STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495113	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hiram W Davis Medical Ctr	26317 West Washington Street Petersburg, VA 23803

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on staff interview, clinical record review, and facility document review, the facility staff failed to complete monthly medication regimen reviews for (4) four of (5) five sampled residents, Resident #1, Resident #6, Resident #4, and Resident #5. The findings included:1. For Resident #1 the facility failed to ensure a monthly medication regimen review (MRR) was completed for the month of March 2025. Resident #1's diagnosis list indicated diagnoses that included, but were not limited to, chronic heart failure, atrial fibrillation, mild neurocognitive disorder, anxiety, agitation, peripheral vascular disease, psychosis, and visual hallucinations. The most recent annual minimum data set (MDS) with an assessment reference date (ARD) of 11/18/25, assigned the resident a BIMS (brief interview for mental status) summary score of 13 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of Resident #1's MRRs did not disclose a MRR was completed for March 2025. On 2/11/26 at 12:23 PM, the pharmacy director (PD) was interviewed and agreed the MRR was not completed for March 2025 for Resident #1. This concern was discussed at the end of day meeting on 2/11/26 at 4:21 PM with the administrator and interim director of nursing. On 2/12/26 at 9:11 AM, pharmacist #1 (P#1) was interviewed and stated after speaking with the pharmacist responsible for the March 2025 MRR, it was agreed the MRR was not completed for March 2025 for Resident #1. On 2/12/26 at 9:38 AM, pharmacist #3 was interviewed and stated they were off work during the first two weeks of March 2025 and agreed the MRR had not been completed for that month for Resident #1. A facility policy titled, Chart Review and Provider Notification of Irregularities with a revision date of 12/8/24, was requested and received and read in part, .1. Medication Regimen Review: A thorough evaluation of the medication regimen with the goal of promoting positive outcomes and minimizing adverse consequences associated with medications.PROCEDURE: A. The.pharmacist shall perform a monthly chart review for his/her assigned patients/residents.per policy to ensure optimal medication use and safety. No further information was provided prior to exit on 2/12/26. (continued on next page)

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. For Resident #6 the facility staff failed to ensure a monthly medication regimen review (MRR) was completed for the month of November 2025. Resident #6's diagnosis list indicated diagnoses that included, but were not limited to, schizoaffective disorder, chronic pain syndrome, depression, pain, and history of breast cancer. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 11/18/25, assigned the resident a BIMS (brief interview for mental status) summary score of 99, indicating the resident was unable to complete the interview and was severely impaired in cognition. A review of Resident #6's MRRs did not disclose a MRR was completed for November 2025. On 2/11/26 at 12:21 PM, the pharmacy director (PD) was interviewed and agreed the MRR was not completed for November 2025 for Resident #6, as the pharmacist assigned to complete it was out of the country. This concern was discussed at the end of day meeting on 2/11/26 at 4:21 PM with the administrator and interim director of nursing. On 2/12/26 at 9:33 AM, pharmacist #2 (P#2) was interviewed and agreed the November 2025 MRR was not completed for Resident #6 due to P#2 being out of the country. A facility policy titled, Chart Review and Provider Notification of Irregularities with a revision date of 12/8/24, was requested and received and read in part, .1. Medication Regimen Review: A thorough evaluation of the medication regimen with the goal of promoting positive outcomes and minimizing adverse consequences associated with medications.PROCEDURE: A. The.pharmacist shall perform a monthly chart review for his/her assigned patients/residents.per policy to ensure optimal medication use and safety. No further information was provided prior to exit on 2/12/26. 3. For Resident #4 the facility failed to ensure monthly medication regimen reviews (MRR) were completed. Resident #4's clinical record listed diagnoses which included but not limited to schizoaffective disorder, bipolar disorder, and leukopenia caused by medication. Resident #4's most recent minimum data set with an assessment reference date of 02/10/26 coded the resident as having both long- and short-term memory problems with severely impaired cognitive skills for daily decision making. Resident #4's comprehensive care plan was reviewed and contained a plan for Psychotropic Medication Use. Interventions for this care plan included Collaborate with pharmacist regarding dose adjustments. Resident #4's clinical record was reviewed, and surveyor could not locate monthly medication regimen reviews for the months of April 2025, June 2025, August 2025, and September 2025. Surveyor spoke with the pharmacy director on 02/11/26 at 11:30 am and informed her of the missing (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MRR's for Resident #4. Pharmacy director informed surveyor on 02/11/26 at 12:25 pm that she could not locate the missing MRR's and the pharmacist responsible for completing them was no longer employed by the facility. Surveyor requested and was provided with a facility policy entitled Chart Review and Provider Notification of Irregularities which read in part, 1. Medication Regimen Review: A thorough evaluation of the medication regimen with the goal of promoting positive outcomes and minimizing adverse consequences associated with medications.Procedure: A. A . (facility omitted) pharmacist shall perform a monthly chart review for his/her assigned patients/residents of . (omitted) and . (omitted) per policy to ensure optimal medication use and safety. B. The pharmacist shall document the review in the EMR (electronic medical record) using the Drug Regimen Review ad hoc form. The concern on completing monthly medication regimen reviews for Resident #4 was discussed with the administrator and interim director of nursing on 02/11/26 at 4:20 pm. No further information was provided prior to exit. 4. For Resident # 5 the facility staff failed to ensure monthly medication regimen reviews (MRR) were completed. Resident #5's clinical record listed diagnoses which included but not limited to dementia and depression. Resident #5's most recent minimum data set with an assessment reference date of 01/20/26 assigned the resident a brief interview for mental status score of 12 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. Section N, medications, coded the resident as receiving antipsychotic and antidepressant medications. Resident #5's clinical record was reviewed, and surveyor could not locate any MMRs for the months of April 2025, May 2025, June 2025, July 2025, August 2025 and September 2025. Surveyor spoke with the pharmacy director on 02/11/26 at 11:30 am and informed her of the missing MRR's for Resident #5. Pharmacy director informed surveyor on 02/11/26 at 12:25 pm that she could not locate the missing MRRs and the pharmacist responsible for completing them was no longer employed by the facility. Surveyor requested and was provided with a facility policy entitled Chart Review and Provider Notification of Irregularities which read in part, 1. Medication Regimen Review: A thorough evaluation of the medication regimen with the goal of promoting positive outcomes and minimizing adverse consequences associated with medications.Procedure: A. A . (facility omitted) pharmacist shall perform a monthly chart review for his/her assigned patients/residents of . (omitted) and . (omitted) per policy to ensure optimal medication use and safety. B. The pharmacist shall document the review in the EMR (electronic medical record) using the Drug Regimen Review ad hoc form. The concern on completing monthly medication regimen reviews for Resident #5 was discussed with the administrator and interim director of nursing on 02/11/26 at 4:20 pm. No further information was provided prior to exit.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure call bell was in reach for (1) one of (14) fourteen sampled residents, Resident #21. The findings included:Resident #21's clinical record listed diagnoses which included but not limited to acquired blindness of bilateral eyes, bilateral hearing loss, agitation, and schizoaffective schizophrenia.Resident #21's most recent minimum data set with an assessment reference date of 01/27/26 coded the resident as having both long- and short-term memory problems with moderately impaired cognitive skills for daily decision making. Resident #21's comprehensive care plan was reviewed and contained a plan for At risk for falls. Interventions for this care plan include call light in reach.Surveyor observed Resident #21 on 02/10/26 at 12:50 pm. Resident #21 was seated in wheelchair beside bed. Surveyor observed Resident #21's call bell located on the floor behind the head of the bed.Surveyor observed Resident #21 on 02/11/26 at 8:45 am and 1:30 pm. Resident was lying in bed during each observation; call bell was located on floor behind head of bed.Surveyor spoke with certified nurse's aide (CNA) #1 on 02/11/26 at 1:30 pm. Surveyor asked CNA #1 where the resident's call bell should be located and CNA #1 stated, It should be right beside him.Surveyor requested and was provided with a facility policy titled Call Bell Policy which read in part, Purpose: To ensure that all residents in our Long-Term Care Skilled Nursing Facility have timely access to assistance and that call bells are responded to promptly and appropriately to maintain resident safety, dignity, and quality of care. Policy Statement: All residents shall always have access to a functioning call bell system.Procedures: Call Bell Availability: Call bells must always be within reach of all residents when they are in bed. Staff should ensure that call bells are properly positioned and functioning during every room check and interaction with residents.During an end of day meeting with the facility administrator and interim director of nursing on 02/11/26 at 4:20 pm, the issue of Resident #21's call light not being within reach was discussed. Administrator stated that it was unsure if resident was capable of using call bell, and that 30-minute checks were done throughout the day. Administrator also stated that any time resident was up in wheelchair, he was seated close to the nurse's station for observation. Surveyor informed administrator of observation of resident seated in wheelchair at his bedside.No further information was provided prior to exit.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, resident interview, staff interview, clinical record review, and facility document review, the facility failed to provide activities of daily living care for (1) one of (14) fourteen sampled residents, Resident #5. The findings included:For Resident #5 the facility staff failed to provide nail care.Resident #5's clinical record listed diagnoses which included but not limited to cerebrovascular accident (stroke) and hemiplegia or hemiparesis.Resident #5's most recent minimum data set with an assessment reference date of 01/20/26 assigned the resident a brief interview for mental status score of 12 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. Section G, functional status coded the resident as needing substantial/maximal assistance with personal hygiene.Resident #5's comprehensive care plan was reviewed and contained a plan for Self-care deficit. Interventions for this care plan include Provide appropriate level of assistance with ADL's (activities of daily living).Surveyor spoke with Resident #5 on 02/10/26 at 12:55 pm. Resident was resting in bed, watching television. Surveyor observed resident's fingernails to be long and sharp-edged. Surveyor asked resident if staff aided with trimming his fingernails and resident stated no. Surveyor asked resident if he would like to have his nails trimmed, and resident stated, Yes, they are too long and sharp and they cut me sometimes.Surveyor spoke with certified nurse's aide (CNA) #1 on 02/11/26 at 1:30 pm regarding residents' nail care. Surveyor asked CNA #1 who provides nail care for residents, and CNA #1 stated, The CNA's do. Surveyor asked CNA #1 how often nail care is provided, and CNA #1 stated, Every Wednesday.Surveyor spoke with registered nurse (RN) #2 on 02/11/26 at 1:35 pm. Surveyor asked RN #2 who provides nail care for the residents, and RN #2 stated, The nurse's and CNA's.Surveyor requested and was provided with a facility policy entitled Nail Cleaning and Cutting which read in part, A. Each resident's nails (toenails and fingernails) are inspected daily at the time the daily bath is given. It is the responsibility of the CNA bathing the resident to cut/clip and/or file the resident nails. E. Nails are to be checked twice a week and as needed, clipped/filed as necessary according to bath shift assignment, so that they grow no longer than one-eighth inch past the tips of the fingers/toes. The concern of not providing nail care for a dependent resident was discussed with the administrator and interim director of nursing during an end of day meeting on 02/11/26 at 4:20 pm. Interim director of nursing stated they would check to ensure resident's nails were trimmed. Surveyor spoke with Resident #5 on 02/12/26 at 9:15 am. Surveyor asked resident if anyone had trimmed his nails, and resident stated they had not, and raised hand to show surveyor that nails remained long. Surveyor informed administrator and interim director of nursing on 02/12/26 at 10:45 am that resident's nails remained untrimmed. During exit conference on 02/12/26 at 11:30 am, administrator informed surveyor that Resident #5's nails have been trimmed. No further information was provided prior to exit.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review, staff interview, and facility document review, the facility staff failed to follow provider orders for medication administration for (1) one of (14) fourteen sampled residents, Resident #7. The findings included:For Resident #7, the facility staff failed to administer a provider ordered medications acetaminophen, chlorpromazine, divalproex, docusate, duloxetine, eucerin cream, gabapentin, menthol-zinc oxide ointment, and senna, on the evening of 1/20/26. Resident #7's diagnosis list indicated diagnoses, which included, but not limited to, pain of left/right leg, schizophrenia, bipolar disorder, constipation, depression, and soft tissue disorder. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 12/23/25, assigned the resident a brief interview for mental status (BIMS) summary score of 11 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. A review of a medical provider orders disclosed the following ordered medications: .acetaminophen.650 mg (milligrams).BID (twice daily).indication: pain. with a start date of 5/21/25.chlorpromazine.200 mg.BID.indication: schizophrenia. with a start date of 4/14/25.divalproex sodium.500 mg.BID.indication: bipolar disorder. with a start date of 8/13/25.docusate.100 mg.BID.indication: constipation. with a start date of 5/21/25.duloxetine.30 mg.BID.indication: depression. with a start date of 2/26/25.eucerin calming cream.1 app (application), topical, cream, BID.indication: dry skin. with a start date of 6/16/25.gabapentin.300 mg.daily w/dinner (with dinner). with a start date of 12/12/25.menthol-zinc oxide topical.1 app, topical, ointment.Q8H (every 8 hours).indication: skin irritation. with a start date of 8/29/25.senna.17.2 mg.2 tab (2 tablets).every day at bedtime. with a start date of 10/24/25. A review of Resident #7's January 2026 MAR (medication administration record) on the evening of 1/20/26 was blank, indicating none of the above prescribed medications were administered as ordered. A review of Resident #7's comprehensive person-centered care plan included interventions in the focus areas of behavioral symptoms and bowel dysfunction, which read in part, .Administer medications as ordered. On 2/11/26 at 12:26 PM, registered nurse #2 (RN#2) was interviewed. RN#2 stated the reason the MAR read as, Not appropriate at this time on 1/20/26, was because the task had to be cleared before the medication administrations for the next shift could be entered. RN#2 agreed they were not the evening nurse on 1/20/26 and agreed the medications were not marked as given by the nurse on duty the evening before. This concern was discussed at the end of day meeting on 2/11/26 at 4:21 PM with the administrator (ADM) and interim director of nursing (IDON). On 2/11/26 at 4:38 PM, the IDON reviewed Resident #7's MAR for 1/20/26 and the IDON agreed the MAR indicated the medications on the evening of 1/20/26 were not given as ordered by the provider. On 2/12/26 at 11:33 AM, the IDON stated evidence of why Resident #7's evening medications were not administered on the evening of 1/20/26 could not be located. A facility policy titled, Administration of Medications with a revision date of 6/5/17 was requested and received and read in part, .medication administration schedule.BID = 1000 (10:00 AM), 1800 (6:00 PM).Q 8 hr = 0600 (6:00 AM), 1400 (2:00 PM), 2200 (10:00 PM).Administer all medications as ordered by physician.(MAR).c. Chart all medication omissions by initialing and then circling initials in the appropriate box and on the MAR. Record reason for omission on back of MAR and in interdisciplinary notes.Chart all medication omissions, reasons for omissions, and actions taken due to omissions.Medications withheld, omitted or refused: Medication nurses will audit MARs daily on every shift for withheld, omitted.medications and submit to nursing supervisors for corrective actions. No further information regarding this concern was presented prior to the exit on 2/12/26.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on staff interview, clinical record review, and facility document review, the facility staff failed to maintain an accurate clinical record for (1) one of (14) fourteen sampled residents, Resident #1. The findings included:For Resident #1, the facility staff failed to accurately document medication regimen reviews (MRRs) for no irregularities on 2/21/25, 4/10/25, 5/15/25, 6/16/25, 7/25/25, 8/29/25, 9/18/25, 10/17/25, 11/12/25, 12/16/25, and 1/22/26. Resident #1's diagnosis list indicated diagnoses that included, but were not limited to, chronic heart failure, atrial fibrillation, mild neurocognitive disorder, anxiety, agitation, peripheral vascular disease, psychosis, and visual hallucinations. The most recent annual minimum data set (MDS) with an assessment reference date (ARD) of 11/18/25, assigned the resident a BIMS (brief interview for mental status) summary score of 13 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of Resident #1's MRRs for 2/21/25, 4/10/25, 5/15/25, 6/16/25, 7/25/25, 8/29/25, 9/18/25, 10/17/25, 11/12/25, 12/16/25, and 1/22/26 were noted to have pharmacy recommendations and the recommendations could not be located in the clinical record. On 2/11/26 at 12:23 PM, the pharmacy director was interviewed and stated there were no irregularities for the MRRs completed on 2/21/25, 4/10/25, 5/15/25, 6/16/25, 7/25/25, 8/29/25, 9/18/25, 10/17/25, 11/12/25, 12/16/25, and 1/22/26 and agreed the MRR forms were marked incorrectly and should have been marked as no irregularities for all of them. This concern was discussed at the end of day meeting on 2/11/26 at 4:21 PM, with the administrator and interim director of nursing. On 2/12/26 at 9:38 AM, pharmacist #3 (P#3) was interviewed and agreed the MRRs on 2/21/25, 4/10/25, 5/15/25, 6/16/25, 7/25/25, 8/29/25, 9/18/25, 10/17/25, 11/12/25, 12/16/25, and 1/22/26 had no irregularities. P#3 thought the last two boxes for physician review had to be marked on the forms. P#3 did not realize there was a box for no irregularities and stated they were never trained on the correct way to document on the form. A facility policy titled, Chart Review and Provider Notification of Irregularities was requested and received with a revision date of 12/8/24 which read in part, .1. Medication Regimen Review: A thorough evaluation of the medication regimen with the goal of promoting positive outcomes and minimizing adverse consequences associated with medications.PROCEDURE.C. If irregularities are not identified, the pharmacist shall mark the form as such. No further information was provided prior to exit on 2/12/26.