STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portsmouth Health and Rehab	900 London Boulevard Portsmouth, VA 23704

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide one of four residents (Resident (R) 106) reviewed for activities out of a total sample of 47 with the opportunity to be offered diversional activities or to be moved to another room when his roommate (R119) passed away. This had the potential for a resident to be traumatized due to being a vulnerable resident.Findings include:Review of R106's admission Record, located under the Profile tab of the electronic medical record (EMR), indicated the resident was admitted to the facility on [DATE].Review of R106's admission Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 09/10/24, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated the resident was able to ambulate on his own.Review of R106's Progress Note, located under the Prog (Progress) Note tab of the EMR and dated 12/17/24, failed to indicate the resident was offered a room change on 12/17/24 when R106's roommate passed away.2. Review of R119s admission Record located under the Profile tab of the EMR, indicated the resident was admitted to the facility on [DATE].Review of R119's death in the facility MDS, located under the MDS tab of the EMR and with an ARD of 12/17/24, revealed the resident passed away on this date.Review of a document for R119 titled Record of Death, located under the Misc (Miscellaneous) tab of the EMR and dated 12/17/24, indicated the resident passed away at 5:20 PM and his body was released to the funeral home at 10:11 PM.During an interview on 09/17/2025 at 2:48 PM, the Central Supply Manager (CSM) stated she was assigned to R106's room to ensure everything was in place. CSM stated she did not remember if the body of R119 was left in his room but stated it was the facility policy to offer the living resident another room.During an interview on 09/17/25 at 5:53 PM, the Administrator stated the process for a resident who has passed away was to offer the roommate outside diversional activities or to offer another room.During an interview on 09/18/25 at 8:37 AM, Licensed Practical Nurse (LPN) 9 who was an agency staff member stated when a resident has passed away, staff were to pull the curtain and offer any roommate another room.During an interview on 09/18/2025 at 3:58 PM, the MDS Coordinator (MDSC) stated she was the staff member who pronounced the death of R119 only and was not the staff member who spoke with R106 about moving to another room. The MDSC stated it was the facility's policy to offer the resident another room after a death of their roommate.During an interview on 09/18/2025 at 4:02 PM R106 stated he was not offered another room after R119 passed away. During an interview on 09/18/25 at 5:15 PM, the Administrator stated, We do not have a specific policy for dignity.

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
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 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 interview, record review, and policy review, the facility failed to protect the residents' right to be free from a verbal threat of potential physical abuse by staff for one of five residents, (Resident (R) 53), reviewed for abuse out of a total sample of 47. This failure had the potential to cause physical or psychosocial harm to the resident.Findings include:Review of the facility's policy titled Resident Abuse, revised 1/2023, revealed Policy It is inherent in the nature and dignity of each resident at the facility that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse. 1. All employees of the facility are charged with a continuing obligation to treat all residents in the most humane manner possible. 2. No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and/or misappropriation of property against any resident . 2. Types of Abuse: . H. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability.Review of R53's admission Record, located in the electronic medical record (EMR) under the profile tab, revealed the resident was admitted to the facility on [DATE] with a diagnosis of adjustment disorder with anxiety.Review of R53's quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 01/27/25, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognately intact.Review of R53's General Note, dated 03/25/25, located in the EMR under the Prog Notes tab, revealed During nursing rounds, nurse was alerted that patient had a verbal altercation that was out of control, and no one could calm patient down. Nurse went to assess patient, and the patient was sitting on side of his bed, stating that he was upset. Nurse asked patient what happened. Patient explained to nurse the details of events. Nurse asked what could nurse do to calm him down. Patient stated he wanted to vent and be heard. He voiced that he felt better but refused to have nurse come back into his room. Nurse informed manager on call. Patient resting in bed, supine, lying on left side, call bell and PO [by mouth] fluids in reach.Review of R53's Care Plan, dated 11/30/23, located in the EMR under the Care Plan tab, indicated the resident had behaviors which included cursing, screaming, shouting, tearing things up, and not easily redirected with interventions to tell him what you are doing before you begin. Two staff members in room during care with the resident was added on 04/23/25. R53's Care Plan, dated 06/04/25, revealed a focused area of can be verbally abusive to staff and follow behind staff in aggressive manners with interventions that included to observe the resident for triggers for verbally abusive episodes and intervene at first sign of trigger(s).Review of the Facility Reported Incident (FRI), dated 03/25/25, revealed the facility performed an internal investigation and confirmed verbal abuse occurred on 03/23/25. The allegation of verbal abuse was submitted to the state agency on 03/25/25. The investigation revealed that R53 reported that he was subjected to verbal abuse by Licensed Practical Nurse (LPN) 14 after she woke him up to administer his medications. LPN14 shoved the medications in his face so he became upset, he followed her out of his room, he picked up a wet floor sign in the hallway and threatened to hit her with it while she was standing at the medication cart. LPN14 picked up the water pitcher off the medication cart and threatened to crack him over the head with it if he came any closer to her. LPN1 heard R53 screaming at LPN14 in the hallway so she escorted him to his room and provided emotional support. LPN14 left the building after the incident and was terminated from employment. Abuse in-services were completed with all staff during the investigation from 03/25/25 and 03/26/25. Additional interventions included R53 receiving a visit from the psychologist for emotional well-being, receiving psychosocial follow-up from the Social Services Director (SSD), and the Director of Nursing (DON) and nurse management ensuring his safety and that his needs were met.During an interview on 09/15/25 at 4:05 PM, R53 stated that on 03/23/25 LPN14 entered his room to give him medications, woke him up by knocking on the door, he told her to come closer to him so he could get the medication cup from her, she shoved the medications in his face and he thought he heard her say something about him under her breath as she was exiting his room. R53 confirmed he got mad, so he got in his wheelchair, went to the hallway, yelled at her at the medication cart, picked up a wet floor sign off the floor, and then LPN14 picked up the water pitcher off the medication cart and

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	495149	A. Building B. Wing	09/19/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure potential allegations of abuse was reported timely to the Administrator and to the State Survey Agency (SSA) two of six residents (Resident (R) 53 and R79) reviewed for abuse out of 47 sampled residents. This failure increased the risk of other vulnerable residents being abused.Findings include: Review of the facility's policy and procedure titled Resident Abuse, revised 01/2023, provided by the facility, revealed . G. procedure for reporting abuse i. all incidents of abuse are reported immediately to the licensed nurse in charge, director of nursing, or the administrator . iii. IF the events that caused the suspicion did not result in serious bodily injury the facility shall report within 24 hours . V. Employee obligation: a. all employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights. Any employee who witnesses or has knowledge of an act of abuse to a resident is obligated to report such information to the licensed nurse in charge, don, or the administrator . 1.Review of R53's admission Record, located in the electronic medical record (EMR) under the profile tab, revealed the resident was admitted to the facility on [DATE] with a diagnosis of adjustment disorder with anxiety. Review of R53's quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 01/27/25, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognately intact. Review of R53's General Note, dated 03/25/25, located in the EMR under the Prog Notes tab, revealed During nursing rounds, nurse was alerted that patient had a verbal altercation that was out of control, and no one could calm patient down. Nurse went to assess patient, and the patient was sitting on side of his bed, stating that he was upset. Nurse asked patient what happened. Patient explained to nurse the details of events. Nurse asked what could nurse do to calm him down. Patient stated he wanted to vent and be heard. He voiced that he felt better but refused to have nurse come back into his room. Nurse informed manager on call. Patient resting in bed, supine, lying on left side, call bell and PO [by mouth] fluids in reach. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility Reported Incident (FRI), dated 03/25/25, revealed the facility performed an internal investigation and confirmed verbal abuse occurred on 03/23/25. The allegation of verbal abuse was submitted to the state agency on 03/25/25 (two days after the incident occurred). The investigation revealed that R53 reported that he was subjected to verbal abuse by Licensed Practical Nurse (LPN) 14 after she woke him up to administer his medications, she shoved the medications in his face so he became upset, he followed her out of his room, he picked up a wet floor sign in the hallway and threatened to hit her with it while she was standing at the medication cart. LPN14 picked up the water pitcher off the medication cart and threatened to crack him over the head with it if he came any closer to her. LPN1 heard R53 screaming at LPN14 in the hallway so she escorted him to his room and provided emotional support. LPN14 left the building after the incident and was terminated from employment. Abuse in-services were completed with all staff during the investigation from 03/25/25 and 03/26/25. Additional interventions included R53 receiving a visit from the psychologist for emotional well-being, receiving psychosocial follow-up from the Social Services Director (SSD), and the Director of Nursing (DON) and nurse management ensuring his safety and that his needs were met. During an interview on 09/17/25 at 5:22 PM, the Administrator confirmed she was not notified of the verbal abuse to R53 when it was observed by LPN1 and reported to the on-call manager on 03/23/25 around 11:00 PM. The Administrator confirmed she did not report it within two hours to the state survey agency (SSA), and did not submit the initial and 5-day follow-up report to the SSA within the required timeframes. The Administrator stated LPN1 left a concern note on 03/25/25 regarding the incident so she submitted the initial report to the SSA on 03/25/25, initiated the investigation, asked LPN14 to write a statement, substantiated abuse in the 5-day report on 04/03/25, and then training was conducted with all the staff on abuse, neglect, and reporting abuse. The Administrator also indicated LPN14 was suspended during the investigation and terminated on 03/25/25. During an interview on 09/18/25 at 5:33 PM, LPN14 stated R53 tried to attack her in the hallway with a wet floor sign and cursed at her at the medication cart after she administered his medications to him on 03/23/25. LPN14 confirmed she picked up the water pitcher off the medication cart and said she would crack him in the head if he didn't get away from her. LPN14 also stated she wrote a statement at the request of LPN1 and left for the evening, verbally quit, and only returned to the facility to provide another statement to the Administrator on 03/25/25. During an interview on 09/19/25 at 9:03 AM, LPN1 stated she saw LPN14 with a water pitcher in her hand at the medication cart in the hallway and R53 was screaming in front of her in his wheelchair with a wet floor sign in his hand. LPN1 indicated she reported abuse to the on-call manager but could not remember the name of the manager after R53 explained what occurred around 11:00 PM on 03/23/25. LPN1 also indicated the on-call manager instructed her to write a statement and to get one from LPN14. LPN1 also stated she thought she reported timely.

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	495149	A. Building B. Wing	09/19/2025

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

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	495149	A. Building B. Wing	09/19/2025

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F 0658 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 interview, record review, and review of the facility's policy, the facility failed to ensure the nursing staff provided care that met professional standards of practice when an order was not obtained from the physician for a controlled substance, lorazepam (narcotic medication), prior to administration to a resident during a seizure for one of four residents (Resident (R) 13) reviewed for nursing standards out of a sample of 47 residents. This failure placed the resident at risk for complications related to administration of the medication without an order.Findings include:Review of the facility's policy titled Physician Orders, dated 8/2021, provided by the facility, revealed . Procedure . Routine Orders: 1. A clinical nurse may accept a telephone order from the Physician, Physician's Assistant, or Nurse Practitioner as sate statue permits . 2. The order shall be recorded exactly as the physician dictates it on a telephone order form .Review of the facility's policy titled Medication Administration General Guidelines, dated 01/23, provided by the facility, revealed Policy Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only persons legally authorized to do so . Procedures Medication Preparation: . 3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record . Review of R13's undated admission Record located in the electronic medical record (EMR) under the Profile tab, revealed he was admitted on [DATE] with epilepsy, unspecified, not intractable, with status epilepticus. Review of R13's Physician's Orders, dated 04/15/25, located in the EMR under the Orders tab, revealed an order for lorazepam injection solution 2 milligrams (MG)/Milliliters (ML) inject 0.5 ML intramuscularly one time only for agitation/combative for one day. Review of R13's General Note, dated 04/25/25, located in the EMR under the Prog Notes tab, revealed At approximately 6:00 PM, resident was reported to me by the CNA [certified nursing assistant] that he was having seizure at the hallway while I was passing medication, I rushed, and we guarded him, positioned him with the head turned to the left side. He was guarded to avoid sustaining any physical injury. The seizure lasted to about 6 minutes and when it stopped, he was assisted back to his room, laid him down with his bed lowered. The physician was called and did not answer, but voice note was left with detailed information and call back number to possibly obtain an order for lorazepam injection. Thereafter, the on-call nurse was notified as well to reach out to the physician on call, but she advised that for the seizure has lasted for about 6-7 minutes , there is no need for lorazepam injection pending when she will talk with the physician, thereafter a while she called me back that I should not administer it because the period of the seizure was very short. Then I was still waiting for the physician on call to call me back and at about 8:00 pm plus, the CNA came back again and reported 2nd episode of active seizure while in his bed and was well positioned to prevent aspiration. Then, other nurses in the facility were alerted for assistant [sic]. When they arrived, the seizure continued for 15 minutes. The RN [registered nurse], asked me to get the lorazepam so we can administer to him as he was in active and continuous seizure for breakthrough, but I told her that I was waiting for the approval of the order from the NP [nurse practitioner] as the nurse on call advised that I should not give without their approval, but she insisted that this is an emergency and has to be done. Then, I rushed and brought it to her then the RN give 0.5ml of it, injected to his right deltoid muscle, while the seizure was still active. Nurse, called 911 at about 8:18 PM, they arrived, took over the care and resident was transport [sic] via stretcher out of the facility. Thereafter, the NP was called again to notify her of the situation and the Lorazepam that was given by the RN for a verbal order as it was an emergency, but NP, refused giving the verbal order that the nurse must obtain an order from her before giving it regardless of emergency situation or not, then on call nurse was notified as well. The family member was notified @ [at] 9:39 PM. The night nurse was as well notified of the situation.Review of R13's Alert Note, dated 04/25/25, located in the EMR under the Prog Notes tab, revealed This nurse called to pt's [patient's] bedside for c/o [complaints of] distress by CNA. Pt. was found in bed, actively seizing. Pt's head was turned to left side. Pt. was spitting, and having pink tinged secretions from mouth. Pt. did not respond, to name calling. Pt continued to have rapid eye movement. Warm to touch. Nurse remained with patient, until 911 called by this nurse. Nurse was advised to maintained a safe environment for patient. Pt. seized for 4 minutes then stopped for 10 sec [seconds] and seized again for 5 minutes. 0.5 cc [cubic centimeters] IM [intramuscular] Ativan given in right deltoid. Pt. continued to seize after medication given. EMS [emergency medical services] arrived and toke [sic] over pt.'s care .Review of the facility's internal investigation, dated 04/29/25, revealed R13 exhibited seizure like activity on 04/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. Building B. Wing	09/19/2025

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to ensure the nursing staff followed the resident's do not resuscitate (DNR) order for one of three residents (Resident (R) 109) reviewed for advance directives out of 47 sampled residents. On [DATE], R109 was found unresponsive in her room, the nursing staff did not verify her code status prior to providing chest compressions in the absence of a pulse; when the code status was verified the nurse stopped chest compressions and R109 was sent to the hospital. Additionally, the nursing staff were not aware where to locate the code status of the residents during a power outage. An Immediate Jeopardy was identified on [DATE] and was determined to exist [DATE] in S483.24, F678 Cardio-Pulmonary Resuscitation (CPR). The Administrator and Regional Clinical Director were notified on [DATE] at 3:08 PM that Immediate Jeopardy existed.The failure of the nursing staff to verify the resident's code status when found unresponsive resulted in the resident receiving CPR which did not honor her wishes created an immediate jeopardy situation. An acceptable Immediate Jeopardy Plan of Removal was provided on [DATE] at 6:24 PM and was validated on [DATE] at 10:00 AM. The Administrator was notified on [DATE] at 10:30 AM that the Immediate Jeopardy was removed. After the removal of the Immediate Jeopardy, the deficiency remained at a scope and severity of a D, (no actual harm with the potential for more than minimal harm).Findings include:Review of the facility's policy and procedure titled Cardiopulmonary Resuscitation (CPR), revised 4/2024, revealed Policy Residents advance directive will be honored . 1. Cardiopulmonary resuscitation is initiated on all residents except those with a no code order and appropriate documentation . Procedure 1. In the case of cardiac and/or pulmonary arrest, after the code status is checked, CPR is initiated if it is the residents' choice to have CPR, using the Red Cross or American Heart Association Guidelines for performing CPR .Review of R109's admission Record located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with a diagnosis of pulmonary fibrosis and was discharged from the facility on [DATE]. Review of R109's Physician's Orders, dated [DATE], located in the EMR under the Orders tab revealed an order for DNR - do not resuscitate. Review of R109's Virginia Department of Health Durable Do Not Resuscitate Order, dated [DATE], located in the EMR under the Misc tab revealed 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment was marked and was signed by the resident and physician. The order stated that on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest .Review of R109's General Note, dated [DATE], located in the EMR under the Prog Notes tab revealed at approximately 1:00 PM, patient observed ambulating back to her room pulling oxygen tank and verbalized to nurse, I'm ready for my Gabapentin now. A Certified Nursing Assistant (CNA) told the nurse that the patient did not look right, she was blue, and not responding. The nurse immediately ran to patient room. Nurse observed patient standing up against bed in a stance, staring with eyes wide open, blue in the face, dark purple around her mouth, mouth wide open. Nurse immediately yelled for assistance and crash cart. and placed the patient on her bed, lowered the head, immediately placed backboard under her. Nurse immediately administered oxygen. Patient remained in stiff, blue around the mouth, and now blue/gray around her eyes. Nurse was alerted by assisting staff that the patient code status was DNR. Nurse continued with oxygen. Nurse had assisting staff obtain VS [vital signs] of 96.3 [temperature]-116 [heart rate]-28 [respirations]-0-44/31-71 [blood pressure]-blood glucose 135. Nurse and assisting staff called PA [physician assistant] who came back to facility, assessed situation, and gave order to send patient to the hospital via 911. Nurse printed paperwork including the DNR code status. 911 was called by assisting staff member. 911 came and transported patient to ED.Review of the Facility Reported Incident (FRI) revealed, Certified Nursing Assistant (CNA)1 observed R109 in her room exhibiting cyanosis and minimal responsiveness and Licensed Practical Nurse (LPN)1 responded and assessed the resident and noted signs of distress. Despite a documented DNR order in place, LPN2 initiated chest compressions and upon verification of the DNR, chest compressions were immediately discontinued. R109 was noted to have shallow respirations and a pulse and was placed in a recovery position. Emergency Medical Services (EMS) was contacted and subsequently transported to the hospital emergency room (ER). Corrective actions included initiating a thorough investigation into the event

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure narcotic pain medications were administered to one of three residents (Resident (R) 106) reviewed for pain management out of a total sample of 47. This resulted in the resident missing multiple doses of pain medication and potentially reducing his quality of life.Findings include:Review of a facility policy titled, Pain Management, dated 01/2020, indicated . Residents will be assessed for pain upon admission, readmission, quarterly, annually, upon significant change, when a resident experiences a new onset of pain or experiencing uncontrolled pain . Review of R106's admission Record, located under the Profile tab of the electronic medical record (EMR), indicated the resident was admitted to the facility on [DATE].Review of R106's admission Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 09/10/24, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated the resident was able to ambulate on his own. The assessment indicated at the time of the assessment, the resident had no pain.Review of R106's Care Plan, located under the Care Plan tab of the EMR and dated 11/04/24, indicated the resident had intermittent pain post motor vehicle accident. The intervention was to medicate for pain as ordered by physician and follow up for effectiveness.Review of R106's Order, located under the Orders tab of the EMR and dated 12/09/24, indicated the resident was ordered by Oxycodone HCl (a narcotic analgesic) tablet 5 milligrams (mg) to be administered every six hours for chronic pain.Review of R106's Medication Administration Record (MAR) for the month of 12/2024, located under the Orders tab of the EMR, indicated the facility failed to assess the resident's pain and administer Oxycodone 5 mg on the following dates: 12/10/24 at 6:00 AM; 12/15/24 at 6:00 AM; 12/23/24 at 12:00 AM; 12/26/24 at 12:00 AM and 6:00 AM; and on 12/28/24 at 6:00 AM. Review of R106's Progress Notes, located under the Prog (Progress) Note tab of the EMR and dated for the month of 12/2024, failed to contain evidence of why the resident was not assessed or administered his physician ordered pain medication.Review of R106's MAR, for the month of 01/2025 and located under the Orders tab of the EMR, indicated the facility failed to assess and administer Oxycodone 5mg on the following dates: 01/04/35 at 6:00 PM; on 01/05/25 at 6:00 AM and 6:00 PM; and on 01/06/25 at 12:00 AM.Review of R106's Progress Notes, located under the Prog Note tab of the EMR and dated for the month of 01/2025, failed to contain evidence of why the resident was not assessed or administered his physician ordered pain medication. During an interview on 09/18/25 at 10:36 AM, the Director of Nursing (DON) stated her expectation was if a resident was on routine pain medication and it was not administered, the nurse should have then documented the reason in the EMR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portsmouth Health and Rehab	900 London Boulevard Portsmouth, VA 23704

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. Building B. Wing	09/19/2025

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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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to remove and destroy a controlled medication, lorazepam (narcotic medication), that was discontinued and subsequently administered to a resident during a seizure without an order for one of four residents (Resident (R) 13) reviewed for pharmacy services. out of a sample of 47 residents. This failure placed the resident at risk for complications related to administration of the medication without an order. (Cross Reference F658)Findings include:Review of the facility's policy titled Controlled Drug Medication Disposal, revised 1/2020, revealed Policy to ensure controlled substances are disposed of, according to Federal/State laws and regulations, by the Director of Nursing and consultant Pharmacist. Appropriate record keeping will be completed and maintained by the Director of Nursing and consultant Pharmacists . 2. Discontinued medication or resident has been discharged . A. The Director of Nursing will remove the medication from the medication cart and the Controlled Drug Declining Inventory Sheet from the MAR or Narcotic Book in the presence of another nurse. B. The Director of Nursing and the other nurse will sign the Controlled Drug medication sheet to verify removal. C. The Controlled Medication and Controlled Drug Declining Inventory Sheet will be held together with a rubber band and placed in a designated double locked area. Medication is to disposed of by the Director of Nursing and another professional person as designated by state policy .Review of R13's undated admission Record located in the electronic medical record (EMR) under the Profile tab, revealed he was admitted on [DATE] with epilepsy, unspecified, not intractable, with status epilepticus. Review of R13's Physician's Orders, dated [DATE], located in the EMR under the Orders tab, revealed an order for lorazepam injection solution 2 milligrams (MG)/Milliliters (ML) inject 0.5 ML intramuscularly one time only for agitation/combative for one day. Review of R13's Alert Note, dated [DATE], located in the EMR under the Prog Notes tab, revealed This nurse called to pt's [patient's] bedside for c/o [complaints of] distress by CNA. Pt. was found in bed, actively seizing . Pt. seized for 4 minutes then stopped for 10 sec [seconds] and seized again for 5 minutes. 0.5 cc [cubic centimeters] IM [intramuscular] Ativan given in right deltoid. Review of the facility's internal investigation, dated [DATE], revealed R13 exhibited seizure like activity on [DATE]. LPN5 provided supportive care and called for assistance from Registered Nurse (RN) 2. LPN5 contacted 911, and RN2 noted R13 had Ativan IM in the narcotic drawer, however, the medication had been discontinued and there was not an active order. LPN5 brought the medication to R13's room and RN2 administered the IM Ativan to stop the seizure. Actions taken included suspending LPN5 during the investigation on [DATE] then terminating him on [DATE]. RN2 was removed from the schedule and agency was informed that she was a do not return to the facility on [DATE]. All nursing staff were re-educated on following physician's orders, medication administration, and the narcotic destruction process for discontinued medications on [DATE] by Director of Nursing (DON) 2. DON2 audited the medication cart narcotic boxes and facilitated the destruction of the discontinued narcotics. During an interview on [DATE] at 11:22 AM, the Director of Nursing (DON) 1 stated discontinued narcotic medications should be pulled from the medication carts along with a completed narcotic sheet and then given to her to destroy with another nurse. During an interview on [DATE] at 1:59 PM, the Administrator stated DON2 initiated the investigation of the incident and facilitated the destruction of the discontinued narcotic medications on [DATE]. The Administrator stated DON2 facilitated destroying the controlled medications with the unit managers during the investigation. During an interview on [DATE] at 11:50 AM, DON2 stated she had worked for the facility a couple of weeks when she completed the investigation and determined RN2 administered R13's discontinued lorazepam which should have been pulled from the medication cart and given to her for destruction. DON2 also stated she asked the unit managers to remove discontinued and expired controlled medications from the medication carts and began destroying the medications with them after the incident on [DATE].