and clinical practice standards. On page 4 of 5 pages, Procedure #14. revealed Medication Refusal - Remember to document the non-administration of scheduled doses. Document medication not administered

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, clinical record review, and review of facility documents, the facility staff failed to provide adequate supervision to prevent accidents for 1 of 17 residents (Resident #8) in the survey sample, which constituted harm. The findings included: The facility staff failed to provide adequate supervision to ensure Resident #8 was safe from falling while ambulating, which constituted harm. Resident #8 was no longer a resident of the facility; therefore, a closed record review was conducted. Resident #8 was admitted to the facility on [DATE] after a hospital stay. The resident's diagnoses included unspecified nondisplaced fracture of the second cervical vertebra, nondisplaced intertrochanteric fracture of the right femur, vascular dementia, and muscle weakness. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/6/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 03 out of a possible 15. This indicated Resident #8’s cognitive abilities for daily decision making were severely impaired. A review of section “GG” (Functional Abilities and Goals) dated 11/6/24 of Resident #8’s Minimum Data Set (MDS) coded the resident as partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for Walk 10 feet (once standing, the ability to walk at least 10 feet in a room, corridor, or similar space), partial/moderate assistance for Walk 50 feet with two turns, and partial/moderate assistance for Walk 150 feet. A care plan problem dated 1/14/24 read, risk for falls. The goal read, resident will be free of falls. The interventions included assist resident with ambulation and transfers, utilizing therapy recommendations. Determine Residents ability to transfer. If fall occurs, alert provider. If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol. If Resident is a fall risk, initiate fall risk precautions. A synopsis of an event dated 12/20/24 revealed that Resident #8 had an unwitnessed fall in another resident's room. The resident was lying in the corner of the room with his head against the heater and his walker on top of him. The resident was sent to the emergency room and was diagnosed with a closed nondisplaced fracture of the second cervical vertebra and a closed nondisplaced intertrochanteric fracture of the right femur. On 8/22/25 at 10:46 AM, an interview was conducted with Licensed Practical Nurse (LPN) #5. LPN #5 stated that Resident #8 had an unwitnessed fall on 12/20/24 in another resident's room and was not being supervised by facility staff. LPN #5 also stated that she was the only Nurse working with two Certified Nursing Assistants (CNA) in the memory unit during this shift. LPN #5 further said that there was not enough staff to provide care for the residents on the memory care unit. LPN #5 lastly stated, “We have asked, asked, and asked, and they would never give us 3 (three) CNAs on the memory care unit. With only three staff members working, residents are unable to be supervised as they should be. This could have absolutely prevented falls such as (Resident name).” (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/22/25 at 12:30 PM, an interview was conducted with the MDS (Minimum Data Set) Coordinator. The MDS Coordinator stated that Resident #8 was coded in section “GG” (Functional Abilities and Goals) dated 11/6/24 as requiring partial/moderate assistance for ambulating. The MDS Coordinator also stated that partial/moderate assistance means that the staff should lay hands on the resident such as on the elbow, hand, arm, the walker, or even using a gait belt while the resident is ambulating. The MDS Coordinator further stated that the staff should have been assisting and supervising Resident #8 with ambulation. On 8/22/25 at 1:36 PM, an interview was conducted with Certified Nursing Assistant (CNA) #1. CNA #1 stated that Resident #8 was not being supervised when he had an unwitnessed fall with injuries. CNA #1 also stated that the staff did not know that Resident #8 required partial/moderate assistance for ambulating. CNA #1 further stated that information such as this is not communicated to the CNAs. On 8/22/25 at 2:10 PM, an interview was conducted with the Certified Occupational Therapy Assistant. The Certified Occupational Therapy Assistant stated that Resident #8 was a fall risk and required supervision for functional transfers and ambulation on the memory care unit. The Certified Occupational Therapy Assistant also stated that Resident #8 required supervision using his front-wheeled walker and needed occasional verbal cues while using his front-wheeled walker. The Certified Occupational Therapy Assistant further stated that Resident #8 required supervision for safety while ambulating to prevent a fall. A review of Resident #8's Interdisciplinary Therapy Screen dated 11/24/24 at 12:04 PM read: Ambulation: Comments: supervision using FWW with occasional VC to use walker. Safety/Restraint Issues: fall risk Additional Comments: Per Nursing and Chart review: Patient is at baseline and continues to require Minimal assistance with all ADLs and supervision for functional transfers and ambulation on the unit. No change in functional status. No therapy needs at this time. A review of Resident #8's nurse's note dated 12/20/24 at 6:22 PM read: Resident was observed lying on the floor in room [ROOM NUMBER]. Resident was lying in the corner of the room with his head against the heater and his walker on top of him. Resident complaining of right leg and hip pain. Skin tear noted to his right elbow. Pillow placed behind residents head and RN supervisor called to assess resident. Resident calling out in pain when right leg manipulated. Per RN supervisor Send resident to ER Emergency transfer . RP called and notified. Resident transported via EMS stretcher at 1800. On call provider notified of transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #8's nurse's note dated 12/20/24 at 6:47 PM read: Fall Details: Date / Time of Fall: 12/20/2024 5:15 PM Fall was not witnessed. Fall occurred elsewhere. Other fall location: another resident's room. Activity at the time of fall: unknown. Reason for the fall was evident. Reason for fall: resident was stuck between the dresser and the wall. Did an injury occur as a result of the fall: Yes. Injury details: skin tear to right elbow and right hip pain Did fall result in an ER visit/hospitalization: Yes. ER Visit/Hospitalization Details: sent to ER for eval Provider: message left for on call provider. and in communication book Time notified: 12/20/2024 Notified of: fall with possible injury to right hip Fall Details Note: Resident was observed lying on the floor in room [ROOM NUMBER]. Resident was lying in the corner of the room with his head against the heater and his walker on top of him. Resident complaining of right leg and hip pain. Skin tear noted to his right elbow. Pillow placed behind residents head and RN supervisor called to assess resident. Resident calling out in pain when right leg manipulated. Per RN supervisor Send resident to ER Emergency transfer . RP called and notified. Resident transported via EMS. A review of Resident #8’s General Hospital Discharge summary dated [DATE] read: Assessment and Plan: closed nondisplaced fracture of second cervical vertebra, and closed nondisplaced intertrochanteric fracture of right femur. (Resident name) is a [AGE] year-old Caucasian gentlemen with a history of dementia who presented to the emergency department after sustaining an unwitnessed fall at his memory care unit where he resides. The patient sustained multiple traumatic injuries. For this reason the Trauma service was contacted regarding admission. On 8/25/25 at approximately 1:05 PM, a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, Assistant Chief Nursing Officer, and Director of Clinical Education. 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.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, staff interviews, and review of the clinical record, the facility staff failed to provide toileting upon request for 1 of 17 residents (Resident #2) in the survey sample. The findings included: Resident #2 was initially admitted to the facility on [DATE], after an acute care hospital stay. The resident's current diagnoses included an L2 - L5 laminectomy and fusion, and left upper extremity edema secondary to a left cephalic vein superficial vein thrombosis.The resident had not been admitted to the facility long enough for the Minimum Data Set (MDS) to be completed; therefore, the following information was obtained from the N Adv - Clinical admission dated 8/12/25. The assessment revealed the resident had mild cognitive impairment (some confusion). The Mobility assessment dated [DATE] revealed: Upper extremity (shoulder, elbow, wrist, hand): No impairment. Lower extremity (hip, knee, ankle, foot): No impairment. Wheelchair (manual or electric). Roll left and right: admission Performance: Partial/moderate assistance. Sit to lying: admission Performance: Partial/moderate assistance. Lying to sitting on the side of the bed: admission Performance: Partial/moderate assistance. Sit to stand: admission Performance: Dependent. Chair/bed-to-chair transfer: admission Performance: Dependent. Toilet transfer: admission Performance: Not attempted due to medical condition or safety concerns. Tub/shower transfer: admission Performance: Not attempted due to medical condition or safety concerns. Car transfer: admission Performance: Not attempted due to medical condition or safety concerns. A note on the whiteboard in the resident's room on 8/21/25 stated she required two persons assistance with transfers using the [NAME] Stedy lift.On 8/19/25 at 12:46 PM, Resident #2 was observed seated in a chair at bedside with her back brace lying on the bed. Resident #2 stated that she was constipated, but currently she had diarrhea. The resident further stated she had awakened with diarrhea up her back. The resident stated that she knows when she needs to use the toilet, but she was encouraged to wear an incontinence brief in case she had another accident. The resident also stated that most of the time, she was unable to get the staff to respond in time for her to utilize the toilet. The resident stated she frequently had an accident because the nurses are unable to locate the lift ([NAME] Stedy) they use to transfer her with, or there is no nurse to assist the assigned nurse. Resident #2 stated that she will need to be able to toilet herself before returning home, as she will not have anyone to assist her. On 8/21/25 at 1:10 PM, the resident stated the toileting concerns had not changed, and she was still wearing incontinence briefs.An interview was conducted with the interim Rehabilitation Director (RD) on 8/20/25 at 12:25 PM. The RD stated that the rehabilitation team communicated the resident's ability to transfer to the nursing staff by writing on the whiteboard in the resident's room.On 8/25/25 at 10:50 AM, the above information was shared with the Administrator, Director of Nursing (DON), the Assistant DON, two Unit Managers, and the Assistant Chief Nursing Officer. The Administrator stated that there are sufficient [NAME] lifts in the facility, and each unit has one to two lifts. The Administrator also stated that two persons are not required to use the [NAME] lift; therefore, she would follow up on the reason the instructions were for two persons.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, resident interviews, staff interviews, and review of the clinical record, the facility staff failed to manage acute pain secondary to fractures for 1 of 17 residents (Resident #1) in the survey sample. The findings included: Resident #1 was initially admitted to the facility 8/13/25, after an acute care hospital stay for a fall with fractures. The resident's current diagnoses included fibromyalgia, acute on chronic lower back pain, a right distal radius fracture, and status post L4 - L5 lumbar laminectomy with fixation and TLIF pedicle screw fixation on 08/07/25. The resident had not been admitted to the facility long enough for the Minimum Data Set (MDS) to be completed; therefore, the following information was obtained from the N Adv - Clinical admission dated 8/13/25. The assessment revealed the resident was alert and oriented three times. The resident communicated verbally; her speech was clear, and she was able to understand and be understood when speaking. The following self-care information was documented in the nurse's notes by the MDS Coordinator: Mobility: Upper extremity (shoulder, elbow, wrist, hand): Impairment on one side. Lower extremity (hip, knee, ankle, foot): No impairment. Roll left and right: admission Performance: Supervision or touching assistance. Sit to lying: admission Performance: Supervision or touching assistance. Lying to sitting on side of bed: admission Performance: Supervision or touching assistance. Sit to stand: admission Performance:Dependent. Chair/bed-to-chair transfer: admission Performance: Dependent. Toilet transfer: admission Performance: Dependent. Tub/shower transfer: admission Performance: Not attempted due to medical condition or safety concerns. Car transfer: admission Performance: Not attempted due to medical condition or safety concerns.On 8/19/25 at 12:37 PM, Resident #1 was observed seated in a chair at the bedside, wearing a back brace and a right hand splint daily. An interview was conducted with the resident. The resident stated that her pain was not being treated effectively, and whenever she requests pain medication, the nurses bring it when they want to. The resident further said she had chronic back pain, degenerative joint disease, old back fractures, osteoporosis, and fibromyalgia, which was maintained at home with Acetaminophen. The resident stated that the pain she currently had could not be treated with Acetaminophen, for it was too severe.The resident said she had a recent fall at home, which resulted in a vertebral fracture and a right wrist fracture, and she had not walked since the fall. The resident stated during the interview that she was experiencing pain in her back, right hip, thigh, and knee. She further stated she was administered Oxycodone 5 milligrams (mg) three times each day, but was no longer receiving the medication, and no one explained to her why. The resident also stated she was not sleeping because of the pain, and her appetite had plummeted because the pain was so severe. The resident stated she was taking Trazodone at home to sleep, and if she was receiving it at the rehabilitation facility, it was not working.On 8/20/25, at approximately 10:50 AM, Resident #1 was revisited. She was seated at the bedside and again complained of the pain she was experiencing. On 8/21/25 at approximately 1:00 PM, Resident #1 was observed in bed. The resident continued to complain about the pain she was experiencing in her back and along her right side. A review of the resident's Medication Administration Record (MAR) revealed the resident had an order dated 8/13/25 through 8/19/25 for Acetaminophen tablet 325 mg two tablets by mouth every 6 hours as needed for mild pain, which was administered for three doses. The resident received a new order dated 8/19/25, at 1:00 PM for Acetaminophen tablet 500 mg, two tablets by mouth three times a day for pain. On 8/14/25, through 8/22/25, a Lidocaine Pain Relief External Patch 4% was ordered to be applied to the resident's back topically two times a day for pain. This order was reordered on 8/22/25. On 8/14/25, at 8:00 PM, an order was obtained for Pregabalin 50 mg capsules, give one capsule by mouth two times a day for pain. This order was discontinued on 8/19/25, at 11:56 AM and another order was obtained for Pregabalin 75 mg capsules, give one capsule by mouth two times a day for pain. The Medical Director (MD) stated during an interview by phone on 8/25/25 at 12:21 PM, that the Acetaminophen, Lidocaine patch, and Pregabalin were ordered to treat Fibromyalgia pain, which is a challenging pain to treat. Also on 8/13/25 through 8/18/25, the resident had an order for Oxycodone HCl 5 MG (give 2.5 mg) by mouth every 8 hours as needed for pain. The resident received nine administrations for pain rated four through nine. On 8/18/25 at 3:15 PM, the resident received an order for Oxycodone HCl 5 MG (Give 2.5 mg) by mouth every 8 hours as needed for pain. The resident received a dose on 8/19/25 at 8:27 AM for pain rated ten out of ten.From 8/18/25 at 8:26 AM through 8/19/25 at 8:27 AM, Tylenol was the only pain medication received. On 8/19/25, a one-time dose of Oxycodone HCl 5 mg (give 0.5 tablet by mouth) was administered at 3:22 PM for pain rated ten out of ten. On 8/19/25, at 12:00 PM another order was received for Oxycodone HCl 5 mg, give one

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	495071	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Lifelong H & R Warwick Forest	1000 Old Denbeigh Boulevard Newport News, VA 23602

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews and review of facility documentation the facility failed to provide pharmaceutical services to assure the accurate acquiring, receiving, dispensing and administration of drugs to meet the needs of each the resident for 1 of 17 residents. Resident #11.Findings included: For Resident #11, the facility staff failed to administer her scheduled Gabapentin (a seizure medication commonly used for neuropathic pain) on 2/17/24 at 8:00 PM, 2/18/24 at 8:00 AM, midday and 8:00 PM, 2/19/24 at 8:00 AM and midday as ordered by the physician.Resident #11 was originally admitted to the facility on [DATE] with diagnoses including but not limited to: hypertension, major depressive disorder, chronic pain, insomnia, muscle spasms, reduced mobility, anxiety, treatment for malignant neoplasm right kidney, cardiomegaly, polyneuropathy, chronic pulmonary disease, morbid (severe) obesity due to excessive calories, osteoporosis, atrial fibrillation and peripheral vascular disease. On the most recent MDS (Minimum Data Set) a Quarterly Assessment with ARD (assessment reference date) of 5/13/25, Section C: Cognitive Patterns was coded as 15 out of 15, as cognitively intact. This indicates Resident #11 cognitive ability for daily decision making is intact. On 8/19/25 approximately 1:00 PM an interview was conducted with Resident #11 to review incident of her scheduled Gabapentin not administered on 2/17/24 through 2/19/24. During the interview Resident #11 initially stated she had never missed any medications. I shared with her the report from the Ombudsmen where the resident had left her a message on 2/19/24 stating she had not received her Gabapentin on evening of 2/17/24 through 2/19/24. She replied, Oh, yes, I call her all the time about lots of things. I remember now, that was a long time ago. Yes, I didn't get them for a few days. When asked about any pain she experienced because of the missing Gabapentin she stated, No, not that I remember, my pain is always about the same. I have arthritis. When asked why she was still in bed at 1:00 PM in the afternoon she replied, Oh, they usually get me up in the mornings, but I fell asleep again after breakfast, so they let me sleep in. I have problems with insomnia, so they let me sleep a little longer in the mornings sometimes. I asked her how her pain was today, and she replied, Oh it's ok today. Further interview about if she had any other incidents about missing her Gabapentin and she replied, Oh, they are late sometimes with my morning Gabapentin but that about it. I asked her why she was prescribed Gabapentin, and she replied, I have nerve pain. On 8/19/25 at 1:30 PM a control drug count was completed on 2 of the medication carts on the Rehab Unit with LPN#2 and LPN# 3 to verify medications were available. A review of physician orders revealed Resident #11 had an order for Gabapentin 300 MG Give 1 capsule by mouth three times a day for Neuropathy Start Date 2/2/24. A review of the medication administration record for 2/17/24 through 2/19/24 revealed: 2/17/24 at 8:00 PM coded as 9 2/18/24 at 8:00 AM, midday, and 8:00 PM coded as 9 2/19/24 at 8:00 AM - blank/hole in the medication administration record, midday dose coded 9A review of the progress notes for code 9 revealed:2/17/24 at 8:43 PM the nurse documented that she re-ordered the Gabapentin 2/18/24 at 8:00 AM no explanation of code 9 2/18/24 at 2:01 PM no explanation of code 9 2/18/24 at 10:02 PM the nurse documented new script needed 2/19/24 at 8:25 AM the nurse documented MD (physician) was notified about resident's missing Gabapentin. There is a current order with 90 refills remaining signed on 2/2/24 by the MD (physician), however, (name redacted) pharmacy provider is stating she does not have an active order 2/19/24 at 1:36 PM (midday dose) medication order noted, no explanation of code 9 2/19/24 at 6:36 PM, nurse documented Received a one-time pull code to administer Gabapentin 300mg. Spoke with (name redacted), the physician, and he stated to give the resident her scheduled Gabapentin 300mg at HS. On-coming nurse made aware.On 8/20/25 at approximately 12:45 PM, an interview was conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on what code 9 meant on the Medication Administration Record, and the DON replied, The nurse is to document an explanation in the progress notes. A request for the Medication Administration and When Medications are not Available Policies. At 3:27 PM, the Assistant Director of Nursing provided a copy of the facility's Medication Administration Policy #6562. On page 1 of 5 pages, the policy revealed Medications will be administered in accordance with regulatory guidelines, infection control, and clinical practice standards. On page 4 of 5 pages, Procedure #14. revealed Medication Refusal - Remember to document the non-administration of scheduled doses. Document medication not administered in the electronic medical record and the reason. #15. Revealed When medication errors occur, they must be reported to the physician and resident representative notifications and have post monitoring documented as indicated. A review was conducted with

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, staff interview, clinical record review, and facility document review the facility staff failed to provide necessary documents for two Residents receiving hospice care (Resident #15, and 6) in a survey sample of 17 Residents. 1. The Facility staff failed to provide Hospice nurses' notes and wound care measurements pertaining to Resident #15. Resident #15 was initially admitted to the facility on [DATE] and readmitted on [DATE] from the community. The current diagnoses included cerebral vascular disease. The admission, significant change, annual quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of [DATE] coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This indicated that Resident #15's cognitive abilities for daily decision making were severely impaired. In sectionGG(Functional Abilities) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, eating, toileting, personal hygiene. In section “M” (Skin Conditions), the number of stage 2 pressure ulcers =1. Number of unstageable with slough/eschar =1. The care plan dated [DATE] read: Resident #15 has a terminal prognosis as of [DATE] prior to admission to the facility r/t Nutritional marasmus with hospice service. The Goal is to maintain comfort through the review date of [DATE]. The interventions are to Adjust provision of ADLS to compensate for resident's changing abilities, Encourage participation to the extent the resident wishes to participate, Observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain, Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. On [DATE] at approximately 12:05 pm, Licensed Practical Nurse (LPN) #6 was approached by two surveyors concerning hospice notes not found in the medical records. LPN #6 was asked for hospice notes dated [DATE] -[DATE]. [DATE] at approximately 1:00 pm., approached LPN #6 concerning the hospice notes and other documents not found in the resident’s medical records. LPN #6 stated that she will look for the communication binder that the hospice nurse writes in. [DATE] at approximately 1:38 pm., the administrator said that the hospice notes should be in the resident’s binder. [DATE] at approximately 1:45 pm., LPN #6 presented the surveyor with the Hospice Nurse Binder for Resident #15. A review of the Hospice Nurse’s binder revealed a care plan and other documents, but no nurses' notes were found. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at approximately 4:15 pm, an interview was conducted with the Hospice Nurse/Case Manager. The Hospice Nurse/Case Manager said, “We document in our system if the facility wants them (notes), we will fax them over. I mostly update the facility nurse who takes care of the resident.” The Hospice Nurse also said that the resident’s daughter keeps her informed because she doesn’t hear from the facility. The Hospice Agreement was executed on the 9th day of [DATE]: RECORDS: 1. Maintenance and Retention of Records-The nursing home and hospice shall prepare and maintain complete and appropriate medical records concerning each hospice patient. 2.Content: The clinical record shall contain past and current findings for each hospice patient. 3. Access: Subject to applicable law, nursing home and hospice shall each permit the other to review and make photocopies of the medical record. On [DATE], a pre-exit interview was conducted at approximately 11:40 am. The above findings were shared with the Administrator, Director of Nursing, and Corporate Consultant. No additional information was provided. 2. The Facility staff failed to provide Hospice nurses’ notes and the comprehensive care plan in the electronic clinical record for Resident #6. Resident #6 was originally admitted to the facility on [DATE] and admitted to Hospice on [DATE], with diagnoses of, but not limited to, Alzheimer’s disease with late onset, hypertension, unsteadiness on feet, major depressive disorder, history of falls, and terminal agitation. Resident #6 expired in the facility on [DATE]. Resident #6’s most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of [DATE] was a Quarterly Assessment. The MDS coded Resident #6 with a BIMS (Brief Interview for Mental Status) score of 99 out of 15 possible points, indicating the resident was unable to complete the interview. The cognitive assessment revealed that Resident #6 had memory problems related to short- and long-term memory, and that Resident #6 was severely impaired in making daily decisions. Section GG(Functional Abilities) of the MDS coded Resident #6 as requiring substantial/maximal and dependent with bed mobility, transfers, eating, toileting, and personal hygiene. The care plan dated [DATE] revealed: Resident #6 had a terminal prognosis r/t Alzheimer's disease, decreased PO intake, declining health, and heart failure. The resident was admitted to hospice as of [DATE]. Resident discharged from hospice services as of [DATE]. The resident was readmitted to hospice services as of [DATE]. The interventions included working cooperatively with the hospice team to ensure that the residents’ spiritual, emotional, intellectual, physical, and social needs were met. Work with nursing staff to provide maximum comfort for the resident. On [DATE], at 1:00 PM, the Administrator was interviewed and asked about the hospice notes care plan not found in the resident’s clinical record. The administrator stated that the hospice notes and care plan should be in the resident’s binder. The Hospice Nurse Binder for Resident #6 was reviewed and revealed a care plan and other documents, but no nurses’ notes were found. On [DATE] at approximately 9:00 AM, an interview was conducted with the Hospice Nurse/Case Manager. The Hospice Nurse/Case Manager said, “We document in our system if the facility wants them (notes), we will fax them over. I mostly update the facility nurse who takes care of the resident.” (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Hospice Agreement was executed on the 9th day of [DATE]: RECORDS: 1. Maintenance and Retention of Records-The nursing home and hospice shall prepare and maintain complete and appropriate medical records concerning each hospice patient. 2.Content: The clinical record shall contain past and current findings for each hospice patient. 3. Access: Subject to applicable law, nursing home and hospice shall each permit the other to review and make photocopies of the medical record. On [DATE], during the end-of-day meeting, the Administrator, Director of Nursing, Assistant Director of Nursing, Assistant Chief Nursing Officer, and Director of Clinical Education were notified of the concerns and findings. No further information was provided prior to exit.