STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27660 Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to assess a resident for the self-administration of medication for one of 43 residents in the survey sample, Resident #32. The findings include: For Resident #32, the facility staff failed to assess the resident for self-administration of medications, Breyna (1). Observation was made on 12/10/24 at 2:30 p.m. of the R32's room. The resident was observed to have his Breyna respiratory inhaler on the bedside table. He stated he keeps it there for when he needs it. The physician order dated, 3/4/24, documented, Breyna (budesonide - formoterol) HFA aerosol inhaler; 160 - 4.5 mcg (micrograms) per actuation; amt (amount) 2 puffs; Inhalation. Special Instruction: 2 puff inhale orally two times a day for COPD (1), rinse mouth with water after each use. Review of the clinical record, failed to evidence a physician order for the resident to self-administer his medication. Review of the clinical record failed to evidence an assessment for the self-administration of medications. Review of the comprehensive care plan dated 8/30/24, failed to evidence documentation for self-administration of medications. An interview was conducted with LPN (licensed practical nurse) #4, on 12/12/24 at 8:10 a.m. When asked if residents are allowed to keep medications at the bedside, LPN #4 stated medications, such as creams and ointments, can be left at the bedside if there is a physician order to do so. LPN #4 was asked if the resident needs to be assessed to keep medications at the bedside, she didn't know anything about that. She stated that the inhaler should not be kept at the bedside. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 12/12/24 at 2:11 p.m. No further information was provided prior to exit. (continued on next page)

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	References: (1) Breyna - The combination of budesonide and formoterol is used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by asthma in adults and children 6 years of age and older. The combination of budesonide and formoterol is also used to treat chronic obstructive pulmonary (COPD; a group of diseases that affect the lungs and airways, that includes chronic bronchitis and emphysema) in adults. Budesonide is in a class of medications called steroids. It works by reducing swelling in the airways. Formoterol is in a class of medications called long-acting beta agonists ([NAME]). It works by relaxing and opening air passages in the lungs, making it easier to breathe. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a623022.html.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on observations, staff/resident interviews facility document review and clinical record review, it was determined the facility staff failed to accommodate resident needs for one of 43 residents in the survey sample, R25. The findings include: For R25, the facility staff failed to maintain the call light in a position where they could access it. Resident #25 was admitted to the facility on [DATE] with diagnosis that included but were not limited to ESRD (end stage renal disease), Sepsis and bilateral osteoarthritis. The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 10/18/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring supervision for transfer/dressing/toileting and eating. A review of the comprehensive care plan dated 11/27/24 revealed, PROBLEM: Resident has increased nutrition /hydration risk related to: ESRD and diet / fluid restriction. APPROACH: Dialysis Monday, Wednesday and Friday. On 12/10/24 at 9:43 AM, observation of call bell on floor between bed A & B. R25 when asked where his call bell was located, stated, not sure where this is. An interview was conducted on 12/10/24 at 9:50 AM with LPN (licensed practical nurse) #1. LPN #1 was asked to locate the call device for R25. LPN #1 found the call device on the floor between bed A and bed B. LPN #1 stated, here it is on the floor between the beds. I am going to clip this to your covers. When asked if R25's needs were accommodated when unable to reach call bell, LPN #1 stated, no, they were not. On 12/11/24 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations was made aware of the above concerns. A review of the facility's Resident Communication and Call Light policy revealed in part, When the resident is in bed or confined to a chair, be sure the call light is within easy reach. No further information was provided prior to exit.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27660 Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to evidence a written notification was provided to the resident and/or responsible party upon transfer to the hospital for three of 43 residents in the survey sample, Residents #16, #9, and #90. The findings include: 1. For Resident #16, the facility staff failed to evidence the resident and/or responsible party was provided a written notification upon transfer to the hospital on 11/4/24. The nurses note dated 11/4/24 at 9:11 a.m. documented, Writer was informed by AIDE that resident was vomiting. Upon assessment resident was vomiting up coffee ground emesis in a large amount. NP (nurse practitioner) and DR. (doctor) examined resident and recommended sending to the ER (emergency room). Per NP resident had a previous incident earlier this morning with the same results. 911 was called and dispatched to the facility. (Name of responsible party) has been notified and he said that he would notify the sitter. Transfer paperwork, face sheet, DNR (do not resuscitate), transfer to hospital, SBAR (situation, background, assessment, response), care plan, order/medication, and bed hold has been sent with the resident. An interview was conducted with LPN (licensed practical nurse) #4 on 12/12/24 at 8:20 a.m. LPN #4 stated they do not give the resident and/or family anything in writing when the resident is transferred to the hospital. They call the family and notate it in the chart. The facility did not provide a policy related to the written notice provided to residents and/or responsible parties upon transfer to the hospital. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 12/12/24 at 2:11 p.m. No further information was provided prior to exit. 42106 2. For Resident #9 (R9), the facility staff failed to evidence written notification of transfer was provided to the responsible party for a facility-initiated transfer on 11/24/24. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/8/24, R9 was coded as being cognitively intact for making daily decisions, having scored 13 out of 15 on the BIMS (brief interview for mental status) assessment. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R9's clinical record revealed the following progress note: 11/24/2024 09:00 Paramedics arrived and tended to resident while SN gave paramedics report. The resident continued to rapidly decline and resident was placed on a non-rebreather by paramedics. Facesheet, InterAct form, med list and DNR (do not resuscitate) form sent with resident which was emergently transported to [Name of hospital]. Report called to ER and to [Name of insurance company]. Message left with wife who is primary contact and legal representative. Further review of the clinical record failed to reveal evidence that written notification of transfer was provided to the responsible party for the transfer on 11/24/24. On 12/11/24 at 3:47 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that the nursing staff called the responsible party when a resident was transferred to the hospital but did not provide any written notification of transfer. On 12/11/24 at approximately 2:30 p.m., a request was made via written list to ASM (administrative staff member) #5, administrative support, for evidence of written notification of transfer provided to the responsible party for the facility-initiated transfer on 11/24/24. On 12/12/24 at approximately 8:30 a.m., ASM #2, the director of nursing provided progress notes and an SBAR (situation, background, assessment, and recommendation) assessment for R9. The documents provided failed to evidence written notification of transfer provided to the responsible party for the facility-initiated transfer on 11/24/24. On 12/12/24 at approximately 2:09 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4, the regional director of clinical services, and ASM #5, administrative support were made aware of the findings. No further information was provided prior to exit. 42183 3. The facility staff failed to evidence provision of required written RP (responsible party) notification at the time of discharge for Resident #90. Resident #90 was transferred to the hospital on 11/18/24. Resident #90 was admitted to the facility on [DATE] with diagnosis that included but were not limited to colon cancer, dementia, falls and femur fracture. The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 12/2/24, coded the resident as scoring a 02 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the comprehensive care plan dated 5/27/24 revealed, PROBLEM: Resident at risk for falling related to generalized weakness with dementia and history of colon cancer. APPROACH: Observe frequently and place in supervised area when out of bed. Encourage resident to assume a standing position slowly. Keep bed in lowest position with brakes locked. Always keep call light in reach. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no evidence of provision of required written RP notification when Resident #90 was sent to the hospital on 11/18/24. A review of the progress note dated 11/18/24 at 2:40 AM, revealed, Resident had an unwitnessed fall in her room. Resident was heard by nurse screaming asking for help. Upon entering the room resident was found on the floor sitting on buttocks. When asked what happened resident stated that she did not know. Nurse did full head to toe assessment on resident to rule out any abnormalities. Resident's vitals reading at Bp:102/58, HR, 62, Temp: 97.9, O2 96% RA, and RR 18. Pain noted in right leg when nurse attempted to extend extremity. No other injuries noted. Family notified (daughter) and requested that resident be sent to ED for further observations. Hospital and physician notified of situation. Resident sent to the hospital with order, face sheet, care plan, and bed hold form. On 12/11/24 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations was made aware of the above concerns. No further information was provided prior to exit.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 42106 Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to evidence bed hold notice provided for a facility-initiated transfer for one of 43 residents in the survey sample, Resident #9. The findings include: For Resident #9 (R9), the facility staff failed to evidence bed hold notice was provided to the responsible party for a facility-initiated transfer on 11/24/24. The progress notes for R9 documented in part, - 11/24/2024 09:00 Paramedics arrived and tended to resident while SN gave paramedics report. The resident continued to rapidly decline and resident was placed on a non-rebreather by paramedics. Facesheet, InterAct form, med list and DNR (do not resuscitate) form sent with resident which was emergently transported to [Name of hospital]. Report called to ER and to [Name of insurance company]. Message left with wife who is primary contact and legal representative. - 11/25/2024 0:31 (12:31 a.m.) This writer called [Name of hospital] for resident update. Per [Name of staff member] resident has been admitted to ICU (intensive care unit). Admitting diagnosis is aspiration pneumonia. Further review of the clinical record failed to reveal evidence that bed hold notice was provided to the responsible party for the transfer on 11/24/24. On 12/11/24 at 3:47 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that the nursing staff should send a bed hold notice with the resident when they transferred them to the hospital. She stated that they sent it with the face sheet, medication list, transfer form, orders and care plan. She stated that this was documented in the progress notes. On 12/11/24 at approximately 2:30 p.m., a request was made via written list to ASM (administrative staff member) #5, administrative support, for evidence of bed hold notice provided to the responsible party for the facility-initiated transfer on 11/24/24. On 12/12/24 at approximately 8:30 a.m., ASM #2, the director of nursing provided progress notes and an SBAR (situation, background, assessment, and recommendation) assessment for R9. The documents provided failed to evidence bed hold notice provided to the responsible party for the facility-initiated transfer on 11/24/24. The facility policy Bed Hold Letter Policy revised 9/26/20 documented in part, .Business Office or designee will complete the Medicaid Bed Hold Letter and send to the appropriate parties' certified/return receipt requested. The Medicaid Bed Hold Letter can be given directly to the responsible party if they are present. Medicaid Copy will be retained in resident's financial file. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at approximately 2:09 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4, the regional director of clinical services, and ASM #5, administrative support were made aware of the findings. No further information was provided prior to exit.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to provide an accurate assessment for four of 43 residents, R25, R124, R125 and R10. The findings include: 1. The facility failed to provide an accurate assessment including dialysis treatment for R25. Resident #25 was admitted to the facility on [DATE] with diagnosis that included but were not limited to ESRD (end stage renal disease), Sepsis and bilateral osteoarthritis. The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 10/18/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring supervision for transfer/dressing/toileting and eating. Section O: dialysis not checked. A review of the comprehensive care plan dated 11/27/24 revealed, PROBLEM: Resident has increased nutrition /hydration risk related to: ESRD and diet / fluid restriction. APPROACH: Dialysis Monday, Wednesday and Friday. A review of the physician orders dated 10/12/24 revealed, dialysis in center 11:00 AM chair time, pick up at 10:30am, M_W_F. Davita dialysis in centerHarborview. M-W-FSpecial Instructions: 11amchairtime, pick up at 10:30am, M_W_F An interview was conducted with LPN (licensed practical nurse) #5, the MDS coordinator. When asked to review R25's 10/18/24 MDS, LPN #5 stated, he was not coded for dialysis and that will be modified. When asked the standard for completing a MDS, LPN #5 stated, we use the RAI (resident assessment instrument). On 12/12/24 at 2:10 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations was made aware of the above concerns. No further information was provided prior to exit. 2. The facility failed to provide an accurate assessment including discharge disposition for R124 on the 10/31/24 MDS. During the closed record review, R124 was identified for review for hospitalization . MDS dated [DATE] coded the resident as discharge disposition to short term hospital. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #124 was admitted to the facility on [DATE] with diagnosis that included but were not limited to gangrene, osteomyelitis, Diabetes and below the knee amputation. A review of the progress note dated 10/31/24 at 9:42 PM revealed, Resident was discharged from facility, with wife present, completed antibiotic no noted toxicity symptoms, vitals within normal limits, educated on all order discharge instruction and follow up appointments, verbalized understanding, skin check completed, left via vehicle. An interview was conducted with LPN (licensed practical nurse) #5, the MDS coordinator. When asked to review R124's 10/18/24 MDS, LPN #5 stated, he was coded for hospitalization under Section A, when he went home with wife and that will be modified. When asked the standard for completing a MDS, LPN #5 stated, we use the RAI (resident assessment instrument). On 12/12/24 at 2:10 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations was made aware of the above concerns. No further information was provided prior to exit. 3. The facility failed to provide an accurate assessment including discharge disposition for R125. During the closed record review, R125 was identified for review for hospitalization . MDS dated [DATE] coded the resident as discharge disposition to home. Resident #125 was admitted to the facility on [DATE] with diagnosis that included but were not limited to infection and post spinal surgery. A review of the progress note dated 10/31/24 revealed, Resident's husband met her at the doctor's office. Resident was transferred to the hospital as the doctor did not feel that her surgical site was healing properly. An interview was conducted with LPN (licensed practical nurse) #5, the MDS coordinator. When asked to review R125's 10/18/24 MDS, LPN #5 stated, she was coded to go home and she went to the hospital from the doctor's office and that will be modified. When asked the standard for completing a MDS, LPN #5 stated, we use the RAI (resident assessment instrument). On 12/12/24 at 2:10 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations was made aware of the above concerns. No further information was provided prior to exit. 42106 4. For Resident #10 (R10), the facility staff failed to complete the pain assessment interview of section J of the MDS (minimum data set) assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the annual MDS with an ARD (assessment reference date) of 9/12/2024, R10 was assessed as scoring 7 out of 15 on the BIMS (brief interview for mental status) assessment indicating that they were moderately impaired for making daily decisions. Section J documented in part, J0200. Should Pain Assessment Interview be Conducted? Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea). Enter Code. 0. No (resident is rarely/never understood). Skip to and complete J0800, Indicators of Pain or Possible Pain . Section J0800 was observed to be blank. On 12/12/24 at 8:41 a.m., an interview was conducted with LPN (licensed practical nurse) #5, MDS coordinator. LPN #5 stated that when completing Section J, they always interviewed or attempted the interview for pain. She stated that the interview was done to determine whether the resident had pain. LPN #5 reviewed Section J of R10's annual MDS with the ARD of 9/12/24 and stated that she would have to investigate why it was not completed. On 12/12/24 at 9:11 a.m., LPN #5 stated that she had reviewed the MDS and R10 was not interviewed for the pain interview portion of Section J, and they should have been. She stated that she thought that it was an oversight. According to the RAI (resident assessment instrument) manual version 1.19.1, effective 10/1/24, pages J-4 through J-5 documented in part, .Health-related Quality of Life: Most residents who are capable of communicating can answer questions about how they feel. Obtaining information about pain directly from the resident, sometimes called hearing the resident's voice, is more reliable and accurate than observation alone for identifying pain. Planning for Care: Interview allows the resident's voice to be reflected in the care plan. Information about pain that comes directly from the resident provides symptom-specific information for individualized care planning . Coding Instructions Attempt to complete the interview with all residents . On 12/12/24 at approximately 2:09 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4, the regional director of clinical services, and ASM #5, administrative support were made aware of the findings. No further information was provided prior to exit.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on observations, staff/resident interviews facility document review and clinical record review, it was determined the facility staff failed to develop/implement a baseline care plan for two of 43 residents in the survey sample, Resident #176 (R176) and R177. The findings include: 1. A. The facility failed to develop a baseline care plan to include PTSD (post-traumatic stress disorder) for R176. R176 was admitted to the facility on [DATE] with diagnosis that included but were not limited to PTSD (post-traumatic stress disorder), CHF (congestive heart failure) and CVA (cerebrovascular accident). The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 12/3/24, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring moderate assistance for mobility/transfers and eating. Section I: PTSD yes. PTSD is listed on R176's problem list. A review of the baseline care plan dated 11/26/24 did not reveal PTSD as a problem. A review of the physician order dated 12/5/24 revealed, Buspar 7.5 mg po twice daily. An interview was conducted on 12/11/24 at 2:05 PM with LPN (licensed practical nurse) #1. When asked if there should be specific care outlined for a resident with a diagnosis of PTSD, LPN #1 stated, yes, there should be. When asked where that care would be documented, LPN #1 stated, it would be in the care plan. On 12/11/24 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations was made aware of the above concerns. A review of the facility's Interim Baseline Care Plan policy, reveals, Within 48 hours of admission, the facility will develop and implement an interim/baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident until a comprehensive assessment can be completed, leading to a comprehensive care plan. The baseline care plan will be used until the comprehensive assessment and care plan is developed by the interdisciplinary team. No further information was provided prior to exit. 1.B. The facility failed to develop a baseline care plan to include monitoring of anticoagulation therapy for R176. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the physician's order dated 11/27/24 revealed, Eliquis 5 mg po twice daily. A review of the MAR did not reveal evidence of anticoagulation monitoring. On 12/11/24 at 2:05 PM, an interview was conducted with LPN (licensed practical nurse) #1, when asked if anticoagulation monitoring should be on the care plan, LPN #1 stated, yes, we should be monitoring for bleeding and bruising. When asked if a physician's order is required, LPN #1 stated, no, it is nursing practice. On 12/12/24 at 8:16 AM, an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated residents who receive anticoagulant medication such as Eliquis should have a physician's order for nurses to monitor for a risk of bleeding every shift. LPN #4 stated nurses' evidence this monitoring is done by signing off the order on the MAR (medication administration record). On 12/11/24 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations was made aware of the above concerns. No further information was provided prior to exit. 2. A. The facility failed to develop a baseline care plan to include dialysis for R177. R177 was admitted to the facility on [DATE] with diagnosis that included but were not limited to ESRD (end stage renal disease), convulsions and atrial fibrillation. The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 12/2/24, coded the resident as scoring a 01 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers and eating. Section I: ESRD checked and Section O: oxygen: yes. A review of the baseline care plan dated 11/27/24 did not reveal dialysis as a problem/approach. A review of the physician order dated 11/27/24 revealed, Dialysis Monday, Wednesday, Friday at 9:00 AM. An interview was conducted on 12/11/24 at 2:05 PM with LPN (licensed practical nurse) #1. When asked if there should be specific care outlined for a resident with a diagnosis of ESRD, receiving dialysis, LPN #1 stated, yes, there should be. When asked where that care would be documented, LPN #1 stated, it would be in the care plan. On 12/11/24 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations was made aware of the above concerns. (continued on next page)

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	495201	A. Building B. Wing	12/12/2024

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Interim Baseline Care Plan policy, reveals, Within 48 hours of admission, the facility will develop and implement an interim/baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident until a comprehensive assessment can be completed, leading to a comprehensive care plan. The baseline care plan will be used until the comprehensive assessment and care plan is developed by the interdisciplinary team. No further information was provided prior to exit. 2. B. The facility failed to develop a baseline care plan to include oxygen therapy for R177. A review of the baseline care plan dated 11/27/24 did not reveal oxygen therapy as a problem/approach. A review of the physician orders dated 12/1/24 revealed, Oxygen: Administer oxygen(O2) via nasal cannula (NC)continuously at: 2lpm via nasal cannula. An interview was conducted on 12/11/24 at 2:05 PM with LPN (licensed practical nurse) #1. When asked if there should be specific care outlined for a resident receiving oxygen therapy, LPN #1 stated, yes, there should be. When asked where that care would be documented, LPN #1 stated, it would be in the care plan. On 12/11/24 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations was made aware of the above concerns. No further information was provided prior to exit. 2. C. The facility failed to implement a baseline care plan to for fluid restriction for R177. A review of the baseline care plan dated 11/27/24 revealed, PROBLEM: Resident has increased nutrition/hydration risk related to therapeutic diet/fluid restriction, ESRD/HD dependent. APPROACH: Provide fluids per ordered restriction. A review of the physician order dated 11/29/24 revealed, Fluid Restriction 1200cc/24hr. Special Instructions: 1200ccFluid Restriction Dietary to give 840cc BRKFST=360CC, LUNCH= 240CC, DINNER=240CC. Nursing to give 360cc: 1 SHIFT=180CC, 2 SHIFT=180CC. A review of the November and December MAR (medication administration record) revealed, 180 cc fluid restriction exceeded on day/evening shift on 11/30, 12/1, 12/2, 12/3, 12/4, 12/6, 12/7, 12/8, 12/9, 12/10 and 12/11; 180 cc fluid restriction exceeded on evening shift on 11/29, 11/30, 12/2, 12/3, 12/5, 12/6, 12/7, 12/8, 12/9, 12/10 and 12/11. An interview was conducted on 12/12/24 at 9:30 AM with LPN (licensed practical nurse) #2. When asked if the fluid restriction orders had not been followed, had the care plan been implemented, LPN #2 stated, no, it was not implemented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/12/24 at 2:10 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations was made aware of the above concerns. No further information was provided prior to exit.

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	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to develop and/or implement the comprehensive care plan for four of 43 residents in the survey sample, Residents #15, #75, #8, and #70. The findings include: 1. For Resident #15 (R15), the facility staff failed to implement the resident's comprehensive care plan for anticoagulant therapy. R15's comprehensive care plan dated 8/15/24 documented, (R15) is on Anticoagulant therapy . assess/document/report to nurse/MD (medical doctor) PRN (as needed) s/sx (signs and symptoms) of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB (shortness of breath), Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs). A review of R15's clinical record revealed a physician's order dated 11/12/24 for Eliquis (1) 5 mg (milligrams) twice a day for atrial fibrillation. A review of R15's MARs (medication administration records) for November 2024 and December 2024 revealed the resident was administered Eliquis 5 mg two times a day 11/12/24 through 12/11/24. Further review of R15's clinical record (including physician's orders, MARs, and nurses' notes for November 2024 and December 2024) failed to reveal the resident was monitored for side effects (bleeding) from Eliquis. On 12/12/24 at 8:16 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated residents who receive anticoagulant medication such as Eliquis should have a physician's order for nurses to monitor for a risk of bleeding every shift. LPN #4 stated nurses evidence this monitoring is done by signing off the order on the MAR. On 12/12/24 at 8:29 a.m., another interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of the care plan is, For the patient and their care throughout the facility. LPN #4 stated nurses can reference residents' care plans to ensure they are implemented. On 12/12/24 at 2:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Comprehensive Care Planning Policy documented, D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented. No further information was presented prior to exit. Reference: (continued on next page)

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	495201	A. Building B. Wing	12/12/2024

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Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1) ELIQUIS is indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation (NVAF) .Bleeding Risk: ELIQUIS increases the risk of bleeding and can cause serious, potentially fatal, bleeding. This information was obtained from the website: https://www.eliquis.com/eliquis/hcp/wellcarefo rm?cid=sem_2167331&ovl=isi&gclid=64c052d127001aa9ec1836cd1510884c&gclsrc=3p.ds& 42183 2. The facility staff failed to develop the comprehensive care plan for anticoagulation monitoring for Resident #75. Resident #75 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CHF (congestive heart failure), diabetes and cardiovascular accident. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 9/17/24, coded the resident as scoring a 06 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section N-medications coded the resident as anticoagulant-yes. A review of the comprehensive care plan dated 9/11/24 revealed, no evidence of anticoagulation monitoring. A review of the physician orders dated 12/24/22 revealed, Eliquis 2.5mg po twice a day. An interview was conducted on 12/12/24 at 10:30 AM with RN (registered nurse) #1. When asked the purpose of the care plan, RN #1 stated, to outline the care needs for each resident. When asked if anticoagulation monitoring should be included on the care plan, RN #1 stated yes, it should be included. When asked what should be included, RN #1 stated, monitoring for signs of bleeding, bruising, making sure there are fall preventions in place. On 12/12/24 at 2:10 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations was made aware of the above concerns. No further information was provided prior to exit. 27660 3. For Resident #8 (R8), the facility staff failed to implement the care plan to give blood pressure medications per the physician orders. The comprehensive care plan dated, 8/27/24, documented in part, Problem: Resident has risk of cardiovascular complications related to dx (diagnosis) of HF (heart failure), hypertension (high blood pressure), respiratory failure and anemia. The Approach documented in part, Administer medications as ordered. An interview was conducted with R8 on 12/3/24 at 11:53 a.m. She stated she didn't get her blood pressure medications as ordered. (continued on next page)

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	495201	A. Building B. Wing	12/12/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician orders dated, 3/4/24, documented, Amlodipine tablet; 2.5 mg (milligram); 1 tablet by mouth at bedtime for HTN (high blood pressure) hold for SBP (systolic blood pressure) < (less than) 110. Carvedilol tablet 6.5 mg; Give 1 tablet two times a day. Hold if systolic B/P (blood pressure) < 110 or Pulse < 60. The October 2024 MAR (medication administration record) documented the above orders. On the following days, times and blood pressure and pulse readings, the medications were administered: Amlodipine: 10/6/24 - BP (blood pressure) - 102/78 10/29/24 - nothing was documented as given. Carvedilol: 10/6/24 - BP - 102/78 10/24/24 - nothing was documented for the morning dose. 10/29/24 - nothing was documented for the evening dose. The November 2024 MAR documented the above orders. On the following days, times and blood pressure and pulse readings, the medications were administered: Amlodipine: 11/5/24 - BP - 109/57 11/9/24 - BP - 107/59 11/18/24 - BP 109/73 11/25/24 - BP - 103/61 Carvedilol: 11/5/24 - evening dose - BP - 109/57 11/6/24 - morning dose - BP - 109/57 11/9/24 - evening dose - BP - 107/59 11/18/24 - evening dose - BP - 109/73 11/22/24 - morning dose - Pulse - 59 11/25/24 - evening dose - BP 103/61 (continued on next page)

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	495201	A. Building B. Wing	12/12/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The December 2024 MAR documented the above orders. On the following days, times and blood pressure and pulse readings, the medications were administered: Carvedilol: 12/4/24 - morning dose - nothing was documented. On 12/12/24 at 8:29 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of the care plan is, For the patient and their care throughout the facility. LPN #4 stated nurses can reference residents' care plans to ensure they are implemented. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 12/12/24 at 2:11 p.m. No further information was provided prior to exit. References: (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a692044.html (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697042.html 2.b. For Resident #8 (R8), the facility staff failed to implement the care plan to give insulin per the physician orders. The comprehensive care plan dated, 8/26/24, documented in part, Problem: Resident has potential for complications of hypo/hyperglycemia (low and high blood sugars) d/t (due to) dx (diagnosis) of diabetes mellitus. The Approach documented in part, Administer medications as ordered. The physician order dated, 8/11/24, documented in part, Humalog Kwik Pen Insulin (insulin lispro) (a short acting insulin to treat diabetes) (3), administer before meals and at bedtime. Amount to administer: If blood sugar is less than 60, call MD (medical doctor) If blood sugar is 150 - 199. give 2 units If blood sugar is 200 - 249, give 4 units If blood sugar is 250 - 299, give 6 units If blood sugar is 300 - 349, give 8 units If blood sugar is 350 - 400, give 10 units If blood sugar is greater than 400, give 10 units (continued on next page)

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	495201	A. Building B. Wing	12/12/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If blood sugar is greater than 400, call MD. The October 2024 MAR documented the above order. On 10/14/24 for the 7:00 a.m. to 9:00 a.m. dose, the box was blank. The November 2024 MAR documented the above order. On 11/1/24 for the 4:15 p.m. to 6:45 p.m. dose, the box was blank. On 11/2/24, 11/6/24 and 11/15/24, the box was blank for the 7:00 a.m. to 9:00 a.m. dose. The physician order dated, 3/29/24, documented. The December 2024 MAR documented the above order. On 12/5/24 for the 7:00 a.m. to 9:00 a.m. dose, the box was blank. The physician order dated, 3/29/24, documented, Humalog U - 100 insulin (insulin lispro) (short acting insulin to treat diabetes) (3) solution; 100 units/mL (milliliter); Administer 15 units, subcutaneously three times a day. The October 2024 MAR documented the above order. On 10/14/24 at 8:00 a.m. and 10/24/24 at 12:00 p.m. there was a blank in the box for administration. The November 2024 MAR documented the above order. On 11/2/24, 11/6/24 and 11/15/24 at 8:00 a.m. there were blanks in the box for administration. The December 2024 MAR documented the above order. On 12/6/24 at 8:00 a.m. there was a blank in the box for administration. The physician order dated, 8/11/24, documented, Insulin glargine - yfgn (long-acting insulin to treat diabetes) (4); administer 30 units subcutaneously every morning between 8:00 a.m. and 11:00 a.m. Insulin glargine - yfgn; administer 45 units subcutaneously at bedtime. The October 2024 MAR documented the above orders. On 10/24/24 for the morning dose, there was a blank in the box for administration. On 10/29/24 at bedtime, there was a blank in the box for administration. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 12/12/24 at 2:11 p.m. No further information was provided prior to exit. References: (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697021.html (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a600027.html (continued on next page)

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	495201	A. Building B. Wing	12/12/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42106 4. For Resident #70 (R70), the facility staff failed to develop the comprehensive care plan to include the use of an elbow splint. On 12/9/24 at 8:16 p.m., an observation was made of R70 in bed. R70 was observed with limited range of motion (ROM) in the right hand. No splinting device was observed in use. Additional observation on 12/10/24 at 8:25 a.m. revealed R70 in bed with no splinting device and limited ROM in the right hand. The comprehensive care plan for R70 failed to address the limited range of motion or use of any splinting devices. The most recent OT (occupational therapy) evaluation and plan of treatment dated 8/14/24-9/11/24 documented treatments including but not limited to splinting and increasing finger flexion. The evaluation documented a right upper extremity contracture and impairment of the right hand. Under Recommendations it documented Splint/Orthotic Recommendations: It is recommended the patient wear an elbow extension splint on right elbow for during daily tasks in order to inhibit abnormal reflex patterns, develop/establish wearing schedule, inhibit abnormal positions and adapt/modify splint device. The OT discharge summary for R70 dated 9/11/24 documented in part, .Maximum potential achieved, referred for RNP (restorative nursing program) .Discharge Recommendations: RNP, splinting . The physician's orders for R70 failed to evidence an order for the use of a splinting device. On 12/11/24 at 11:49 a.m., an interview was conducted with OSM (other staff member) #1, the director of rehab. OSM #1 stated that they were not currently working with R70 but had seen them in the past. She stated that R70 was last discharged from OT on 9/11/24 with recommendations for restorative nursing and splinting. On 12/11/24 at approximately 12:00 p.m., a request was made to ASM (administrative staff member) #5, administrative support for evidence of splint therapy for R70 from 9/11/24 to the present. On 12/11/24 at approximately 3:00 p.m., ASM #5 provided a Therapy Education Form for R70 which documented a therapy referral to nursing for splinting for 1-2 hours daily and bilateral upper extremity exercises with movement in all planes within the patient's abilities to begin on 9/26/24. A Restorative Nursing Program Manual dated 9/11/24 for R70 documented instructions for restorative nursing staff for the resident's ability to perform tasks and assistance needed. The documents provided failed to evidence documentation of splinting completed by staff as recommended by therapy at discharge from services. On 12/11/24 at 3:47 p.m., an interview was conducted with LPN (licensed practical nurse) #3 who stated that the purpose of the care plan was to show the goals of care for the resident and the things they needed to do to help the resident reach their goals. She stated that the interdisciplinary team developed the care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/12/24 at 8:29 a.m., an interview was conducted with LPN #4. LPN #4 stated the purpose of the care plan was for the patient and their care throughout the facility. LPN #4 stated that she would expect a splint to be on the care plan so that everyone knew what to do for care of the resident. On 12/12/24 at 9:15 a.m., an interview was conducted with CNA (certified nursing assistant) #4, restorative aide who stated that R70 had orders for a splint to the right arm/elbow and for range of motion/stretching exercises. She stated that the other restorative aide recently resigned, and she was not aware of the treatment for R70 until today and she had completed the treatment that morning. She stated that the documentation was placed in the medical record under the POC (plan of care) charting. Review of the POC documentation for R70 documented the passive range of motion last completed for R70 on 10/31/24 and splinting last completed on 10/28/24. On 12/12/24 at approximately 2:09 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4, the regional director of clinical services, and ASM #5, administrative support were made aware of the concern. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 42106 Based on observation, staff interview, clinical record review and facility document review, it was determined the facility staff failed to review and/or revise the comprehensive care plan for four of 43 residents in the survey sample, Residents #23, #70, #20 and #89. The findings include: 1. For Resident #23 (R23), the facility staff failed to revise the care plan for the use of bed rails. On 12/9/24 at 8:04 p.m., an observation was made of R23 in bed with bilateral upper bed rails in place. Additional observation on 12/10/24 at 9:39 a.m. revealed R23 in bed with bilateral upper bed rails in place. The comprehensive care plan for R23 documented in part, Problem Start Date: 08/07/2024. Category: ADLs (activities of daily living) Functional Status/Rehabilitation Potential, Resident is ADL deficit based on limited ability to maintain grooming/personal hygiene r/t (related to) dx. (diagnoses) of CVA (cerebrovascular accident), Hemiplegia, Anemia, Dementia and contracture of muscles- multiple sites. Edited: 09/12/2024. The care plan for R23 failed to evidence the use of bed rails. A physician's order dated 11/25/24 for R23 documented Bedrails as tolerated r/t (related to) bed mobility. An enabler-restraint observation for R23 dated 11/21/24 documented the use of 1/4 side rails bilaterally as an enabler to assist with proper body alignment, posture, assisting with ADLs, defining the boundaries of the bed for the resident, and to increase the feeling of safety and security. On 12/11/24 at 3:47 p.m., an interview was conducted with LPN (licensed practical nurse) #3 who stated that the purpose of the care plan was to show the goals of care for the resident and the things they needed to do to help the resident reach their goals. She stated that the interdisciplinary team reviewed and revised the care plan and that bed rails should be on the care plan because the staff would need to know the reason why the resident had the bed rails. The facility policy Comprehensive Care Planning Policy revised 3/2/21 documented in part, .The Resident Care Conference meets as scheduled to discuss each resident, review the previous Care Plan and to finalize the development of the current care plan. Adjustments are made by the interdisciplinary team to ensure that all programs and identified category of needs are addressed and that the plan is oriented toward preventing a decline in functioning. Plans for discharge are reviewed, revised and addressed accordingly . There may be additional problem areas not triggered by the MDS, which will need to be addressed in the Care Plan . On 12/11/24 at approximately 4:57 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4, the regional director of clinical services, and ASM #5, administrative support were made aware of the concern. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit. 2. For Resident #70 (R70), the facility staff failed to revise the comprehensive care plan for the use of bed rails. A. On 12/9/24 at 8:16 p.m., an observation was made of R70 in bed with bilateral upper bed rails in place. Additional observation on 12/10/24 at 8:25 a.m. revealed R70 in bed with bilateral upper bed rails in place. The comprehensive care plan for R70 documented in part, Problem Start Date: 09/24/2024. Category: ADLs (activities of daily living) Functional Status/Rehabilitation Potential, Resident has ADL self-care deficit based on dx. (diagnoses) of Anoxic brain damage, Functional Quadriplegia, muscle weakness, Anemia, and Epilepsy. Created: 09/24/2024. The care plan for R70 failed to evidence the use of bed rails. A physician order dated 8/14/24 for R70 documented Bedrails as tolerated. An enabler-restraint observation for R70 dated 11/21/24 documented the use of 1/4 side rails bilaterally as an enabler to assist with proper body alignment, posture, assisting with ADLs, defining the boundaries of the bed for the resident, and to increase the feeling of safety and security. On 12/11/24 at 3:47 p.m., an interview was conducted with LPN (licensed practical nurse) #3 who stated that the purpose of the care plan was to show the goals of care for the resident and the things they needed to do to help the resident reach their goals. She stated that the interdisciplinary team reviewed and revised the care plan and that bed rails should be on the care plan because the staff would need to know the reason why the resident had the bed rails. On 12/11/24 at approximately 4:57 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4, the regional director of clinical services, and ASM #5, administrative support were made aware of the concern. No further information was provided prior to exit. 3. For Resident #20 (R20), the facility staff failed to revise the comprehensive care plan for the use of bed rails. On 12/9/24 at 7:59 p.m., an observation was made of R20 in bed with bilateral upper bed rails in place. Additional observation on 12/10/24 at 8:39 a.m. revealed R20 in bed with bilateral upper bed rails in place. The comprehensive care plan for R20 documented in part, Problem Start Date: 08/06/2024. Category: ADLs (activities of daily living) Functional Status/Rehabilitation Potential, Resident has an ADL self-care deficit based on hx. (history) of muscle weakness, Anemia, Depression, Anxiety, limited ROM (range of motion), and Lupus. Edited: 12/09/2024. The care plan for R20 failed to evidence the use of bed rails. A physician order dated 9/20/24 for R20 documented Bedrails on bilateral sides as tolerated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An enabler-restraint observation for R20 dated 11/21/24 documented the use of 1/4 side rails bilaterally as an enabler to assist with proper body alignment, posture, assisting with ADLs (activities of daily living), defining the boundaries of the bed for the resident, and to increase the feeling of safety and security. On 12/11/24 at 3:47 p.m., an interview was conducted with LPN (licensed practical nurse) #3 who stated that the purpose of the care plan was to show the goals of care for the resident and the things they needed to do to help the resident reach their goals. She stated that the interdisciplinary team reviewed and revised the care plan and that bed rails should be on the care plan because the staff would need to know the reason why the resident had the bed rails. On 12/11/24 at approximately 4:57 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4, the regional director of clinical services, and ASM #5, administrative support were made aware of the concern. No further information was provided prior to exit. 27660 4. For Resident #89, the facility staff failed to review and revise the comprehensive care plan for the use of an indwelling catheter. The comprehensive care plan dated, 7/11/24, documented in part, Problem: Urinary Incontinence: Incontinence d/t (due to) dx (diagnosis) of muscle weakness, lack of coordination, dementia and Alzheimer's. The Approach failed to evidence any documentation related to the use of an indwelling catheter. On 12/10/24 at 8:45 a.m. Resident was observed in bed, an indwelling catheter bag was noted hanging off the bedframe. The physician orders dated, 7/8/24, documented, Change foley (indwelling) catheter as needed. 18 fr (french) 10 cc (cubic centimeters). Special Instructions: Document catheter (french) and balloon (ml - milliliters) size inserted PRN (as needed). Further review of the physician orders failed to evidence an order for indwelling catheter care. Review of the MAR for October, November and December 2024, failed to evidence documentation of indwelling catheter care. An interview was conducted with LPN (licensed practical nurse) #4 on 12/12/24 at 8:10 a.m., LPN #4 stated the purpose of the care plan is, For the patient and their care throughout the facility. LPN #4 stated nurses can reference residents' care plans to ensure they are implemented. The care plan is updated throughout the resident's stay for a change in condition or any updates to their care. On 12/12/24 at 1:39 p.m. ASM (administrative staff member) #2, the director of nursing, stated the facility had no evidence of indwelling catheter care for R89. ASM #1, the administrator, and ASM #2, were made aware of the above concern on 12/12/24 at 2:11 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 27660 Based on resident interview, observation, staff interview, and clinical record review, it was determined the facility staff failed to administer medications and/or treatments per the physician orders for two of 43 residents in the survey sample, Residents #32 and #8. The findings include: 1. For Resident #32 (R32), the facility staff failed to apply treatments, to include benzocaine (1) and telfa (non-stick dressing), to the resident's legs per the physician order. An interview was conducted with R32 on 12/10/24 at 2:25 p.m. The resident stated he had vascular wounds on both of his legs. He stated the facility runs out of the non-adhesive dressings and then when they are done the next time, the dressings they have put on sticks to the wounds and when pulled off, even after the nurse wets them with wound cleanser, it pulls off the healing tissue. The physician order dated 3/6/24, documented, Clean left leg with DWC (wound cleanser), pat dry, apply benzocaine to wound bed, place telfa pad, ABD (abdominal pad) and gauze daily and PRN (as needed). Clean right leg with DWC, pat dry, apply benzocaine to wound bed, place telfa pad, ABD and gauze every night and PRN. Observation was made of LPN (licensed practical nurse) #7, the wound care nurse, on 12/11/24 at 2:28 p.m., perform the dressing changes on R32's bilateral legs. Resident #32 was premedicated with pain medication prior to the dressing change. The resident had his eyes closed when we entered the room. LPN #7 started with the left leg. The current dressing was dated 12/11/24 - 7P - 7 a. LPN #7 removed the gauze wrap. She then proceeded to remove the ABD. The dressing stuck to the resident's open areas and proceeded to bleed from two of the open areas. The resident stated, ouch, when the dressing was removed. There was no telfa dressing on the leg. LPN #7 proceeded to clean the leg with wound cleanser, patted the leg dry and applied the telfa pads, ABD and gauze wrap. LPN #7 proceeded to change the dressing on the right leg. She removed the gauze wrap and ABD pad. Again, there was no telfa pad on the resident's leg and one open area proceeded to bleed. The resident stated, ouch, when the dressing was removed. LPN #7 proceeded to clean the right leg with wound cleanser, patted it dry and applied the telfa pads, ABD and gauze. When asked if the resident was to have any ointments applied to the wounds, LPN #7 stated, no, it's just cleaning the area and applying the telfa, ABD and gauze wrap. Observation was made on 12/11/24 at 3:03 p.m. with RN (registered nurse) #1 of the treatment cart on R32's unit. There were no telfa pads on the cart. RN #1 stated that if the nurse's don't have it on the cart, they can go to the supply room or even to the other unit to find them. When asked if she has ever run out of the telfa pads, RN #1 stated, no. The facility policy, Skin and Wound Care Best Practices, documented in part, Pressure injuries and wounds will be treated with evidence-based interventions as ordered by the provider. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 12/12/24 at 2:11 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit. References: (1) Benzocaine topical is a local anesthetic. It temporarily eases minor skin irritations and pain by blocking pain signals. This information was obtained from the following website: https://www.goodrx.com/benzocaine/what-is. 2 a. For Resident #8 (R8), the facility staff failed to administer amlodipine (1) and carvedilol (2), both used to treat high blood pressure per the physician orders. An interview was conducted with R8 on 12/3/24 at 11:53 a.m. She stated she didn't get her blood pressure medications as ordered. The physician orders dated, 3/4/24, documented, Amlodipine tablet; 2.5 mg (milligram); 1 tablet by mouth at bedtime for HTN (high blood pressure) hold for SBP (systolic blood pressure) < (less than) 110. Carvedilol tablet 6.5 mg; Give 1 tablet two times a day. Hold if systolic B/P (blood pressure) < 110 or Pulse < 60. The October 2024 MAR (medication administration record) documented the above orders. On the following days, times and blood pressure and pulse readings, the medications were administered: Amlodipine: 10/6/24 - BP (blood pressure) - 102/78 10/29/24 - nothing was documented as given. Carvedilol: 10/6/24 - BP - 102/78 10/24/24 - nothing was documented for the morning dose. 10/29/24 - nothing was documented for the evening dose. The November 2024 MAR documented the above orders. On the following days, times and blood pressure and pulse readings, the medications were administered: Amlodipine: 11/5/24 - BP - 109/57 11/9/24 - BP - 107/59 11/18/24 - BP 109/73 11/25/24 - BP - 103/61 (continued on next page)

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	495201	A. Building B. Wing	12/12/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Carvedilol: 11/5/24 - evening dose - BP - 109/57 11/6/24 - morning dose - BP - 109/57 11/9/24 - evening dose - BP - 107/59 11/18/24 - evening dose - BP - 109/73 11/22/24 - morning dose - Pulse - 59 11/25/24 - evening dose - BP 103/61 The December 2024 MAR documented the above orders. On the following days, times and blood pressure and pulse readings, the medications were administered: Carvedilol: 12/4/24 - morning dose - nothing was documented. The comprehensive care plan dated, 8/27/24, documented in part, Problem: Resident has risk of cardiovascular complications related to dx (diagnosis) of HF (heart failure), hypertension (high blood pressure), respiratory failure and anemia. The Approach documented in part, Administer medications as ordered. An interview was conducted with LPN (licensed practical nurse) #4 on 12/12/24 at 8:10 a.m. When asked how she evidenced that she has given a medication, LPN #4 stated its signed on the eMAR with my initials. LPN #4 was asked if a medication has parameters for its administration, LPN #4 stated you take the blood pressure and/or pulse and hold the medication if it is outside of the parameters and document why it wasn't given. The facility policy, Physician/Provider Orders, failed to evidence documentation of the administration of medications. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 12/12/24 at 2:11 p.m. No further information was provided prior to exit. References: (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a692044.html (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697042.html (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.b. For Resident #8 (R8), the facility staff failed to administer insulin per the physician orders. An interview was conducted with R8 on 12/3/24 at 11:53 a.m. She stated she doesn't get her insulin all the time. The physician order dated, 8/11/24, documented in part, Humalog Kwik Pen Insulin (insulin lispro) (a short acting insulin to treat diabetes) (3), administer before meals and at bedtime. Amount to administer: If blood sugar is less than 60, call MD (medical doctor) If blood sugar is 150 - 199. give 2 units If blood sugar is 200 - 249, give 4 units If blood sugar is 250 - 299, give 6 units If blood sugar is 300 - 349, give 8 units If blood sugar is 350 - 400, give 10 units If blood sugar is greater than 400, give 10 units If blood sugar is greater than 400, call MD. The October 2024 MAR documented the above order. On 10/14/24 for the 7:00 a.m. to 9:00 a.m. dose, the box was blank. The November 2024 MAR documented the above order. On 11/1/24 for the 4:15 p.m. to 6:45 p.m. dose, the box was blank. On 11/2/24, 11/6/24 and 11/15/24, the box was blank for the 7:00 a.m. to 9:00 a.m. dose. The physician order dated, 3/29/24, documented. The December 2024 MAR documented the above order. On 12/5/24 for the 7:00 a.m. to 9:00 a.m. dose, the box was blank. The physician order dated, 3/29/24, documented, Humalog U - 100 insulin (insulin lispro) (short acting insulin to treat diabetes) (3) solution; 100 units/mL (milliliter); Administer 15 units, subcutaneously three times a day. The October 2024 MAR documented the above order. On 10/14/24 at 8:00 a.m. and 10/24/24 at 12:00 p.m. there was a blank in the box for administration. The November 2024 MAR documented the above order. On 11/2/24, 11/6/24 and 11/15/24 at 8:00 a.m. there were blanks in the box for administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The December 2024 MAR documented the above order. On 12/6/24 at 8:00 a.m. there was a blank in the box for administration. The physician order dated, 8/11/24, documented, Insulin glargine - yfgn (long-acting insulin to treat diabetes) (4); administer 30 units subcutaneously every morning between 8:00 a.m. and 11:00 a.m. Insulin glargine - yfgn; administer 45 units subcutaneously at bedtime. The October 2024 MAR documented the above orders. On 10/24/24 for the morning dose, there was a blank in the box for administration. On 10/29/24 at bedtime, there was a blank in the box for administration. The comprehensive care plan dated, 8/26/24, documented in part, Problem: Resident has potential for complications of hypo/hyperglycemia (low and high blood sugars) d/t (due to) dx (diagnosis) of diabetes mellitus. The Approach documented in part, Administer medications as ordered. An interview was conducted with LPN (licensed practical nurse) #4 on 12/12/24 at 8:10 a.m. When asked how she evidenced that she has given a medication, LPN #4 stated it's signed on the eMAR with my initials. LPN #4 was asked if a medication has parameters for its administration, LPN #4 stated you take the blood pressure and/or pulse and hold the medication if it is outside of the parameters and write a progress note. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 12/12/24 at 2:11 p.m. No further information was provided prior to exit. References: (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697021.html (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a600027.html

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 42106 Based on observation, clinical record review, staff interview and facility document review, it was determined that the facility staff failed to provide services to maintain or improve mobility for one of 43 residents in the survey sample, Resident #70. The findings include: For Resident #70 (R70), the facility staff failed to follow therapy recommendations for the use of a splinting device. On 12/9/24 at 8:16 p.m., an observation was made of R70 in bed. R70 was observed with limited range of motion (ROM) in the right hand. No splinting device was observed in use. Additional observation on 12/10/24 at 8:25 a.m. revealed R70 in bed with no splinting device and limited ROM in the right hand. The most recent OT (occupational therapy) evaluation and plan of treatment dated 8/14/24-9/11/24 documented treatments including but not limited to splinting and increasing finger flexion. The evaluation documented a right upper extremity contracture and impairment of the right hand. Under Recommendations it documented Splint/Orthotic Recommendations: It is recommended the patient wear an elbow extension splint on right elbow for during daily tasks in order to inhibit abnormal reflex patterns, develop/establish wearing schedule, inhibit abnormal positions and adapt/modify splint device. The OT discharge summary for R70 dated 9/11/24 documented in part, .Maximum potential achieved, referred for RNP (restorative nursing program) .Discharge Recommendations: RNP, splinting . The comprehensive care plan for R70 failed to address the limited range of motion or use of any splinting devices. The physician's orders for R70 failed to evidence an order for the use of a splinting device. On 12/11/24 at 11:49 a.m., an interview was conducted with OSM (other staff member) #1, the director of rehab. OSM #1 stated that they were not currently working with R70 but had seen them in the past. She stated that R70 was last discharged from OT on 9/11/24 with recommendations for restorative nursing and splinting. On 12/11/24 at approximately 12:00 p.m., a request was made to ASM (administrative staff member) #5, administrative support for evidence of splint therapy for R70 from 9/11/24 to the present. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at approximately 3:00 p.m., ASM #5 provided a Therapy Education Form for R70 which documented a therapy referral to nursing for splinting for 1-2 hours daily and bilateral upper extremity exercises with movement in all planes within the patient's abilities to begin on 9/26/24. A Restorative Nursing Program Manual dated 9/11/24 for R70 documented instructions for restorative nursing staff for the resident's ability to perform tasks and assistance needed. The documents provided failed to evidence documentation of splinting completed by staff as recommended by therapy at discharge from services. On 12/12/24 at 9:15 a.m., an interview was conducted with CNA (certified nursing assistant) #4, restorative aide who stated that R70 had orders for a splint to the right arm/elbow and for range of motion/stretching exercises. She stated that the other restorative aide recently resigned, and she was not aware of the treatment for R70 until today and she had completed the treatment that morning. She stated that the documentation was placed in the medical record under the POC (plan of care) charting. Review of the POC documentation for R70 documented the passive range of motion last completed for R70 on 10/31/24 and splinting last completed on 10/28/24. On 12/12/24 at approximately 2:09 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4, the regional director of clinical services, and ASM #5, administrative support were made aware of the concern. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 27660 Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services for an indwelling catheter for one of 43 residents in the survey sample, Resident #89. The findings include: For Resident #89 (R89), the facility staff failed to evidence of providing catheter care. On 12/10/24 at 8:45 a.m. Resident was observed in bed, an indwelling catheter bag was noted hanging off the bedframe. the physician orders dated, 7/8/24, documented, Change foley (indwelling) catheter as needed. 18 fr (french) 10 cc (cubic centimeters). Special Instructions: Document catheter (french) and balloon (ml - milliliters) size inserted PRN (as needed). Further review of the physician orders failed to evidence an order for indwelling catheter care. Review of the MAR for October, November and December 2024, failed to evidence documentation of indwelling catheter care. Review of the comprehensive care plan dated, 7/11/24, documented in part, Problem: Urinary Incontinence: Incontinence d/t (due to) dx (diagnosis) of muscle weakness, lack of coordination, dementia and Alzheimer's. The Approach failed to evidence any documentation related to the use of an indwelling catheter. An interview was conducted with LPN (licensed practical nurse) #4 on 12/12/24 at 8:10 a.m. LPN #4 stated both the nurses and CNAs (certified nursing assistants) do indwelling catheter care. It is documented on the eMAR (electronic medication administration record) as there are orders for catheter care. On 12/12/24 at 1:39 p.m. ASM (administrative staff member) #2, the director of nursing, stated the facility had no evidence of indwelling catheter care for R89. ASM #1, the administrator, and ASM #2, were made aware of the above concern on 12/12/24 at 2:11 p.m. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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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 - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to provide monitoring for fluid restriction and intake for one of 43residents, R177. The findings include: The facility failed to provide monitoring for fluid restriction and intake for R177. R177 was admitted to the facility on [DATE] with diagnosis that included but were not limited to ESRD (end stage renal disease), convulsions and atrial fibrillation. The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 12/2/24, coded the resident as scoring a 01 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers and eating. Section I: ESRD checked and Section O: oxygen: yes. A review of the baseline care plan dated 11/27/24 revealed, PROBLEM: Resident has increased nutrition/hydration risk related to therapeutic diet/fluid restriction, ESRD/HD dependent. APPROACH: Provide fluids per ordered restriction. A review of the physician order dated 11/29/24 revealed, Fluid Restriction 1200cc/24hr. Special Instructions: 1200ccFluid Restriction Dietary to give 840cc BRKFST=360CC, LUNCH= 240CC, DINNER=240CC. Nursing to give 360cc: 1 SHIFT=180CC, 2 SHIFT=180CC. A review of the November and December MAR (medication administration record) revealed, 180 cc fluid restriction exceeded on day/evening shift on 11/30, 12/1, 12/2, 12/3, 12/4, 12/6, 12/7, 12/8, 12/9, 12/10 and 12/11; 180 cc fluid restriction exceeded on evening shift on 11/29, 11/30, 12/2, 12/3, 12/5, 12/6, 12/7, 12/8, 12/9, 12/10 and 12/11. An interview was conducted on 12/12/24 at 9:30 AM with LPN (licensed practical nurse) #2. When shown R177's MAR fluid restriction documentation and asked if the fluid restriction orders had been followed, LPN #2 stated, no, they have not been. It may be that the agency nurses did not know how to document this. On 12/12/24 at 2:10 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations was made aware of the above concerns. A review of the facility's Intake and Output policy revealed, when intake is being recorded for fluid restrictions purposes, the licensed nurse will verify the resident has received the recommended amount and will investigate any variances. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42106 Based on observation, clinical record review, staff interview and facility document review, it was determined that the facility staff failed to obtain a physician's order for oxygen administration for one of 43 residents in the survey sample, Resident #9. The findings include: For Resident #9 (R9), the facility staff failed to obtain an order for the administration of oxygen (O2). The progress notes for R9 documented in part, - 11/23/2024 20:10 (8:10 p.m.) Resident in bed awake/alert and verbal. Resident has scattered rhonchi. Resident has O2 @ 2L/min (liters per minute) via NC (nasal cannula). IsoSource (enteral tube feeding) is not connected at this time per physician order. Staff will continue to monitor closely for any status change. - 12/07/2024 18:09 (6:09 p.m.) Resident completed ABT (antibiotic) for Pneumonia. No adverse reactions noted. Bed in low position, HOB (head of bed), and o2 running 2 L via nasal cannula. Will continue to monitor and report any changes in status. - 12/09/2024 20:20 (8:20 p.m.) During routine f/u (follow up) visit w/ MD [Name of physician], family concerns were addressed by NP [Name of nurse practitioner]/ MD [Name of physician]. Head to toe assessment completed; Resident observed w/ no c/o pain or discomfort, lethargic, slightly congested, VS WNL (vital signs within normal limits), on continuous 02 via nasal cannula . The re-admission assessment for R9 dated 12/2/24 for R9 documented the resident using oxygen at 2 lpm. Further review of R9's clinical record failed to reveal evidence an order for oxygen. On 12/12/24 at 8:30 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that residents receiving oxygen should have orders. She stated that they had standing orders that they used in emergencies but when a resident came in with oxygen the order was placed in the medical record so that the staff would know the prescribed rate for the oxygen, check the rate every shift and change the tubing every week. LPN #4 reviewed R9's orders and stated that she did not see an order in place and would make sure there was one placed. She stated that she knew R9 wore the oxygen continuously since they had been back from the hospital. The facility policy Oxygen Administration (All routes) Policy revised 7/30/24 documented in part, .POLICY: Licensed clinicians with demonstrated competence will administer oxygen via the specified route as ordered by a provider. In an emergency situation, clinicians may administer oxygen and obtain a provider's order as soon as practicably possible after patient stabilization or transfer . (continued on next page)

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	495201	A. Building B. Wing	12/12/2024

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Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at approximately 2:09 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4, the regional director of clinical services, and ASM #5, administrative support were made aware of the findings. No further information was provided prior to exit.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide trauma informed care for one of 43 residents in the sample Resident #176 (R176). The findings include: The facility failed to evidence provision of trauma informed care for Resident #176. R176 was admitted to the facility on [DATE] with diagnosis that included but were not limited to PTSD (post-traumatic stress disorder), CHF (congestive heart failure) and CVA (cerebrovascular accident). The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 12/3/24, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring moderate assistance for mobility/transfers and eating. Section I: PTSD yes. PTSD is listed on R176's problem list. A review of the baseline care plan dated 11/26/24 did not reveal PTSD as a problem. A review of the physician order dated 12/5/24 revealed, Buspar 7.5 mg po twice daily. A review of the progress note dated 11/27/24 at 5:31 PM revealed, When given the PHQ9 questionnaire, patient responded to #9 that he did feel he would be better off dead what do I have to live for but that he would not do anything to hurt himself. This was reported to the SW, DON, ADON and unit manager nurse. A review of the progress note dated 11/27/24 at 6:05 PM revealed, S.W. met with resident this evening to discuss his PHQ interview with the Rehab Director, he stated to her he would be better on dead. When addressed the matter to resident, he to this writer Hell NO I'm not going to bring any harm to myself. But at times I say like that if that's the case I would have done something to myself long time ago. Writer did ask resident if he would like to have psych intervention or to be seen by a Chaplain. He stated: NO S.W. will continue provide supportive therapy weekly. Nursing Staff/ Social Worker will continue to monitor/document. A review of the physician note dated 12/5/24 revealed, Resident refused psychiatry consult, will try Buspar. An interview was conducted on 12/11/24 at 2:05 PM with LPN (licensed practical nurse) #1. When asked if there should be specific care outlined for a resident with a diagnosis of PTSD, LPN #1 stated, yes, there should be. When asked where that care would be documented, LPN #1 stated, it would be in the care plan. (continued on next page)

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	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations was made aware of the above concerns. A review of the facility's Social Services policy, reveals, Social Services will assist in implementing interventions for the resident's needs by developing and maintaining care plans which are individualized, realistic, with measurable goals, including, but not limited to; Trauma, PTSD. No further information was provided prior to exit.

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	495201	A. Building B. Wing	12/12/2024

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Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 42106 Based on clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to ensure timely physician visits for 1 of 43 residents in the survey sample, Resident #127. The findings include: For Resident #127 (R127), the facility staff failed to evidence a physician visit between 6/8/21 and 10/14/21. A review of the clinical record for physician visits documented a physician progress note for R127 dated 6/8/21 and the next dated 10/14/21, 127 days without a physician's visit. On 12/12/24 at 10:15 a.m., an interview was conducted with ASM (administrative staff member) #6, medical doctor who stated that long term care residents were seen every 60 days for recertification visits and she and the nurse practitioner alternated the visits. A request was made for a policy for physician visits however none was provided by the facility prior to exit. On 12/12/24 at approximately 2:09 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4, the regional director of clinical services, and ASM #5, administrative support were made aware of the findings. No further information was provided prior to exit.

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	495201	A. Building B. Wing	12/12/2024

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Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure residents were free from unnecessary medications for two of 43 residents in the survey sample, Residents #15, and #176. The findings include: 1. For Resident #15 (R15), the facility staff failed to monitor the resident for side effects from the anticoagulant (blood thinning) medication Eliquis (1). A review of R15's clinical record revealed a physician's order dated 11/12/24 for Eliquis 5 mg (milligrams) twice a day for atrial fibrillation. A review of R15's MARs (medication administration records) for November 2024 and December 2024 revealed the resident was administered Eliquis 5 mg two times a day 11/12/24 through 12/11/24. Further review of R15's clinical record (including physician's orders, MARs, and nurses' notes for November 2024 and December 2024) failed to reveal the resident was monitored for side effects from Eliquis. On 12/12/24 at 8:16 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated residents who receive anticoagulant medication such as Eliquis should have a physician's order for nurses to monitor for a risk of bleeding every shift. LPN #4 stated nurses evidence this monitoring is done by signing off the order on the MAR. On 12/12/24 at 2:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Anticoagulation Policy documented, On admission, nursing will identify individuals who are currently anticoagulated. Residents will be monitored for possible complications associated with anticoagulation and providers will be promptly notified of any such complications. No further information was presented prior to exit. Reference: (1) ELIQUIS is indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation (NVAF) .Bleeding Risk: ELIQUIS increases the risk of bleeding and can cause serious, potentially fatal, bleeding. This information was obtained from the website: https://www.eliquis.com/eliquis/hcp/wellcarefo rm?cid=sem_2167331&ovl=isi&gclid=64c052d127001aa9ec1836cd1510884c&gclsrc=3p.ds& 42183 2.The facility staff failed to ensure R176 was free of unnecessary medications by monitoring anticoagulant as ordered. (continued on next page)

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	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R176 was admitted to the facility on [DATE] with diagnosis that included but were not limited to PTSD (post-traumatic stress disorder), CHF (congestive heart failure) and CVA (cerebrovascular accident). The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 12/3/24, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring moderate assistance for mobility/transfers and eating. Section N: anticoagulant: yes. A review of the physician's order dated 11/27/24 revealed, Eliquis 5 mg po twice daily. A review of the MAR did not reveal evidence of anticoagulation monitoring. On 12/11/24 at 2:05 PM, an interview was conducted with LPN (licensed practical nurse) #1, when asked if anticoagulation monitoring should be done, LPN #1 stated, yes, we should be monitoring for bleeding and bruising. When asked if a physician's order is required, LPN #1 stated, no, it is nursing practice. When asked where this should be documented, LPN #1 stated, it should be on the medication administration record. On 12/12/24 at 8:16 AM, an interview was conducted with LPN #4. LPN #4 stated residents who receive anticoagulant medication such as Eliquis should have a physician's order for nurses to monitor for a risk of bleeding every shift. LPN #4 stated nurses' evidence this monitoring is done by signing off the order on the MAR (medication administration record). On 12/11/24 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations was made aware of the above concerns. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42106 Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to maintain fans in a sanitary manner in one of one kitchen and dispose of expired supplements in one of two facility nourishment rooms. The findings include: A. On [DATE] at 6:38 p.m., an observation was made of the facility kitchen. Observation of the dishwasher area revealed two approximately 12-inch round fans hanging from the wall in the dishwasher area facing the passthrough dishwasher. Visible dust and rust was observed on the cage of both fans. On [DATE] at 11:48 a.m., observation of the two round fans in the dishwasher area of the kitchen revealed the same as above. On [DATE] at 12:10 p.m., an interview was conducted with OSM (other staff member) #6, dietary manager. OSM #6 stated that the dietary staff were responsible for cleaning dust off the fans and maintenance fixed the fans if they malfunctioned. He stated that they brushed them off when they were dusty, and they had a problem with condensation in the room which caused the rust on the fan cages and the vents. On [DATE] at 12:35 p.m., an interview was conducted with OSM #3, maintenance director. OSM #3 stated that he thought that maintenance would be responsible for cleaning the fan blades to remove dust and he was not sure if there was any schedule in place because he was new to the facility. OSM #3 stated that he had been at the facility for four weeks and had not had any requests to clean the fans in the kitchen or reports of rust on the cage until the survey. The facility policy Equipment Cleaning and Sanitation Policy revised [DATE] documented in part, The food and nutrition services staff will maintain a clean and sanitary environment in food service areas through compliance with a written, comprehensive cleaning schedule . B. On [DATE] at 10:00 a.m., an observation of the Unit two nourishment room revealed seven 8-ounce cartons of Novasource renal 19% nutritional supplement with a use by date of [DATE] located in a cabinet with other supplements and tube feeding products. On [DATE] at 10:08 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that the nurses checked the dates of the items in the refrigerator and the kitchen stocked the drinks and snacks. She stated that central supply stocked the supplements and the tube feedings. LPN #3 stated that all the supplements in the cabinet were available for use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:11 a.m., an interview was conducted with OSM #10, central supply. OSM #10 stated that they checked supplies in the nutrition rooms once or twice a week. She stated that she checked the dates, threw away any expired supplies and restocked the items. OSM #10 observed the seven 8-ounce cartons of Novasource renal 19% and stated that it was slower to move than the others because there were only one or two residents who used it. She stated that it was past its use by date, and it should have been thrown away. The facility policy Nourishments and Supplements Policy revised [DATE] failed to evidence guidance on use by dates. On [DATE] at approximately 4:57 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4, the regional director of clinical services, and ASM #5, administrative support were made aware of the concern regarding the kitchen fans. On [DATE] at approximately 2:09 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4, the regional director of clinical services, and ASM #5, administrative support were made aware of the concern regarding the nourishment room on Unit two. No further information was provided prior to exit.

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	495201	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portside Health & Rehab Center	4201 Greenwood Drive Portsmouth, VA 23701

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 42106 Based on observation, staff interview, clinical record review and facility document review, it was determined the facility staff failed to evidence bed inspections for four of 43 residents in the survey sample, Residents #23, #70, #10 and #20. The findings include: 1. For Resident #23 (R23), the facility staff failed to evidence a bed inspection prior to the use of bed rails. On 12/9/24 at 8:04 p.m., an observation was made of R23 in bed with bilateral upper bed rails in place. Additional observation on 12/10/24 at 9:39 a.m. revealed R23 in bed with bilateral upper bed rails in place. A physician's order dated 11/25/24 for R23 documented Bedrails as tolerated r/t (related to) bed mobility. An enabler-restraint observation for R23 dated 11/21/24 documented the use of 1/4 side rails bilaterally. The assessment failed to evidence a bed inspection for safety. The comprehensive care plan for R23 failed to evidence the use of bed rails. A review of the facility's bed and rail maintenance evaluation book documented all facility beds inspected on 12/10/24. On 12/11/24 at 12:35 p.m., an interview was conducted with OSM (other staff member) #3, the maintenance director who stated that to his knowledge bed inspections were conducted quarterly or at a minimum annually. OSM #3 stated that he had searched for any inspections of the beds and was not able to find anything, so he and his staff had conducted facility wide inspections on 12/10/24. The facility policy Bed Identification and Safety Inspection Policy revised 1/25/24 documented in part, The use of bed rails will be limited to circumstances where they are used to treat a medical condition and enhance the resident's functional abilities. Whenever a bed/side rail or grab/enabler bar or anything else is attached to the bedframe or added to the bed environment/system, evaluation of the entrapment zones as laid out below will occur . Inspections will be completed annually and as needed when bed/mattress configuration changes. The inspection checklists will be kept in a separate binder or tab kept current by environmental services/ maintenance. The checklists will be kept for a minimum of 3 years . On 12/11/24 at approximately 4:57 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4, the regional director of clinical services, and ASM #5, administrative support were made aware of the concern. No further information was provided prior to exit. (continued on next page)

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	495201	A. Building B. Wing	12/12/2024

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. For Resident #70 (R70), the facility staff failed to evidence a bed inspection prior to the use of bed rails. On 12/9/24 at 8:16 p.m., an observation was made of R70 in bed with bilateral upper bed rails in place. Additional observation on 12/10/24 at 8:25 a.m. revealed R70 in bed with bilateral upper bed rails in place. A physician order dated 8/14/24 for R70 documented Bedrails as tolerated. An enabler-restraint observation for R70 dated 11/21/24 documented the use of 1/4 side rails bilaterally. The assessment failed to evidence a bed inspection for safety. The comprehensive care plan for R70 failed to evidence the use of bed rails. A review of the facility's bed and rail maintenance evaluation book documented all facility beds inspected on 12/10/24. On 12/11/24 at 12:35 p.m., an interview was conducted with OSM (other staff member) #3, the maintenance director who stated that to his knowledge bed inspections were conducted quarterly or at a minimum annually. OSM #3 stated that he had searched for any inspections of the beds and was not able to find anything, so he and his staff had conducted facility wide inspections on 12/10/24. On 12/11/24 at approximately 4:57 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4, the regional director of clinical services, and ASM #5, administrative support were made aware of the concern. No further information was provided prior to exit. 3. For Resident #10 (R10), the facility staff failed to evidence a bed inspection prior to the use of bed rails. On 12/9/24 at 8:24 p.m., an observation was made of R10 in bed with bilateral upper bed rails in place. Additional observation on 12/10/24 at 9:28 a.m. revealed R10 in bed with bilateral upper bed rails in place. An enabler-restraint observation for R10 dated 11/21/24 documented the use of 1/4 side rails bilaterally. The assessment failed to evidence a bed inspection for safety. The comprehensive care plan for R10 documented in part, Bed rails to be used as ordered. Approach Start Date: 06/12/2024 . The physician orders for R10 failed to evidence an order for bed rails. A review of the facility's bed and rail maintenance evaluation book documented all facility beds inspected on 12/10/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. Building B. Wing	12/12/2024

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/24 at 12:35 p.m., an interview was conducted with OSM (other staff member) #3, the maintenance director who stated that to his knowledge bed inspections were conducted quarterly or at a minimum, annually. OSM #3 stated that he had searched for any inspections of the beds and was not able to find anything, so he and his staff had conducted facility wide inspections on 12/10/24. On 12/11/24 at approximately 4:57 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4, the regional director of clinical services, and ASM #5, administrative support were made aware of the concern. No further information was provided prior to exit. 4. For Resident #20 (R20), the facility staff failed to evidence a bed inspection prior to the use of bed rails. On 12/9/24 at 7:59 p.m., an observation was made of R20 in bed with bilateral upper bed rails in place. Additional observation on 12/10/24 at 8:39 a.m. revealed R20 in bed with bilateral upper bed rails in place. A physician order dated 9/20/24 for R20 documented Bedrails on bilateral sides as tolerated. An enabler-restraint observation for R20 dated 11/21/24 documented the use of 1/4 side rails bilaterally. The assessment failed to evidence a bed inspection for safety. The comprehensive care plan for R20 failed to evidence the use of bed rails. A review of the facility's bed and rail maintenance evaluation book documented all facility beds inspected on 12/10/24. On 12/11/24 at 12:35 p.m., an interview was conducted with OSM (other staff member) #3, the maintenance director who stated that to his knowledge bed inspections were conducted quarterly or at a minimum annually. OSM #3 stated that he had searched for any inspections of the beds and was not able to find anything, so he and his staff had conducted facility wide inspections on 12/10/24. On 12/11/24 at approximately 4:57 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations, ASM #4, the regional director of clinical services, and ASM #5, administrative support were made aware of the concern. No further information was provided prior to exit.