

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Maimonides Health Center of Virginia Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 6401 Auburn Dr Virginia Beach, VA 23464	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and facility policy review, the facility failed to ensure two medications were not left on top of a medication cart unsecured. The facility further failed to ensure three of five medication carts observed were locked when not in sight of staff. This had the potential for the misappropriation of medications. Findings include: 1. During medication administration observation and interview on the 100 hall on 07/15/26 from 9:10 AM to 9:51 AM, a Lovenox (an anticoagulant) 40 microgram (mcg) syringe was observed sitting out on top of the medication cart, unsecured. One resident was observed wheeling past the cart in his wheelchair. The Licensed Practical Nurse (LPN)8 was in an out of sight of the medication cart at this time. LPN8 confirmed the Lovenox syringe was on top of the medication cart, unsecured, and stated, I would not leave any medications out. The resident had requested the injection be given later. It shouldn't have been left out. During an interview on 07/16/26 at 4:22 PM, the Director of Nursing (DON) stated, Medications are expected to be locked up in the cart before leaving the cart and not leaving medications on top of the medication cart. Review of the facility's policy titled, Medication Storage revised 12/25, indicated, All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms). During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage cart. 2. During an observation and interview on 07/15/26 at 9:23 AM revealed an unlocked and unattended medication cart in front of room [ROOM NUMBER]. There were no staff around the medication cart. No residents were observed to be wandering near the unlocked medication cart. Continued observation and interview 9:28 AM Licensed Practical Nurse (LPN) 6 exited room [ROOM NUMBER] and locked the medication cart. She said, I'm sorry, I thought I would be in and out. LPN 6 said the medication cart should have been locked to prevent access to those not authorized. 3. During an observation and interview on 07/15/26 at 9:32 AM revealed LPN9 in the hallway next to room [ROOM NUMBER]. LPN 9 left the medication cart unlocked and entered room [ROOM NUMBER] and closed the door. Continued observation revealed LPN9 exited room [ROOM NUMBER] at 9:34 AM. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN placed an insulin pen in the medication cart and locked it. LPN 9 said I have problems sometimes locking the cart. 4.During an observation and interview on 07/16/26 at 5:46 AM of the nurses' station near [NAME] Hall revealed an unlocked and unattended medication cart. There were no staff within sight of the cart. There was a round white tablet in a transparent medication cup on top of the cart. At that time LPN5 exited the station's nutrition room and then went to the restroom. After LPN5 exited the restroom she identified the tablet in the medication cup as Tramadol (narcotic pain medication) 50 milligrams (mg). LPN5 locked the medication cart and took the dispensed medications to a resident. 5.During an observation and interview on 07/16/26 at 6:05 AM of the nurses' station near [NAME] Hall revealed the same medication cart near the [NAME] Hall was unlocked and unattended again. LPN5 was in a room in an adjacent hall, out of sight of the medication cart. LPN5 exited the room at 6:07 AM and went to the station's nutrition room. At 6:08 AM LPN 5 emerged from the nutrition room and locked the medication cart. The LPN confirmed the medications cart was unlocked two times, once at 5:46 AM and then again at 6:08 AM. 6.During an observation and interview on 07/16/26 at 6:10 AM of the [NAME] Hall revealed an unlocked and unattended medication cart. There were no staff within sight of the cart. No staff was seen for three minutes. At 6:13 AM LPN7 confirmed she had retrieved a medication from that unlocked/unattended medication cart recently. 7.During a continuous observation on 07/16/26 from 4:10 AM to 4:40 AM, two unattended medication carts were observed in the Blue unit. One cart was sitting next to the nurses' station in the center of the unit and one cart was sitting off to the side against the wall in the unit, both carts were unlocked. One Certified Nurse Aide (CNA) was observed entering and exiting the unit on four occasions. During an interview on 07/16/26 at 4:40 AM, Registered Nurse Supervisor (RNS) confirmed both carts were unlocked and should not be. RNS locked both carts. During an interview on 07/16/26 at 4:55 AM, Licensed Practical Nurse (LPN) 5 entered the Blue unit and stated she was the only nurse assigned to the unit. She stated medication carts should always be locked unless medications are administered. LPN 5 stated she remembered the carts were not locked and should have been. Review of the facility policy titled, Medication Storage revised December 2026 revealed, . 1. General Guidelines: .c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.		