STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495117	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Taylor Hosp	1309 Kempsville Rd Norfolk, VA 23502

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 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. (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 0677 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, interview, record review, and policy review, the facility failed to provide appropriate meal assistance for two of two residents (Resident (R)9 and R85) reviewed for activities of daily living (ADLs) in a sample of 47 residents. This failure could cause residents to become malnourished, aspirate, or an exacerbation of health conditions.Findings include:Review of the facility's policy titled Activities of Daily Living dated 11/22, provided by the facility revealed, To provide care for residents that give them a sense of comfort and wellbeing. Residents are provided assistance with all activities of daily living by clinical staff as desired and based on the individual care needs.1. Review of R85's face sheet, provided by the facility revealed R85 was admitted on [DATE] and had diagnoses of dementia, epilepsy, and gastro-esophageal reflux disease. Review of R85's nurse notes, dated 09/10/25 provided by the facility revealed, pt [patient] admitted for anxiety, COPD [chronic obstructive pulmonary disease], depression, dementia, macular degenerative disorders . Pt have hard to see vision problem .Review of R85's Diet Order dated 09/10/25 provided by the facility, revealed, liquid consistency: thin liquids, consistency: Mech [mechanical] Soft Chopped, comments: dysphagia advanced texture.Review of R85's Care Plan dated 09/10/25 provided by the facility revealed Decreased ability to independently complete ADLs and functional mobility, related to Decrease in Range of Motion, Weakness or deconditioning. An intervention included Set up [R199] ADL supplies and encourage or allow [R199] to complete care as able and then assist with completion. Interventions included, Silverware w/ [with] built up handles mealtimes.Divided plates mealtimes.On 09/22/25 at 4:50 PM and 5:15 PM, R85 was in bed and served dinner on an overbed table across her lap. R85 was observed touching the items on her tray and noted to be vision impaired. A bowl of soup still had a cover over the top as well as a cover over the plate of food. No staff assisted her or set her tray up. On 09/22/25 at 5:25 PM, R85 received no staff assistance, and her intake was poor, little consumed.Review of R85's Meal Acceptance History, provided by the facility revealed for dinner on 09/22/25 it was blank.On 09/24/25 at 8:30 AM and 8:55 AM, R85 was asleep in bed and her breakfast tray next to her. The food was untouched and included scrambled eggs, pancakes, milk, open yogurt, ground sausage, and apple juice.On 09/24/25 at 9:03 AM, the Hospitality Aide (HA)1 removed R85's breakfast tray.HA1 confirmed the food on R85's tray was not consumed. On 09/24/25 at 12:08 PM, R85 was seated in a wheelchair in the dining room. R85 was being fed her lunch meal by HA3 while standing.On 09/24/25 at 12:17 PM, HA3 was still feeding R85in the dining room. Licensed Practical Nurse (LPN)4 was asked should HA3 be standing while feeding R85. LPN4 stated, some stand and some sit depending on the situation.During an interview on 09/25/25 at 2:03 PM, Certified Nurse Aide (CNA)3 was asked about R85's eating status. CNA3 stated R85 was not on the feeding list that was kept at the nurse's station. CNA3 stated they fed her sometimes and other times R85 fed herself as R85 was still new to them. CNA3 was asked if R85 had vision problems. CNA3 stated she thought so.During an interview on 09/25/25 at 6:39 PM, LPN4 was asked about R85's feeding ability and why she wasn't on the feeding list at the nurse's station. LPN4 stated she didn't know but R85 ate better if she was fed. LPN3 stated thatR85 didn't do well if she was left to feed herself, LPN3 confirmed R85 was vision impaired.2. Review of R9's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 09/17/25 and located in the MDS tab of the electronic medication record (EMR) revealed an admission date 07/09/18 and a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated R9 was cognitively intact. The MDS indicated that R9 required supervision or touching assistance with eating, had two unstageable pressure ulcers and diagnoses of quadriplegia, multiple sclerosis, and dysphagia.Review of R9's diet order dated 10/17/24, provided by the facility revealed a Thin Liquids, consistency: Regular, Comments: Ensure daily with meal-staff to assist with set-up PRN [as needed] indications: dysphagia resolved.Review of R9's care plan provided by the facility did not include a care plan for activities of daily living and eating ability.On 09/23/25 at 12:02 PM, R9 was served her lunch in bed on an overbed table, and her room door closed. R9's lunch includes beef/macaroni casserole, green beans, gelatin, a side of macaroni, coffee, a supplement, and ice cream.On 09/23/25 at 12:19 PM and 12:36 PM, R9 was in bed with her meal and her door closed. No assistance was observed with her meal.On 09/23/25 at 1:16 PM, R9 was in bed with her lunch tray, and her consumption was poor. R9's door remained closed, and no assistance was provided. R9 was asked if she received assistance with her meal and R9 stated, No.Review of R9's Meal Acceptance History provided by the facility revealed 09/23/25 for lunch was documented as 25% On 09/23/25 at 4:51 PM and 5:00 PM, R9 was served her

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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 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** Number of residents sampled: 47Number of residents cited: 2 Based on record review, interview, and policy review, the facility failed to ensure residents' safety for two (Resident (R) 11 and R195) of two residents reviewed for accident hazards in the sample of 47 residents. Specifically, R11 fell to the floor during an assisted transfer by nursing staff from the commode to the bed, which resulted in a femur fracture and R195 rolled out of bed when nursing staff were providing incontinence care and fell to the floor which resulted in a femur fracture. This had the potential to affect residents who required staff assistance during care. Findings include: 1.Review of R11's Face Sheet in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, left knee prosthetic joint, and chronic kidney disease. Review of R11's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/28/25 in the resident's EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was moderate cognitively impaired. Review of R11's Care Plan dated 08/26/25 and located in the EMR under the Care Plan tab revealed R11 was at risk for falls due to requiring assistance with transfers. Interventions in place were to monitor for steadiness and assistance as needed. Review of R11's Outpatient Consultation Record provided by the facility dated 05/06/25 revealed that patient was okay to increase weight bearing from 50% to 100% as tolerated. When ambulating the resident should wear knee immobilizer to prevent knee buckling due to weakness in knees. Review of R11's Physician Progress Note dated 05/13/25 and located in the EMR under Notes tab revealed that resident stated she felt weaker in therapy yesterday with possible buckling of the legs. She is 50% to 100% weightbearing as tolerated to left lower extremity with knee immobilizer per orthopedics. May remove knee immobilizer when in bed and not ambulating. Review of R11's Nurse's Note dated 05/13/25 and located in the EMR under the "Notes" tab written by Licensed Practical Nurse (LPN) 3 revealed that Certified Nurse Aide (CNA)1 reported that the resident had a fall when transferring. Resident stated that her leg felt like it would give out. Resident not wearing knee immobilizer. Review of R11's Radiology Note dated 05/14/25 and located in the EMR under the "Notes" tab revealed suspicious for mid femur fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 09/25/25 at 9:56 AM, LPN3, who was a former charge nurse, revealed that R11 was considered a fall risk. On 05/13/25 she was notified by CNA1 that the resident had fallen and went into the resident's room and the first thing she noticed was R11 wasn't wearing her knee mobilizer. She said it was placed inside the bag on the back of R11's wheelchair. She said CNA1 had not put her knee immobilizer on her prior to getting her up and out of bed. She asked CNA1 why the resident didn't have her leg immobilizer on, CNA1 stated what immobilizer. CNA1 was under the impression that R11 did not use it anymore and didn't know that it was in the room. LPN3 stated that she didn't ask CNA1 if she looked for it prior to the transfer. During an interview on 09/25/25 at 11:05 AM, CNA1 stated that on 05/13/25 around 8:30 PM to 9:00 PM, R11 rang her call light and was ready to get ready for bed. She said she assisted R11 from the chair onto the bedside commode and then was attempting to assist R11 to bed when R11 started sliding down. She helped R11 onto the floor and called for assistance. She was unaware that R11 required a leg immobilizer during ambulation or transfers and never observed one in the resident's room. During an interview on 09/25/25 at 6:45 PM the Director of Nursing (DON) said she expected to have better communication in place when there was a change in orders, and agreed there was a breakdown in communication regarding expectation for R11 to wear a knee immobilizer during transfers and when ambulating. The DON stated that she expected the CNAs to look at the resident's fact sheet at the start of every shift to ensure they were aware of what type of care each resident required. 2.Review of R195's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, age related osteoporosis, chronic kidney disease, and kidney transplant status. Review of the EMR revealed that R195 had a hip fracture at home. R195 was admitted to the facility from home due to pressure sores. Review of R195's admission MDS with an ARD of 05/21/24 and located in the resident's EMR under the MDS tab revealed a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. R195's MDS indicated she was a one person assist for bed mobility including turning and repositioning. Review of R195's Care Plan dated 07/01/24 and located in the EMR under the Care Plan tab revealed R195 was at risk for complications related to Osteoporosis to include pain and bone fracture. Interventions in place were to identify any injury or fracture and render treatment. The care plan also included decreased ability to perform activities of daily living (ADLS). R195 required one-person physical assist with all ADLS including bed mobility. Review of R195's Nurse's Note dated 06/06/24 and located in the EMR under the "Notes" tab written by LPN 2 revealed, resident rolled over and fell during personal care by assigned CNA 8, resident assessed with left hip and knee pain. R195 did not want to go to the hospital, however x-rays were ordered and revealed a fractured left hip. She was sent to the emergency room via ambulance and underwent left hip repair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R195's Incident Report dated 06/06/24 completed by LPN2 revealed, assigned CNA8 was yelling for help in R195's room at 6:04 AM. LPN2 went to the room, and the resident was found lying on the floor, complaining of pain in her left hip and left knee, CNA8 stated resident rolled out of bed while he was turning her over during incontinent care. Further review revealed a statement by CNA8 that indicated, I was turning [R195] during personal care, her leg was sliding off the bed and I went to the other side, and she fell off the bed onto the floor. During an interview on 09/23/25 at 4:10 PM, CNA8 said he was providing care for R195 when her right leg was sliding off the bed. He said he went to the other side of the bed but was unable to catch her before she fell to the floor. CNA8 said she was a one person assist, and he had not had any issues with turning her in the past. He was asked what he could have done differently, and he said he could have called for assistance, but everything happened so fast. He did not call for assistance. During an interview on 09/24/25 at 1:57 PM, the DON stated she expected staff to try and identify root cause of falls, especially during care with staff. She stated after reading the incident report she did not feel there was anything that could have been done differently. Review of the facility's policy titled Fall Risk Assessment and Prevention dated 04/2025 revealed to protect and safeguard residents from injury and decrease the incidents of falls.