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 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)

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

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 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. 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 (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	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.

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. **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 (continued on next page)

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	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 dinner in bed, and her tray was covered. R9's door remained closed, and no assistance was provided.On 09/23/25 at 5:21 PM, R9 was asleep in bed with her dinner tray unconsumed and sitting at her bedside.Review of R9's Meal Acceptance History provided by the facility revealed 09/23/25 for dinner was documented as refused.During an interview on 09/25/25 at 12:33 PM, LPN5 was asked why R9 hadn't received feeding assistance for two meals on 09/23/25. LPN5 stated R9 could feed herself.During an interview on 09/25/25 at 2:01 PM, CNA3 confirmed that she was assigned to R9.CNA3 was asked how she would know who needed assistance with eating. CNA3 stated they get information from the family or the previous nursing home on meal intake, and they also follow a feeding list at the nurse's station. CNA3 provided the list which indicated that R9 was to receive queueing/supervision. CNA3 confirmed R9 was to receive queueing/supervision.During an interview on 09/25/25 at 2:08 PM, the Nurse Manager (NM)3 was asked about the feeding list and R9 listed as queueing/supervision which was different from her diet order instructions. UM3 stated it was the same as queuing/supervision.During an interview on 09/25/25 at 2:14 PM, the Speech Therapist (ST) was asked about R9's diet order. The ST stated, Someone should be with R9 to cue/supervise. ST stated R9 would accept someone feeding her. ST confirmed R9 had poor meal consumption and had a pressure sore.

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure ongoing communication and collaboration with the dialysis facility for one resident (Residents (R)11) reviewed for dialysis out of a total sample of 47. This had the potential to effect the continuity of care for residents who receive dialysis treatment. Findings include:Findings include: 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 congested heart failure and chronic kidney disease. Review of R11's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/28/25 EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of three out of 11, which indicated the resident was moderate cognitively impaired. R11 was documented as receiving hemodialysis. Review of R11's Care Plan dated 08/26/25 and located in the EMR under the Care Plan tab revealed R11 was not care planned for dialysis treatment. Review of R11's Physician Orders located under the Orders tab in the EMR dated 08/22/25 revealed hemodialysis every Tuesday, Thursday, and Saturday. Review of R11's Treatment Details Report forms dated 07/26/25 through 09/18/25 revealed thirteen out of nineteen days that did not have any documentation provided by the dialysis center after treatment. During an interview on 04/30/25 03:45 PM, Nurse Manager (NM)1 stated on dialysis days nursing staff completed the dialysis communication log and send it along with the resident's binder to dialysis. She said it has been a challenge receiving the post communication information from the dialysis center. In those instances, the unit secretary reached out to the dialysis company, but there wasn't a lot of feedback from them. NM1 stated that she was unaware if this concern had been reported to any administrative staff. During an interview on 09/25/25 at 12:37, the Unit Secretary (US) said it has been a challenge getting post dialysis information sent back to the facility after R11's dialysis. She has reached out to the dialysis center and reported it to her supervisor, but it is still an ongoing issue. She stated she has spoken with the nurses at the dialysis center, but she has never spoken with anyone in management. During an interview on 09/25/25 at 6:45 PM, the Director of Nursing (DON) said she felt if there was information, the dialysis center needed to communicate with the facility.

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 47Number of residents cited: 1Based on observation, interview, record review, and policy review, the facility failed to ensure residents received alternative measures prior to the installation of side rails; documented discussion related to risk versus benefits; and signed informed consent prior to bed rail use for one of four residents (Resident (R)89 reviewed for side rails out of 47 sampled residents. The lack of alternate side rail measures and proper assessment/consent could lead to potential restraint or side rail entrapment.Findings include Review of R89's admission Record in the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnosis of hemiplegia. Review of R89's admission Minimum Data Set (MDS) assessment under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 09/15/25 revealed a Brief Interview for Mental Status (BIMS) score of three out of 15 indicating severe cognitive impairment. Review of R89's Care Plan located under the Care Plan tab of the EMR dated 09/09/25 revealed R89 did not have a care plan for side rail use. Review of R89's Physician Orders located under the Orders tab in the EMR dated 09/08/25 revealed, 1/2 rails every shift to assist with bed mobility and repositioning. Review of R89's Nursing admission Assessment located under Assessments tab in the EMR dated 09/08/25 revealed no documentation that alternates were explored prior to bed rail/side rail use; risk and benefits were discussed; and that informed consent was obtained prior to bed rail use. Observation on 09/23/25 at 11:40 AM, R89 was in bed with side rails up on both sides. During an interview on 09/25/25 at 9:56 AM, Licensed Practical Nurse (LPN)3, who was a former charge nurse, said all residents were admitted with side rails already on the beds for use. She said staff would ensure there was not a restraint, but they did not look at alternatives. Most of the residents wanted side rails. She said they go over the risks and benefits related to side rail use, but they don't have the resident or family sign anything. She was also unsure how often side rails were reassessed after admission. During an interview on 09/25/25 at 11:18 PM, LPN2 said after residents were admitted to the facility and wanted side rails they would educate them on the risk and benefits. She said most residents were more comfortable with having side rails. But they did not look at alternates prior to use, because bed rails were already on the beds. She said they have a consent form, but nobody signed them. During an interview on 09/25/25 at 6:45 PM, the Director of Nursing (DON) said she was unaware that there needed to be documentation that alternates were explored prior to bedrail use; discussion of risk and benefits of bedrail use and that there needed to be signed consent in the medical record.

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, record review, and review of the manufacturer's manual, the facility failed to maintain air loss mattresses at the proper setting for two of three residents (Resident (R)9 and R15) observed for patient care equipment. This failure could lead to increased risk of skin breakdown.Findings include:Review of the facility's mattress manual dated 2018 provided by the facility revealed instructions to Turn the Pressure Adjust Knob to set a comfortable pressure level by using the weight scale as a guide. The manual illustrated the pressure adjust knob was to be set to the weight of patient.1. 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 had two unstageable pressure ulcers and diagnoses of quadriplegia and multiple sclerosis.Review of R9's order dated 05/10/25 provided by the facility revealed, Low air loss mattress Every Shift, Request Type: Routine.Review of R9's Care Plan dated 05/12/25, provided by the facility, revealed [R9] has pressure area to Lt. [left] gluteal fold/buttocks and sacrum. Potential for further skin breakdown, infection and deterioration of wounds. An intervention included, Pressure relief device on bed and chair.Review of R9's Weekly Wound Progress Update dated 09/22/25, provided by the facility, revealed R9 had a pressure injury to her sacrum Stage 4- Unstageable and Wound Prevention Intervention: Low Air Loss Mattress.Review of R9's Treatments Orders dated 09/25/25, provided by the facility, revealed R9 weighed 123.6 pounds.During an observation and interview on 09/25/25 at 8:28 AM, R9 was asked if she had sores on her body and R9 stated, Yes. R9 then complained that her mattress was Going down. R9's mattress was noted to be flat and the air mattress setting on 50.During an interview on 09/25/25 at 8:32 AM, Certified Nurse Aide (CNA)9 stated that she was assigned to R9.CNA9 was asked about R9's mattress and the setting at 50. CNA9 entered R9's room and observed the mattress and the setting at 50. CNA9 confirmed the setting and how flat the mattress was. CNA9 then stated she would report the mattress. CNA9 stated that CNAs have nothing to do with the mattress setting.During an interview on 09/25/25 at 9:26 AM, Licensed Practical Nurse (LPN)4 was asked about R9's mattress setting at 50 and R9 was complaining it was too flat. LPN4 stated setting of 50 was incorrect and it should be set at the resident's weight. LPN4 was asked who set the mattress setting. LPN4 stated either the CNA or the Nurse. LPN4 was told CNA9 stated she doesn't touch the setting. LPN4 was asked if the CNA would know the resident's weight. LPN4 didn't comment.During an interview on 09/25/25 at 12:33 PM, LPN5 was asked if she was aware R9's air mattress was set at 50 and R9 complained that the mattress was flat the morning of 09/25/25. LPN5 stated she wasn't aware, but they had difficulty with the air mattress not holding pressure. LPN5 stated the mattress should be adjusted according to the resident's weight. LPN5 stated R9's setting should be between 120 and 150.2. Review of R15's quarterly MDS with an ARD date of 08/20/25 and located in the MDS tab of the EMR, revealed an admission date 05/37/23 and a BIMS score of nine out of 15, which indicated R15's cognition was moderately impaired. The MDS indicated that R15 had two pressure ulcers and diagnoses of diabetes mellitus, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, osteomyelitis, ankle, and foot.Review of R15's Care Plan dated 04/28/25, provided by the facility, revealed, Pressure ulcer- at risk for altered skin integrity and pressure ulcers. Related to decreased in ADL abilities, poor PO [oral] intake, decreased mobility, incontinence. An intervention included Provide low air loss mattress on bed.Review of R15's Order dated 04/28/25, provided by the facility, revealed Low air loss mattress Every Shift, Request Type: Routine.Review of R15's weight dated 09/05/25, provided by the facility, indicatedR15 weighed 144.4 pounds.On 09/23/25 at 9:15 AM and 1:13 PM, and on 09/25/25 at 9:20 AM, R15 was observed asleep in bed with an air mattress in use. The mattress was set at 180.During an interview on 09/25/25 at 9:26 AM, LPN4 was asked about R15's air mattress setting and if it should be set at 180 (continued on next page)

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN4 stated it shouldn't be at 180 and should be set at her weight. LPN4 then walked into R15's room and confirmed the setting was at 180 and reset it between 120 and 150.During an interview on 09/25/25 at 12:40 PM, LPN5 was asked about R15's wound and about the air mattress setting. LPN5 stated the purpose of the air mattress was to promote healing and should be at the appropriate setting.