STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maimonides Health Center of Virginia Beach	6401 Auburn Dr Virginia Beach, VA 23464

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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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on family interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to inform the the resident's representative and Nurse Practitioner of a change in condition for 2 of 10 residents (Resident #4, and #2) which resulted in harm at Past Non-Compliance, for Resident #4 in the survey sample.The findings included: 1.Resident #2 was admitted to the facility on [DATE] with diagnoses including nephrostomy tubes for urine excretion, chronic heart failure and chronic heart disease with 3 cardiac arterial bypass grafts, an artificial heart valve, and a left ventricular ejection fraction of only 26% revealing a severely weakened heart muscle. The Resident's admission weight was 120 pounds, and she used oxygen in the hospital and was ordered to be administered Oxygen at 3 liters per minute via nasal cannula as needed upon discharge. Review of the clinical record revealed nursing and physician progress notes dated 3-2-25, through 3-5-25 with the following condensed information. On 3-2-25 at 8:00 p.m., the Skilled unit nurse wrote that the Resident's son had called multiple times, and she had just answered his inquiries about his mother's weights and medication administration. The Resident's weight was 128 pounds, an increase of 8 pounds since admission. On 3-4-25 at 8:00 a.m., the Registered Nurse Practitioner (NP) wrote that an assessment of the Resident had been conducted, and she found 2+ pitting edema in the Resident's lower extremities and a 3-pound weight increase (in error). On 3-4-25 at 12:00 noon, the Physiatrist wrote that an assessment of the Resident had been conducted, and he found 3+ pitting edema in the Resident's lower extremities, and the Resident told him that she did not feel good. On 3-4-35 at 3:00 p.m., the Skilled unit nurse wrote that the Resident was short of breath and had a weight of 127.7 pounds. On 3-5-25 at 9:45 p.m., the Skilled unit nurse wrote that the Resident's son had called and complained that the Resident was weak and confused at dinner (6:00 p.m.) and he wanted her sent to the emergency room at the hospital for evaluation. The order to send the Resident was received at 10:00 p.m., however, the Resident was not sent until 1:17 a.m. (3 hours later) on 3-6-25. She did not return and expired in the hospital 2 days later on 3-8-25. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	This 3-5-25 interaction as documented by nursing staff revealed that the family member called the facility as the decision-making authority, and the facility did not notify him of the preceding 2 days of concerning symptoms that the Resident was experiencing. The Resident's son was interviewed on 11-17-25 at 12:00 noon, and stated he had to call them, they never called him, nor returned his calls. He further stated that he had difficulty reaching the staff, often calling multiple times a day before reaching a staff member. Weights were ordered on admission, completed daily, and documented as revealed in the review of the clinical record. The hospital discharge summary did denote that if the Resident should experience a 3-pound weight gain in one day or a 5-pound weight gain in one week, that the cardiology physician should be contacted immediately. The Resident's care plan was also reviewed and revealed that worsening edema, and weight gain were to be assessed for, and the physician notified, should this issue arise as it would underscore a worsening condition. Review of the weight documents further revealed that from 2-4-25 through 2-9-25 the Residents weight increased from 121.0 pounds to 128.4 pounds in 5 days. Her weight continued to be elevated and from 2-26-25 until the Resident was discharged to the emergency room on 3-6-25 at 1:17 a.m., (7 days later). The Resident's weight stayed at its highest elevation during this week of 8.8 pounds since the admission weight of (120 pounds), ranging between 127.7 to 128.8. There is no indication that the cardiology doctor was ever notified. On 11-17-25 at 3:00 p.m., at the end of day debriefing held with the Director of Nursing (DON), and Assistant Director of Nursing (ADON), they were informed by surveyors of the staff failure to notify the responsible party of a Resident's worsening condition, and both stated they had nothing further to provide. 2.The facility staff failed to ensure the resident's Power of Attorney/Daughter and the Nurse Practitioner were notified of resident being in severe abdominal pain. Resident #4 was originally admitted to the facility 6/13/25 after an acute hospital stay and discharged on 7/28/25 to an acute care facility. The current diagnoses included; Type 2 Diabetes Mellitus with hyperglycemia and Pain in Right Knee, Chronic Kidney Disease stage 4, anemia, heart failure, and Chronic Respiratory failure. Resident #4 was admitted to the facility on [DATE] after an acute hospital stay and discharged on 7/28/25 to an acute care facility. The current diagnoses included; Type 2 Diabetes Mellitus with hyperglycemia and Pain in Right Knee, Chronic Kidney Disease stage 4, anemia, heart failure, and Chronic Respiratory failure. The significant change, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/13/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #4 cognitive abilities for daily decision making were moderately impaired. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	In sectionGG(Physical functioning) the resident was coded as independent with eating, requiring set up or clean up assistance with oral hygiene, requiring substantial/maximal assistance with toileting and personal hygiene and resident coded as dependent with shower/bathe self. In section J (Health Conditions) J0100-Pain Management (B) coded resident as not receiving scheduled or prn pain medications. The person-centered care plan dated 3/06/24 and revised on 6/05/25 read the resident has chronic pain r/t knees. The Goal for the resident is the resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through 6/29/25. The interventions for the resident were as follows: Administer analgesia (Tylenol) as per orders. Give 1/2 hour before treatments or care, monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician, monitor/record pain characteristics (knees) and PRN: Quality (e.g. sharp, burning); Severity (1 to 10 scale); Anatomical location; Onset; Duration (e.g., continuous); Aggravating factors; Relieving factors (Revised 7/26/24). A review of the July 2025 Medication Administration Record (MAR) and Physician Order Summary (POS) revealed the following orders were received for Resident #4 during her course of pain and discomfort beginning on 7/27/25 through 7/28/25: Resident #4 received Lactulose Solution 10 GM/15ML -30 ml by mouth three times a day for constipation for 2 Days, (Hold for loose stool) on 07/28/2025 at 12:00 pm. The resident received Tylenol 325 mg 2 tablets, prn every 4 hours on 7/27/25 at 12:30 am., and on 7/28/25 at 10:19 am., On 7/28/25 bladder scan ordered for urinary retention was completed at 1:24 pm. The (MAR) revealed resident was given Albuterol Sulfate Inhalation Aerosol on 7/27/25 through 7/31/25 but seemed questionable due to the resident being discharged on 7/28/25 in the evening. On 7/28/25 at 2:58 pm., a STAT Order for Fleets Enema was given to resident rectally per order. On 7/28/25 at 11:15 am., an order for Simethicone Oral Tablet 80 MG (Simethicone) 2 tablet by mouth every 6 hours as needed for Gas pain/bloating, was ordered but not administered. On 7/28/25 at 3:02 pm., A STAT KUB was ordered for Abdominal pain/distention, was not administered due to resident being transported to the hospital at 5:19 pm. A timeline of events leading to residents' hospitalization revealed the following: A review of text messages sent on 7/28/25 from Resident #4 and her daughter/Power of Attorney read: 1:21 am, sent from Resident #4 reading: Help me. 5:56 am., the daughter responded: Hey mom, you ok? You texted me at 1 in the morning to help you. What help did you need? 6:45 am., the resident responded: I'm in pain. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	7:54 am., the daughter responded: Ok press your button! what hurts?? Is it your knee? 2:28 pm., the resident responded: No stomach very bad. Help 2:28 pm., the daughter responded: Oh, that's awful. Hit that button!!!!!! 2:29 pm., the daughter responded: If (unknown name) is around ask her to get you help. If no one answers you let me know. On 7/28/25 at 12:04 am., a health status note read resident c/o abdominal pain at 11:20 pm (7/27/25). The resident was repositioned, stated she could not breathe but after repositioned she felt better, pain level went from 8 to 3-4 after repositioning and after ginger ale and her oxygen saturation was 98% on 2L N.C Resident family visited this evening and brought in donuts (Prior to complaining). The resident also ate two peanut butter and jelly sandwiches this evening. Resident is now resting with her eyes closed, fan blowing on bed side. She feels better and felt some relief from her abdominal pain. The resident is not on the BM (Bowel Movement) due list. The above health status note revealed that the resident was not on the list for bowel movement, which could indicate other issues were impending, possibly causing her abdominal pain and discomfort. A review of the Medication Administration Record (MAR) dated 7/27/25 at 12:30 am., read that Tylenol 325 mg, 2 tabs were given. On 7/28/25 at 5:52 a.m., A late entry health status note read that a Certified Nursing Assistant (CNA) reported to this writer that resident experienced an episode of vomiting and has been complaining of pain throughout the night. Upon assessment, resident was observed sitting upright in wheelchair, napping. Resident was gently awakened and assessed. Resident verbalized, My neck has been bothering me all night and I have pain over here, while pointing to the right side of her abdomen. She was unable to describe the quality of the pain and, when prompted with descriptors (pressure, sharp, burning, dull), responded, All of the above. Nurse on duty was alerted and reported that resident received analgesia at the beginning of the shift and is due for the next dose in one hour. Nurse also stated that resident was administered Milk of Magnesia approximately one hour ago. A review of Health status and nursing notes revealed the following: A review of the above nurses' and health status notes revealed that Resident #4 first complained of pain on 7/27/25 at 11:20 pm., was administered Tylenol 2 tablets 325 mg (according to the late entry note), On 7/28/25 at 5:52 am, (6 hours and 32 minutes later) the Certified Nursing Assistant reported that Resident #4 had pain and vomiting throughout the night, pointing to the right side of her abdomen. On 7/28/25 at 6:05 am. (6 hours and 45 minutes later) per health status note resident is still complaining about having abdominal pain, Miralax given for possible constipation. On 7/28/25 at approximately 10:30 am., (11 hours and 10 minutes later) the nurse practitioner came in to evaluate resident for complaining of having abdominal pain and nausea after being notified within 10 minutes by nursing staff of resident's complaints. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	According to the health status notes neither the on-call doctor nor the Nurse Practitioner were notified in a timely manner of resident's abdominal pain or discomfort for hours, it wasn't until 11 hours and 10 minutes later, that the NP was notified, which resulted in a delay in treatment, neglect and notification. On 7/28/2025 at 12:33 pm., a late entry health status note read: Resident's roommate notified facility staff resident still complaining of pain and shortness of breath (SOB). Vital signs were taken, Resident on 02 at 3 liters per nasal cannula. Nursing staff says she is waiting to hear from primary care provider. On 7/28/25 at 1:53 pm., according to the Medication Administration Record (MAR) resident received 2 Tylenol tablets, 325 mg. The follow-up read was ineffective with pain scale being a 6. According to the health status notes Resident #4 was still experiencing pain and discomfort since her initial complaint of pain, and was administered Tylenol 2 tablets, 325 mg at 11:20 pm, on 7/27/25 for a total of 14 hours and 33 minutes, the resident had still remained at the facility. On 7/28/2025 at 2:00 pm., Late Entry Health Status Note: Resident continues to c/o abdominal pain and right-side neck pain from previous shift and stated that lying down relieves pain some. Not able to consume breakfast. Fluid intake adequate. ADL care was provided. Resident rang call light several times between breakfast and lunch hour c/o pain. NP down to assess resident. New orders given for bladder scan and lactulose x1 along with gas-x x1. Resident stated that gas-x relieved pain minimally. Lactulose ineffective. Bladder scan shown 28cc urine. Verbal order received for resident to have foley placed. Writer disagreed and immediately went to unit. According to the health status note the Power of Attorney (POA) Responsible Party (RP), daughter was not notified of the above issues from the facility staff until 4:49 pm, on 7/28/25, which was 17 hours and 29 minutes later. According to the health status note dated 7/28/25 at 5:15 pm, Resident #4 was picked up by medical transport via ambulance to be transported to the local hospital. The POA was notified of the pick-up time. On 11/15/25 at approximately 6:15 pm, a telephone interview was conducted with the complainant Daughter/Power of Attorney (POA) concerning Resident #4. The resident's daughter said that a text message was sent to her by her mom reading I'm in pain. The daughter thought that her mother was having knee pain, but she indicated that she felt bad because her stomach was hurting. My mother's roommate later mention that my mother was crying and screaming all night long. The resident's daughter also said that she was not informed until late 7/28/25. The daughter also mentioned that the doctor at the hospital said my mom became septic due to having a perforated ulcer. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	On 11/12/25 at approximately 3:35 pm., an interview was conducted with Licensed Practical Nurse (LPN) #1. LPN #1 said that the resident's daughter visited her on the night of 7/27/25 and that the resident never complained of any discomfort until an hour after the daughter left. LPN #1 said that the resident complained of having a hard time breathing but he repositioned her and she also complained that her stomach was hurting. He said that the resident had eaten 2 sandwiches before her daughter arrived and ate donuts-this was after 8 pm. LPN#1 said the resident started burping and he gave her ginger ale due to her feeling nauseated. It was past 11:00 pm, when she complained of pain. I stayed until she felt better around 12:30am. , then I clocked out. LPN #1 also said that when he returned on 7/28/25 to work the 3-11 shift, the nurse that he was relieving said that the resident is not better. LPN #1 also mentioned they tried to transfer the resident to the toilet, but she appeared like she was going to pass out, saying she was having discomfort with her stomach. LPN #1 also that he contacted her daughter later on 7/28/25. LPN #1 also mentioned that he approached the Nurse Practitioner (NP) and said, we should do something. On 11/17/25 at approximately 1:25 pm., an interview was conducted with Certified Nursing Assistant (CNA) #1. CNA#1 said that Resident #4 was able to make her needs known, use a call bell and able to communicate discomfort or pain. CNA #1 said that the morning the resident wasn't feeling good she reported it to the charge nurse that the resident was pointing to her belly saying she wasn't feeling well. The resident didn't want anything to eat in the morning or at lunch, I kept pushing fluids in her. CNA was asked the resident needed to have a bowel movement. CNA #1 said that the resident didn't need to go to the toilet. On 11/17/25 at approximately 3:05 pm, an interview was conducted with the ADON concerning Resident #4. The ADON said there was a delay in treatment relating to the NP waiting too late for the STAT KUB and on sending the resident to the ER. The ADON also said that the family should have been informed of the change in condition but wasn't notified until 7/28/25 at 5:15 pm. The ADON also mentioned that the DON had instructed the unit manager to speak to the NP to send the resident to the ER. On 11/17/25 at approximately 3:25 pm., an interview was conducted with LPN #4. LPN #4 said that on the 3-11 shift on the night of 7/27/25 due to eating a lot of food the resident was complaining of having pain in the back of her neck, with her hand placed on her stomach, the resident was given ginger ale and belched. LPN#4 said, We thought she had indigestion. Compliance with Reporting Allegations of Abuse/Neglect/Exploitation. Date implanted: 9/24. Policy: It is the policy of this facility to report all allegations of Abuse/Neglect/Exploitation or mistreatment. Including injuries of unknown sources and misappropriation of resident property are reported immediately to the administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. Compliance Guidelines: The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences. Identification: Neglect: Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid pain. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	On 11/12/25 at approximately 12:30 pm, a brief interview was conducted with the administrator, asking if the facility had any current (2025) Performance Improvement Plans (PIPs), and Facility Related Synopsis to present to the survey team. The administrator was given 20 minutes to bring in evidence of the above requested documents. On 11/12/25 at approximately 12:53 pm, the Director of Nursing (DON) brought in a PIP. It was reviewed. There was no resident identifiable information on the PIP, no corrective action dates, no Allegation of Compliance (AOC) date. The DON said that it would be 4 weeks from 9/19/25 but later changed the date to 9/29/25. On 11/12/25 at approximately 1:47 pm, the survey team met with the DON, the Assistant Director of Nursing (ADON), and the administrator. They were asked to identify the resident in question for the PIP. The administrator said they were working on HIPAA for privacy, (The Health Insurance Portability and Accountability Act), we're calling it a POC so we can get Past Non-Compliance (PNC) 9/19/25 as our end date. The DON and the administrator meant to say 4 weeks from compliance from date. DON said that the resident's name should have been written on the PIP. The administrator said that we missed the name and date. The following five-point plan was discussed secondary to Resident #4's pain, notifications and abuse concerns: The facility identified Resident #4's care resulted in the areas of pain management, notification and abuse. The facility completed a 100 percent review of all pain assessments in the facility previous to determine like-residents. Staff education was 100 percent for all nursing staff by the Director of Nursing and ADON to educate staff on pain management, notifications and abuse. The Administrator, Director of Nursing and ADON completed weekly audits 5 times per week for 4 weeks to include pain management, notifications and abuse. All Quality Assurance and Performance Improvement (QAPI) findings will be forwarded to the QAPI committee. Corrective action was completed on 9/29/25. On 11/12/25 at approximately 4:05 pm., during the end of day meeting the DON said that the AOC date will be 9/29/25. We have not had any incidents since 9/29/25. The survey team reviewed the PNC POC documents. It was determined by the survey team through interviews, record reviews and resident observations that the above practices were not identified since 9/29/25 nor during the course of the survey from 11/12/25 through 11/17/25. On 11/17/25 at approximately 4:25 p.m., the above findings were shared with the Director of Nursing (DON), the Assistant Director of Nursing (ADON) and via telephone the local Ombudsman was present. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided. It was determined that the facility implemented its Corrective Action Plan, and there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance at the time of the current survey for the regulatory requirements, F580, Past Non-Compliance.

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F 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, secure text messaging, family interviews and review of facility documents, the facility's staff neglected to ensure a resident who was in severe abdominal pain received care and treatment in a timely for 2 of 10 residents (Resident #2 and Resident #4) in the survey sample which resulted in Harm for Resident #4. Past Non-Compliance was issued for this deficient practice.The findings include:1. 1.Resident #2 was admitted to the facility on [DATE] with diagnoses including nephrostomy tubes for urine excretion, chronic heart failure and chronic heart disease with 3 cardiac arterial bypass grafts, an artificial heart valve, and a left ventricular ejection fraction of only 26% revealing a severely weakened heart muscle. The Resident's admission weight was 120 pounds, and she used oxygen in the hospital and was ordered to be administered Oxygen at 3 liters per minute via nasal cannula as needed upon discharge. Review of the clinical record revealed nursing and physician progress notes dated 3-2-25, through 3-5-25 with the following condensed information. On 3-2-25 at 8:00 p.m., the Skilled unit nurse wrote that the Resident's son had called multiple times, and she had just answered his inquiries about his mother's weights and medication administration. The Resident's weight was 128 pounds, an increase of 8 pounds since admission. On 3-4-25 at 8:00 a.m., the Registered Nurse Practitioner (NP) wrote that an assessment of the Resident had been conducted, and she found 2+ pitting edema in the Resident's lower extremities and a 3-pound weight increase (in error). On 3-4-25 at 12:00 noon, the Physiatrist wrote that an assessment of the Resident had been conducted, and he found 3+ pitting edema in the Resident's lower extremities, and the Resident told him that she did not feel good. On 3-4-35 at 3:00 p.m., the Skilled unit nurse wrote that the Resident was short of breath and had a weight of 127.7 pounds. On 3-5-25 at 9:45 p.m., the Skilled unit nurse wrote that the Resident's son had called and complained that the Resident was weak and confused at dinner (6:00 p.m.) and he wanted her sent to the emergency room at the hospital for evaluation. The order to send the Resident was received at 10:00 p.m., however, the Resident was not sent until 1:17 a.m. (3 hours later) on 3-6-25. She did not return and expired in the hospital 2 days later on 3-8-25. Resident #2's discharge hospital orders were reviewed and revealed a hospital physician's order for labs to be drawn in 3 days, however, upon the resultant admission to the skilled nursing facility the Resident was ordered by the physician there to begin drawing labs on 1-29-25 (8 days after admission). The lab draw schedule then went on to be ordered randomly for 2-5-25, 2-8-25, 2-12-25, 2-18-25, and 3-4-25. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Weights were ordered on admission, completed daily, and documented as revealed in the review of the clinical record. The hospital discharge summary did denote that if the Resident should experience a 3-pound weight gain in one day or a 5-pound weight gain in one week, that the cardiology physician should be contacted immediately. The Resident's care plan was also reviewed and revealed that worsening edema, and weight gain were to be assessed for, and the physician notified, should this issue arise as it would underscore a worsening condition. Review of the weight documents further revealed that from 2-4-25 through 2-9-25 the Residents weight increased from 121.0 pounds to 128.4 pounds in 5 days. Her weight continued to be elevated and from 2-26-25 until the Resident was discharged to the emergency room on 3-6-25 at 1:17 a.m., (7 days later). The Resident's weight stayed at its highest elevation during this week of 8.8 pounds since the admission weight of (120 pounds), ranging between 127.7 to 128.8. During the Resident's 43 day stay a gradual increase in weight, edema, and shortness of breath, all indicated a worsening condition. There is no indication that the cardiology doctor was ever notified of this, however, four medication changes were made by the skilled nursing facility physician to manage the symptoms of fluid overload. Those 4 medications follow below. 1. 1. Bumex 2 milligram (mg) every day ordered 1-21-25 through 2-21-25 (one month), 2-5-25 through 2-6-25 (2 days), then every day from 2-24-25 through discharge. 2. 2. Bumex 1 mg every day ordered 1-28-25 through 1-29-25 (2 days), and 2-18-25 through discharge every day. 3. 3. Metolazone 2.5 mg every day ordered 1-29-25 through 1-31-25 (2 days). 4. 4. Metoprolol 25 mg every day ordered 1-21-25 through 2-2-25 (12 days). A review of nursing progress notes revealed staff documentation that the Resident was noncompliant with her fluid restriction. Interviews conducted with staff and family also revealed that Resident #2 often asked others for fluids such as a roommate, family members, and dining services staff with complaints of thirst. The fluid weight gain experienced by Resident #2 was further questioned as review of the Resident's Intake and output records were reviewed and revealed a concerning revelation. The Resident was ordered to have a 1500 milliliter (ml) fluid restriction for each 24-hour day. The documents showed that upon admission on [DATE] and 1-22-25 no fluids were recorded as consumed. The Resident complained of thirst to her son frequently, and records show a pattern of not providing fluids to the bedridden Resident. The rest of the days documented during her stay of fluid consumption follow below. (January 2025) - 1-23-25 (420 ml), 1-24-25 (712 ml), 1-25-25 (240 ml), 1-26-25 (240 ml), 1-27-25 (1360 ml), 1-28-25 (1500 ml), 1-29-25 (720 ml), 1-30-25 (1490 ml), 1-31-25 (924 ml). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maimonides Health Center of Virginia Beach	6401 Auburn Dr Virginia Beach, VA 23464

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F 0600 Level of Harm - Actual harm Residents Affected - Few	(February 2025) - 2-1-25 (1660 ml), 2-2-25 (1440 ml), 2-3-25 (480 ml), 2-4-24 (960 ml), 2-5-25 (720 ml), 2-6-25 (900 ml), 2-7-25 (720 ml), 2-8-25 (482 ml), 2-9-25 (720 ml), 2-10-25 (1200 ml), 2-11-25 (660 ml), 2-12-25 (840 ml), 2-13-25 (480 ml), 2-14-25 (720 ml), 2-16-25 (720 ml), 2-17-25 (478 ml), 2-18-25 (420 ml), 2-19-25 (598 ml), 2-20-25 (598 ml), 2-21-25 (720 ml), 2-22-25 (716 ml), 2-23-25 (598 ml), 2-24-25 (480 ml), 2-25-25 (720 ml), 2-26-25 (720 ml), 2-27-25 (720 ml), 2-28-25 (720 ml). (March 2025) - 3-1-25 (960 ml), 3-2-25 (960 ml), 3-3-25 (716 ml), 3-4-35 (720 ml), 3-5-25 (720 ml). Only one time in January (1-28-25) did Resident #2 receive the 1500 ml of fluids allowed in her special diet. This reveals that the edema, weight gain, and shortness of breath were indeed symptoms of a worsening illness, and not related to fluid consumption nor noncompliance. The Resident's Activities of Daily Living (ADL) records were reviewed and revealed bathing and showering records. Those records indicated that Resident #2 received a bed bath only 3 times, on 1-23-25, 1-24-25, and 3-2-25. Documents recorded refusals to be bathed by the Resident only twice, on 2-10-25, and 3-1-25. No other baths nor showers were provided to Resident #2 during her entire 43-day stay in the facility. Staff members (2 LPNs licensed practical nurses and 2 CNAs Certified Nursing Assistants) on the unit where this Resident formerly resided were asked how often bathing was provided to the residents. The response by all was 2 times per week for showers or tub baths, and every day if they received bed baths. Other Residents were placed in the survey sample and reviewed for hygiene care which was found to be adequate at the time of survey. No pervasive odors, nor soiled linens on beds were found. Residents and family members were interviewed and had no issues with hygiene care being provided. A general finding of neglect based upon the other findings of withholding of goods and services required to care for this Resident is found. A preponderance of Observations, staff and family interviews, clinical record review, and facility document review indicate deficient practice in 3 specific areas of need for this Resident. Harm is not identified, as the complex comorbidities and severe cardiac illness for this [AGE] year-old Resident would have resulted in hospitalization, and likely death at a point in the near future as all available avenues of intervention had been exhausted. Notification to family members, bathing, and added fluid provision would not have improved the outcome for this Resident; however, they were required by federal regulation to be provided. On 11-17-25 at 3:00 p.m., at the end of day debriefing held with the Director of Nursing (DON), and Assistant Director of Nursing (ADON), they were informed by surveyors of the staff failure to provide goods and services required for this Resident resulting in neglect. Namely notifying the responsible party of a Resident's worsening condition, providing adequate bathing, and adequate fluids. Both stated they had nothing further to provide. 2.The facility staff failed to ensure a resident that was in severe abdominal pain received care, treatment and services to prevent complications. Resident #4 was originally admitted to the facility 6/13/25 after an acute hospital stay and discharged on 7/28/25 to an acute care facility. The current diagnoses included; Type 2 Diabetes Mellitus with hyperglycemia and Pain in Right Knee, Chronic Kidney Disease stage 4, anemia, heart failure, and Chronic Respiratory failure. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #4 was admitted to the facility on [DATE] after an acute hospital stay and discharged on 7/28/25 to an acute care facility. The current diagnoses included; Type 2 Diabetes Mellitus with hyperglycemia and Pain in Right Knee, Chronic Kidney Disease stage 4, anemia, heart failure, and Chronic Respiratory failure. The significant change, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/13/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #4 cognitive abilities for daily decision making were moderately impaired. In sectionGG(Physical functioning) the resident was coded as independent with eating, requiring set up or clean up assistance with oral hygiene, requiring substantial/maximal assistance with toileting and personal hygiene and resident coded as dependent with shower/bathe self. In section J (Health Conditions) J0100-Pain Management (B) coded resident as not receiving scheduled or prn pain medications. The person-centered care plan dated 3/06/24 and revised on 6/05/25 read the resident has chronic pain r/t knees. The Goal for the resident is the resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through 6/29/25. The interventions for the resident were as follows: Administer analgesia (Tylenol) as per orders. Give 1/2 hour before treatments or care, monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician, monitor/record pain characteristics (knees) and PRN: Quality (e.g. sharp, burning); Severity (1 to 10 scale); Anatomical location; Onset; Duration (e.g., continuous); Aggravating factors; Relieving factors (Revised 7/26/24). A review of the July 2025 Medication Administration Record (MAR) and Physician Order Summary (POS) revealed the following orders were received for Resident #4 during her course of pain and discomfort beginning on 7/27/25 through 7/28/25: Resident #4 received Lactulose Solution 10 GM/15ML -30 ml by mouth three times a day for constipation for 2 Days, (Hold for loose stool) on 07/28/2025 at 12:00 pm. The resident received Tylenol 325 mg 2 tablets, prn every 4 hours on 7/27/25 at 12:30 am., and on 7/28/25 at 10:19 am., On 7/28/25 bladder scan ordered for urinary retention was completed at 1:24 pm. The (MAR) revealed resident was given Albuterol Sulfate Inhalation Aerosol on 7/27/25 through 7/31/25 but seemed questionable due to the resident being discharged on 7/28/25 in the evening. On 7/28/25 at 2:58 pm., a STAT Order for Fleets Enema was given to resident rectally per order. On 7/28/25 at 11:15 am., an order for Simethicone Oral Tablet 80 MG (Simethicone) 2 tablet by mouth every 6 hours as needed for Gas pain/bloating, was ordered but not administered. On 7/28/25 at 3:02 pm., A STAT KUB was ordered for Abdominal pain/distention, was not administered due to resident being transported to the hospital at 5:19 pm. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A timeline of events leading to residents' hospitalization revealed the following: A review of text messages sent on 7/28/25 from Resident #4 and her daughter/Power of Attorney read: 1:21 am, sent from Resident #4 reading: Help me. 5:56 am., the daughter responded: Hey mom, you ok? You texted me at 1 in the morning to help you. What help did you need? 6:45 am., the resident responded: I'm in pain. 7:54 am., the daughter responded: Ok press your button! what hurts?? Is it your knee? 2:28 pm., the resident responded: No stomach very bad. Help 2:28 pm., the daughter responded: Oh, that's awful. Hit that button!!!!!! 2:29 pm., the daughter responded: If (unknown name) is around ask her to get you help. If no one answers you let me know. On 7/28/25 at 12:04 am., a health status note read resident c/o abdominal pain at 11:20 pm (7/27/25). The resident was repositioned, stated she could not breathe but after repositioned she felt better, pain level went from 8 to 3-4 after repositioning and after ginger ale and her oxygen saturation was 98% on 2L N.C Resident family visited this evening and brought in donuts (Prior to complaining). The resident also ate two peanut butter and jelly sandwiches this evening. Resident is now resting with her eyes closed, fan blowing on bed side. She feels better and felt some relief from her abdominal pain. The resident is not on the BM (Bowel Movement) due list. The above health status note revealed that the resident was not on the list for bowel movement, which could indicate other issues were impending, possibly causing her abdominal pain and discomfort. A review of the Medication Administration Record (MAR) dated 7/27/25 at 12:30 am., read that Tylenol 325 mg, 2 tabs were given. On 7/28/25 at 5:52 a.m., A late entry health status note read that a Certified Nursing Assistant (CNA) reported to this writer that resident experienced an episode of vomiting and has been complaining of pain throughout the night. Upon assessment, resident was observed sitting upright in wheelchair, napping. Resident was gently awakened and assessed. Resident verbalized, My neck has been bothering me all night and I have pain over here, while pointing to the right side of her abdomen. She was unable to describe the quality of the pain and, when prompted with descriptors (pressure, sharp, burning, dull), responded, All of the above. Nurse on duty was alerted and reported that resident received analgesia at the beginning of the shift and is due for the next dose in one hour. Nurse also stated that resident was administered Milk of Magnesia approximately one hour ago. A review of Health status and nursing notes revealed the following: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the above nurses' and health status notes revealed that Resident #4 first complained of pain on 7/27/25 at 11:20 pm., was administered Tylenol 2 tablets 325 mg (according to the late entry note), On 7/28/25 at 5:52 am, (6 hours and 32 minutes later) the Certified Nursing Assistant reported that Resident #4 had pain and vomiting throughout the night, pointing to the right side of her abdomen. On 7/28/25 at 6:05 am. (6 hours and 45 minutes later) per health status note resident is still complaining about having abdominal pain, Miralax given for possible constipation. On 7/28/25 at approximately 10:30 am., (11 hours and 10 minutes later) the nurse practitioner came in to evaluate resident for complaining of having abdominal pain and nausea after being notified within 10 minutes by nursing staff of resident's complaints. According to the health status notes neither the on-call doctor nor the Nurse Practitioner were notified in a timely manner of resident's abdominal pain or discomfort for hours, it wasn't until 11 hours and 10 minutes later, that the NP was notified, which resulted in a delay in treatment, neglect and notification. On 7/28/2025 at 12:33 pm., a late entry health status note read: Resident's roommate notified facility staff resident still complaining of pain and shortness of breath (SOB). Vital signs were taken, Resident on 02 at 3 liters per nasal cannula. Nursing staff says she is waiting to hear from primary care provider. On 7/28/25 at 1:53 pm., according to the Medication Administration Record (MAR) resident received 2 Tylenol tablets, 325 mg. The follow-up read was ineffective with pain scale being a 6. According to the health status notes Resident #4 was still experiencing pain and discomfort since her initial complaint of pain, and was administered Tylenol 2 tablets, 325 mg at 11:20 pm, on 7/27/25 for a total of 14 hours and 33 minutes, the resident had still remained at the facility. On 7/28/2025 at 2:00 pm., Late Entry Health Status Note: Resident continues to c/o abdominal pain and right-side neck pain from previous shift and stated that lying down relieves pain some. Not able to consume breakfast. Fluid intake adequate. ADL care was provided. Resident rang call light several times between breakfast and lunch hour c/o pain. NP down to assess resident. New orders given for bladder scan and lactulose x1 along with gas-x x1. Resident stated that gas-x relieved pain minimally. Lactulose ineffective. Bladder scan shown 28cc urine. Verbal order received for resident to have foley placed. Writer disagreed and immediately went to unit. According to the health status note the Power of Attorney (POA) Responsible Party (RP), daughter was not notified of the above issues from the facility staff until 4:49 pm, on 7/28/25, which was 17 hours and 29 minutes later. According to the health status note dated 7/28/25 at 5:15 pm, Resident #4 was picked up by medical transport via ambulance to be transported to the local hospital. The POA was notified of the pick-up time. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 11/15/25 at approximately 6:15 pm, a telephone interview was conducted with the complainant Daughter/Power of Attorney (POA) concerning Resident #4. The resident's daughter said that a text message was sent to her by her mom reading I'm in pain. The daughter thought that her mother was having knee pain, but she indicated that she felt bad because her stomach was hurting. My mother's roommate later mention that my mother was crying and screaming all night long. The resident's daughter also said that she was not informed until late 7/28/25. The daughter also mentioned that the doctor at the hospital said my mom became septic due to having a perforated ulcer. On 11/12/25 at approximately 3:35 pm., an interview was conducted with Licensed Practical Nurse (LPN) #1. LPN #1 said that the resident's daughter visited her on the night of 7/27/25 and that the resident never complained of any discomfort until an hour after the daughter left. LPN #1 said that the resident complained of having a hard time breathing but he repositioned her and she also complained that her stomach was hurting. He said that the resident had eaten 2 sandwiches before her daughter arrived and ate donuts-this was after 8 pm. LPN#1 said the resident started burping and he gave her ginger ale due to her feeling nauseated. It was past 11:00 pm, when she complained of pain. I stayed until she felt better around 12:30am. , then I clocked out. LPN #1 also said that when he returned on 7/28/25 to work the 3-11 shift, the nurse that he was relieving said that the resident is not better. LPN #1 also mentioned they tried to transfer the resident to the toilet, but she appeared like she was going to pass out, saying she was having discomfort with her stomach. LPN #1 also that he contacted her daughter later on 7/28/25. LPN #1 also mentioned that he approached the Nurse Practitioner (NP) and said, we should do something. On 11/17/25 at approximately 1:25 pm., an interview was conducted with Certified Nursing Assistant (CNA) #1. CNA#1 said that Resident #4 was able to make her needs known, use a call bell and able to communicate discomfort or pain. CNA #1 said that the morning the resident wasn't feeling good she reported it to the charge nurse that the resident was pointing to her belly saying she wasn't feeling well. The resident didn't want anything to eat in the morning or at lunch, I kept pushing fluids in her. CNA was asked the resident needed to have a bowel movement. CNA #1 said that the resident didn't need to go to the toilet. On 11/17/25 at approximately 3:05 pm, an interview was conducted with the ADON concerning Resident #4. The ADON said there was a delay in treatment relating to the NP waiting too late for the STAT KUB and on sending the resident to the ER. The ADON also said that the family should have been informed of the change in condition but wasn't notified until 7/28/25 at 5:15 pm. The ADON also mentioned that the DON had instructed the unit manager to speak to the NP to send the resident to the ER. On 11/17/25 at approximately 3:25 pm., an interview was conducted with LPN #4. LPN #4 said that on the 3-11 shift on the night of 7/27/25 due to eating a lot of food the resident was complaining of having pain in the back of her neck, with her hand placed on her stomach, the resident was given ginger ale and belched. LPN#4 said, We thought she had indigestion. According to the hospital admission records Resident #4 arrived at the hospital on 7/28/25 at 5:35 pm., via ambulance. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Emergency Department (ED)Triage note dated 7/28/25 at 5:54 pm read that Resident #4 presented with complaints of a low blood pressure of 91/54, abdominal pains, appearing pale and currently on 95% 02 at 4 liters per nasal cannula. A Sepsis / Febrile Neutropenia (FN) Screen - Patient assessment indicating risk for infection: Shortness of Breath, Alteration of Mental Status; Heart Rate greater 90 beats/min. Other Risk Factors of Infection: Skilled Nursing Facility. The ED note read transferred patient from stretcher to bed. Patient suddenly became nauseous then vomited coffee ground color emesis/liquid. The same day a diagnosis of Septic Shock was given at 11:58 pm. According to the medical records dated 8/06/25, Resident #4 was diagnosed as having a perforated ulcer. Febrile Neutropenia: Neutropenic fever is when there is a single oral temperature greater than or equal to 101 F (38.3 C) or a temperature greater than or equal to 100.4 F (38 C) for at least an hour. https://www.ncbi.nlm.nih.gov/books/NBK541102/ Septic shock is the last and most severe stage of sepsis. Sepsis occurs when your immune system has an extreme reaction to an infection. The inflammation throughout your body can cause dangerously low blood pressure. You need immediate treatment if you have septic shock. Treatment may include antibiotics, oxygen and medication. https://my.clevelandclinic.org/health/diseases/23255-septic-shock A peptic ulcer is an open sore in the stomach lining or the upper part of the small intestine (duodenum). An ulcer can go through all the layers of the digestive tract and form a hole. This is called a perforated ulcer. A perforated ulcer lets food and digestive juices leak out of the digestive tract. This is a serious health problem that needs urgent medical care. Symptoms of a perforated ulcer may include: Sudden, severe pain in the belly, usually in the upper area, pain spreading to the back or shoulder, nausea or vomiting, lack of appetite or feeling full, swollen belly or feeling bloated, feeling lightheaded, increased heart rate. Perforated ulcers can have serious complications. These include: Infection and inflammation of the lining of the abdomen (peritonitis), bloodstream infection (sepsis), Death. Contact your doctor right away if you have: Blood in your vomit, or vomit that looks like coffee grounds, bloody, black, or tarry-looking stools, fever of 100.4°F (38°C) or higher, or as directed by your doctor, Chills, pain that gets worse, symptoms that don't get better with treatment, or symptoms that get worse, or new symptoms. https://www.ummhealth.org/health-library/understanding-perforated-ulcers Compliance with Reporting Allegations of Abuse/Neglect/Exploitation. Date implanted: 9/24. Policy: It is the policy of this facility to report all allegations of Abuse/Neglect/Exploitation or mistreatment. Including injuries of unknown sources and misappropriation of resident property are reported immediately to the administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. Compliance Guidelines: The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences. Identification: Neglect: Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid pain. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	All residents who had issues with pain and pain assessments were reviewed since 9/19/25. The 9/19/25 pain interventions, notifications and abuse interventions were put in place, monitored every shift by the facility staff as well as current residents, that were placed in the survey sample by the survey team presented with no issues. On 11/12/25 at approximately 12:30 pm, a brief interview was conducted with the administrator, asking if the facility had any current (2025) Performance Improvement Plans (PIPs), and Facility Related Synopsis to present to the survey team. The administrator was given 20 minutes to bring in evidence of the above requested documents. On 11/12/25 at approximately 12:53 pm, the Director of Nursing (DON) brought in a PIP. It was reviewed. There was no resident identifiable information on the PIP, no corrective action dates, no Allegation of Compliance (AOC) date. The DON said that it would be 4 weeks from 9/19/25 but later changed the date to 9/29/25. On 11/12/25 at approximately 1:47 pm, the survey team met with the DON, the Assistant Director of Nursing (ADON), and the administrator. They were asked to identify the resident in question for the PIP. The administrator said they were working on HIPAA for privacy, (The Health Insurance Portability and Accountability Act), we're calling it a POC so we can get Past Non-Compliance (PNC) 9/19/25 as our end date. The DON and the administrator meant to say 4 weeks from compliance from date. DON said that the resident's name should have been written on the PIP. The administrator said that we missed the name and date. The following five-point plan was discussed secondary to Resident #4's pain, notifications and abuse concerns: The facility identified Resident #4's care resulted in the areas of pain management, notification and abuse. The facility completed a 100 percent review of all pain assessments in the facility previous to determine like-residents. Staff education was 100 percent for all nursing staff by the Director of Nursing and ADON to educate staff on pain management, notifications and abuse. The Administrator, Director of Nursing and ADON completed weekly audits 5 times per week for 4 weeks to include pain management, notifications and abuse. All Quality Assurance and Performance Improvement (QAPI) findings will be forwarded to the QAPI committee. Corrective action was completed on 9/29/25. On 11/12/25 at approximately 4:05 pm., during the end of day meeting the DON said that the AOC date will be 9/29/25. We have not had any incidents since 9/29/25. The survey team reviewed the PNC POC documents. It was determined by the survey team through interviews, record reviews and resident observations that the above practices were not identified since 9/29/25 nor during the course of the survey from 11/12/25 through 11/17/25. On 11/17/25 at approximately 4:25 p.m., the above findings were shared with the Director of Nursing (DON), the Assistant Director of Nursing (ADON) and via telephone the local Ombudsman was present. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided. It was determined that the facility implemented its Corrective Action Plan, and there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance at the time of the current survey for the regulatory requirements, F600 at Past Non-Compliance.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on family and staff interviews, clinical record review and facility document review the facility staff failed to provide adequate bathing and ADL care to a dependent resident (Resident #2) in a survey sample of 10 residents.The findings included.Resident #2 was admitted on [DATE] with diagnoses including nephrostomy tubes for urine excretion, chronic heart failure and chronic heart disease with 3 cardiac arterial bypass grafts, an artificial heart valve, and a left ventricular ejection fraction of only 26% revealing a severely weakened heart muscle. The Resident's admission weight was 120 pounds, and she used oxygen in the hospital and was ordered to be administered Oxygen at 3 liters per minute via nasal cannula as needed upon discharge. The Resident's Activities of Daily Living (ADL) records were reviewed and revealed bathing and showering records. Those records indicated that Resident #2 received a bed bath only 3 times, on 1-23-25, 1-24-25, and 3-2-25. Documents recorded refusals to be bathed by the Resident only twice, on 2-10-25, and 3-1-25. No other baths nor showers were provided to Resident #2 during her entire 43-day stay in the facility. Resident #2 had nephrostomy tubes and at times those are known to leak causing a need for frequent bathing. They are inserted into the lower back of a resident to provide a way for urine to flow directly from the kidneys to the outside of the body. The underlying reason for nephrostomy tube surgical insertion is due to a blockage in the normal pathway of urine exit from the body. Movement, while in bed, can compress or disrupt the skin in the areas where the tubes exit the body and interfere with the seal of the tubes in the skin. Staff members (2 LPNs licensed practical nurses and 2 CNAs Certified Nursing Assistants) on the unit where this Resident formerly resided were asked how often bathing was provided to the residents. The response by all was 2 times per week for showers or tub baths, and every day if they received bed baths.Other Residents were placed in the survey sample and reviewed for hygiene care which was found to be adequate. No pervasive odors, nor soiled linens on beds were found. Residents and family members were interviewed and had no issues with hygiene care being provided.On 11-17-25 at 3:00 p.m., at the end of day debriefing held with the Director of Nursing (DON), and Assistant Director of Nursing (ADON), they were informed by surveyors of the staff failure to provide adequate bathing required for this dependent Resident. Both stated they had nothing further to provide.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maimonides Health Center of Virginia Beach	6401 Auburn Dr Virginia Beach, VA 23464

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review, and review of facility documents, the facility staff failed to provide adequate supervision to prevent accidents for 1 of 10 residents (Resident #1) in the survey sample.The findings included: The facility staff failed to provide adequate supervision to ensure Resident #1 was safe from falling while toiletingResident #1 was no longer a resident of the facility; therefore, a closed record review was conducted. Resident #1 was admitted to the facility on [DATE] after a hospital stay. The resident's diagnoses included acute kidney failure, chronic obstructive pulmonary disease, unsteadiness on feet, and chronic congestive heart failure. The 5-day Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of [DATE] coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were moderately impaired. A synopsis of an event dated [DATE] revealed that Resident #1 had an unwitnessed fall in the bathroom. Resident #1 was left unattended in the bathroom while toileting. The Certified Nursing Assistant (CNA) heard a noise and went into the bathroom and found Resident #1 lying on the bathroom floor. 911 was notified. Resident #1 was pronounced deceased by Virginia Beach Emergency Medical Services at the facility. A review of section GG (Functional Abilities) dated [DATE] of Resident #1's Minimum Data Set (MDS) coded Resident #1 for toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement) as dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity). A care plan problem dated [DATE] read: I have limited physical mobility r/t weakness. The goal read: I will demonstrate the appropriate use of wheelchair to increase mobility through the review date. The interventions/tasks included, I need assistance of 1 caregiver to transfer bed to chair, chair to bed, and chair to chair. A review of a Virginia Beach Emergency Medical Services Prehospital Patient Care Report dated [DATE] read, Narrative: E10 was dispatched to a cardiac arrest and arrived on-scene to find a pulse less and apneic female patient who had been placed in her hospital bed after being found deceased earlier in the day. On-scene providers explained that they believe she had fallen while attempting to use the bathroom. E10 assessed the patient and found that she was in rigor mortis and presented with no discernible pulse. Upon being presented with a valid and signed DNR, E10 pronounced the patient deceased at 0801 at the scene. See the attached DNR included under attachments. E10 subsequently cleared any addition VBEMS resources, cleared the scene, and returned to service without incident. On [DATE] at 11:52 AM an interview was conducted with the Nurse Practitioner (NP). The NP stated that she did not perform a full assessment of Resident #1 after the fall on [DATE]. The NP also stated that she did not pronounce Resident #1 deceased on [DATE]. The NP further stated that she observed a cut on Resident #1's head near the hairline with bleeding. A review of Resident #1's NP's note dated [DATE] at 9:15 AM read: (Resident name), [AGE] years old female, notification received that she died this morning. Patient was assisted to the bathroom by a staff member. She requested privacy, with staff closing the bathroom door but remaining in the patient room. A short time later a noise was heard and patient was found on the floor of the bathroom without a pulse or respirations. 911 was notified, but upon arrival a DNR was produced signed by the patient. EMS declared time of death.On [DATE] at 12:40 PM an interview was conducted with Licensed Practical Nurse (LPN) #3. LPN #3 stated that a CNA alerted her that Resident #1 was on the floor. LPN #3 also stated that she went to the room and observed Resident #1 lying on the floor in between the toilet and the shower and blood was on the floor. LPN #3 further stated that she did not complete an assessment on Resident #1 or document any information in the resident's medical record regarding this fall due to never experiencing anything like this before in her (7) seven year nursing career and being really shook up. LPN #3 lastly stated, I left the room and when I came back to the room, the Resident was in her bed. I do not know who used the hoyer lift and moved the resident to the bed. I was the charge nurse and did not tell anyone to move her to the bed. The Resident was not responding and did not have a pulse. She had blood coming from her head. She had only been here a few days and I did not know her functional abilities. The facility's Fall policy was presented on [DATE] at 11:20 AM from the Assistant Director of Nursing (ADON) without an effective date. The policy read: Do not move resident until assessment has been completed by the nurse. The Physician's Order Summary (POS) for [DATE] read: Apixaban Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for a fib with a start date of

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	495186	A. Building B. Wing	11/17/2025

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (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 0692 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 family and staff interviews, clinical record review, and facility document review, the facility staff failed to maintain hydration for one Resident (Resident #2) in a survey sample of 10 residents.The findings included: Resident #2 was admitted on [DATE]. The discharge hospital orders were reviewed and revealed a hospital physician's order for labs to be drawn in 3 days, however, upon the resultant admission to the skilled nursing facility the Resident was ordered by the physician there to begin drawing labs on 1-29-25 (8 days after admission). The lab draw schedule then went on to be ordered randomly for 2-5-25, 2-8-25, 2-12-25, 2-18-25, and 3-4-25. Weights were ordered on admission, completed daily, and documented as revealed in the review of the clinical record. The hospital discharge summary did denote that if the Resident should experience a 3-pound weight gain in one day or a 5-pound weight gain in one week, that the cardiology physician should be contacted immediately.The Resident's care plan was also reviewed and revealed that worsening edema, and weight gain were to be assessed for, and the physician notified, should this issue arise as it would underscore a worsening condition.Review of the weight documents further revealed that from 2-4-25 through 2-9-25 the Residents weight increased from 121.0 pounds to 128.4 pounds in 5 days. Her weight continued to be elevated and from 2-26-25 until the Resident was discharged to the emergency room on 3-6-25 at 1:17 a.m., (7 days later). The Resident's weight stayed at its highest elevation during this week of 8.8 pounds since the admission weight of (120 pounds), ranging between 127.7 to 128.8. During the Resident's 43 day stay a gradual increase in weight, edema, and shortness of breath, all indicated a worsening condition. There is no indication that the cardiology doctor was ever notified of this, however, four medication changes were made by the skilled nursing facility physician to manage the symptoms of fluid overload. Those 4 medications follow below.1. Bumex 2 milligram (mg) every day ordered 1-21-25 through 2-21-25 (one month), 2-5-25 through 2-6-25 (2 days), then every day from 2-24-25 through discharge. 2. Bumex 1 mg every day ordered 1-28-25 through 1-29-25 (2 days), and 2-18-25 through discharge every day. 3. Metolazone 2.5 mg every day ordered 1-29-25 through 1-31-25 (2 days). 4. Metoprolol 25 mg every day ordered 1-21-25 through 2-2-25 (12 days). A review of nursing progress notes revealed staff documentation that the Resident was noncompliant with her fluid restriction. Interviews conducted with staff and family also revealed that Resident #2 often asked others for fluids such as a roommate, family members, and dining services staff with complaints of thirst.The fluid weight gain experienced by Resident #2 was further questioned as review of the Resident's Intake and output records were reviewed and revealed a concerning revelation. The Resident was ordered to have a 1500 milliliter (ml) fluid restriction for each 24-hour day. The documents showed that upon admission on [DATE] and 1-22-25 no fluids were recorded as consumed. The Resident complained of thirst to her son frequently, and records show a pattern of not providing fluids to the bedridden Resident. The rest of the days documented during her stay of fluid consumption follows below:(January 2025) - 1-23-25 (420 ml), 1-24-25 (712 ml), 1-25-25 (240 ml), 1-26-25 (240 ml), 1-27-25 (1360 ml), 1-28-25 (1500 ml), 1-29-25 (720 ml), 1-30-25 (1490 ml), 1-31-25 (924 ml).(February 2025) - 2-1-25 (1660 ml), 2-2-25 (1440 ml), 2-3-25 (480 ml), 2-4-24 (960 ml), 2-5-25 (720 ml), 2-6-25 (900 ml), 2-7-25 (720 ml), 2-8-25 (482 ml), 2-9-25 (720 ml), 2-10-25 (1200 ml), 2-11-25 (660 ml), 2-12-25 (840 ml), 2-13-25 (480 ml), 2-14-25 (720 ml), 2-16-25 (720 ml), 2-17-25 (478 ml), 2-18-25 (420 ml), 2-19-25 (598 ml), 2-20-25 (598 ml), 2-21-25 (720 ml), 2-22-25 (716 ml), 2-23-25 (598 ml), 2-24-25 (480 ml), 2-25-25 (720 ml), 2-26-25 (720 ml), 2-27-25 (720 ml), 2-28-25 (720 ml).(March 2025) - 3-1-25 (960 ml), 3-2-25 (960 ml), 3-3-25 (716 ml), 3-4-35 (720 ml), 3-5-25 (720 ml).Only one time in January (1-28-25) did Resident #2 receive the 1500 ml of fluids allowed in her special diet. This reveals that the edema, weight gain, and shortness of breath were indeed symptoms of a worsening illness, and not related to fluid consumption nor noncompliance.On 11-17-25 at 3:00 p.m., at the end of day debriefing held with the Director of Nursing (DON), and Assistant Director of Nursing (ADON), they were informed by surveyors of the staff failure to provide adequate hydration required for this dependent Resident. Both stated they had nothing further to provide.