| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 495210 | A. Building<br>B. Wing | 09/24/2025 |

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| Norfolk Health Care Center | 901 East Princess Anne Road<br>Norfolk, VA 23504 |

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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 0725<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, Facility documentation reviews, and clinical record reviews, the facility staff failed to ensure competent Professional nursing staff oversight, assessment, and administration of tracheostomy care for three residents (Resident #185, #186, and #190) in a survey sample of 60 Residents, resulting in Immediate Jeopardy. After accepting the plan to remove the immediacy from the Administrator and confirming that the Immediate Jeopardy was removed, the deficiency was assigned a Scope and Severity level of 3 (G), isolated (harm).The findings included: 1. Resident #185 was initially admitted to the nursing facility on 7-7-25 with diagnoses including stroke, respiratory failure with tracheostomy for breathing, dysphagia with gastrostomy tube for feeding, anemia, diabetes, stage 4 pressure ulcer, and malnutrition.<br><br>Review of hospital records revealed that the Resident was sent back out to the hospital 6 days after admission on [DATE] with methicillin-resistant Staphylococcus aureus (MRSA) pneumonia and Clostridium Difficile diarrhea combined infections resulting in sepsis (whole body blood infection), and a fecal impaction. The Resident was also dehydrated and received 2 liters of IV (intravenous) fluid upon arrival in the emergency department.<br><br>The Resident returned to the nursing facility after 11 days in the hospital on 7-24-25. The Resident was ordered to receive strong antibiotic therapy with Vancomycin. There were two orders issued upon his return, as follows:<br><br>1. Vancomycin 1.25 grams every 18 hours intravenously (IV) infused for the sepsis treatment for 8 days.<br><br>2. Oral Vancomycin drops 125 MG (milligrams) to be given in the Resident's Peg feeding tube every day at 9:00 A.M. until 8-5-25.<br><br>During review of the Resident's medication Administration record (MAR), the following was revealed.<br><br>7-24-25 – No antibiotic given.<br><br>7-25-25 – IV vancomycin given one time at 6:02 P.M. No oral drops given.<br><br>7-26-25 – Oral drops given at 9:00 A.M., no IV Vancomycin given.<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0725<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 7-27-25 - Oral drops given at 9:00 A.M., no IV Vancomycin given.<br><br>7-28-25 – IV at 10:40 A.M., and oral drops given at 9:00 A.M.<br><br>The IV vancomycin was decreased to one dose daily with no reason given at 9:00 A.M. on 7-29-25.<br><br>7-29-25 - IV at 5:22 A.M., and oral drops given at 9:00 A.M.<br><br>7-30-25 – IV at 9:00 A.M., and oral drops given at 9:00 A.M<br><br>7-31-25 - IV at 9:00 A.M., and oral drops given at 9:00 A.M<br><br>8-1-25 – IV at 9:00 A.M., and oral drops given at 9:00 A.M<br><br>8-2-25 – IV at 9:00 A.M., and oral drops given at 9:00 A.M<br><br>8-3-25 – IV at 9:00 A.M., and oral drops given at 9:00 A.M<br><br>8-4-25 – IV at 9:00 A.M., and oral drops given at 9:00 A.M<br><br>8-5-25 – IV at 9:00 A.M., and oral drops given at 9:00 A.M<br><br>8-6-25 – only IV given at 9:00 A.M.<br><br>This review indicated that the IV antibiotic was omitted on 7-24-25, 7-26-25, 7-27-25, and the oral drops were omitted on 7-24-25 and 7-25-25. Analysis reveals that the necessary antibiotic treatment was not fully implemented in a timely manner to treat the pneumonia for the new tracheostomy patient and was not effectively administered for 4 days. This prolonged the sporadic treatment to 13 days. The resident returned to the facility from the hospital for continuing treatment, specifically due to contracting sepsis in this nursing facility.<br><br>Review of Resident #185's nursing and physician progress notes revealed the following worsening course of events in chronological order.<br><br>On 8-11-25 at 2:13 A.M, the resident exhibited a low-grade fever of 100.0 Fahrenheit (F) after receiving oxycodone with Tylenol previously at midnight. The Resident had a resting heart rate of 88 beats per minute, a blood pressure of 94/65, and 18 respirations per minute with large amounts of dark liquid stool on the bed. The resident was under the care of a Licensed Practical Nurse (LPN) during the entire 11:00 P.M. to 7:00 A. M. shift.<br><br>On 8-11-25 at 11:52 P.M., an LPN (agency nurse) documented temp 99.4 F tympanic.<br><br>On 8-12-25 at 2:03 A.M., the nurse documented No fentanyl patch available at midnight (8-11-25), ordered to be applied every 72 hours for the Resident. This reveals that his pain medication was not administered from 8-11-25 through 8-13-25 (3 days), according to the Medication administration record, because he was admitted to the hospital on [DATE], and the pain patch was not documented as administered for those days.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 8-12-25 at 2:50 P.M., the following assessment note indicated that the nurse practitioner saw the Resident and reported to the staff nurse that the Resident was febrile with a fever of 102.5. The note goes on to say STAT (immediate) orders were received for a Tylenol suppository and to remove the PICC (central line catheter for Antibiotic infusions). At 9:33 P.M., a note describes BP (blood pressure) low. There was no dedicated Registered Nurse (RN) on the 3:00 P.M. to 11:00 P.M. shift this night as mandated by state law to perform assessments and make treatment decisions for Residents on a specialized tracheostomy unit.<br><br>On 8-13-25 at 4:45 A.M., a note describes temp 100.2. pulse Ox (oxygenation) 96% .trach care and suction provided. At 6:48 A.M., (2 hours later) a note describes (oxygen) Saturation at 54% on trach collar, heart rate 143 beats per minute, temp 100.7, blood sugar 188, 911 called, (oxygen) sats increased to 64% with rescue squad. An oxygen saturation level below 88% is considered critical and, if not quickly reversed, will lead to hypoxia and death according to the National Institutes of Health (NIH).<br><br>A physician's order was placed, stating that the doctor had instructed the resident to be sent to the emergency department via 911 at 5:41 A.M. However, nursing documents revealed that he did not go out for over an hour after the order was received. Resident #185 left at 6:59 A.M. and expired the same day in the hospital.<br><br>During the survey, LPNs and Certified Nursing Assistants (CNAs) were interviewed and stated that they did remember the 2 Residents involved during these [DATE] incidents. They said there were times when RNs were not present to help and admitted that they often felt inadequate to care for tracheostomy Residents. They further stated they were not always sure when those residents were exhibiting signs of distress or worsening conditions until the residents were seriously ill. Those staff members would only speak on grounds of anonymity for fear of job loss from the administration. None were able to answer what strength of suctioning in millimeters of mercury was safe for the Residents.<br><br>The facility assessment was reviewed and revealed that the specialty care unit for tracheostomies would be staffed with RNs on every shift and every day indicating that they were aware of that state and federal requirement for the specialty unit.<br><br>The Resident's care plan was reviewed and revealed focuses for Respiratory, and the Resident is at risk for complications secondary to a tracheostomy added upon admission on [DATE] with interventions including administer oxygen as ordered, vitals as needed, observe for signs and symptoms of respiratory complications including infection and or respiratory blockage or mucus plug and notify MD (doctor) as indicated, suction as needed, tracheostomy care per order, and tracheostomy tie change per order.<br><br>On 8-5-25 new care plan interventions were added after returning from the hospital with pneumonia on 7-24-25 (12 days after return) that revealed a focus for Respiratory infection the resident has developed an infection secondary to pneumonia MRSA (Methicillin Resistant Staphylococcus Aureus) and is on antibiotics. The interventions included Auscultate lung sounds as needed, diagnostics and labs as ordered, head of bed elevated to prevent shortness of breath as tolerated, medications as ordered, oxygen as ordered, vitals as needed.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Resident #185 exhibited symptoms of a worsening infection for a period of greater than 48 hours without adequate assessment or intervention. The Resident had recently been hospitalized for known sepsis from pneumonia. The combination of medication administration lapses and Registered Nursing insufficiency, assessment and care on the dedicated tracheostomy specialty unit potentially resulted in therapeutic interventions being overly prolonged or omitted.<br><br>Within 5 days of the completion of the antibiotics the Resident was again seriously ill. He was eventually sent out 911 to the hospital and did not recover. This was not a singular event, and the insufficient staffing on the dedicated specialty tracheostomy unit had a profound impact on a neighbor of this Resident during this time period as well.<br><br>On 9-11-25 at 3:00 P.M., the facility's corporate staff were asked to provide time clock records for the relevant period, which they supplied. Both the Director of Nursing and the Administrator were new employees of only a few days. The Corporate staff responded that they were aware Registered Nurses had not been dedicated to the tracheostomy unit on the specified days and times, and stated they had nothing further to provide as evidence.<br><br>2. Resident #186 was ordered to have low-dose Aspirin for pain and anticoagulation, 81 milligrams every day, increasing the likelihood of bleeding should trauma occur at the trach site, making the Resident high risk for hemorrhage.<br><br>Review of physician and nursing progress notes the following chronological record of events occurred:<br><br>On 8-16-25, the oncoming LPN at 11:00 P.M. assumed care of the Resident. At 12:31 A.M. (1.5 hours later) on 8-17-25, the LPN completed a respiratory evaluation.<br><br>On 8-17-25 at 2:09 A.M., that nurse documented that the Resident was coughing up large amounts of bright red blood with what appeared to be lung tissue. Nurse suctioned mouth and trachea and denoted an oxygen saturation of 59% on 10 liters of oxygen via trachea. Nurse assessed lung sounds and patient has rhonchi (coarse gurgling sounds) in all fields. 911 called, .Patient to ER. (emergency room). Third eye contacted and RP (responsible party) notified.<br><br>On 8-18-25 at 4:00 A.M., another nursing note reveals that the Resident was admitted to the hospital with a tracheal tear and was on comfort measures. The resident expired that day.<br><br>LPNs are not permitted to complete Deep tracheal suctioning, and they may only independently provide oral and nasopharyngeal suctioning after training for such without the direct supervision of an RN, according to the National Library of Medicine.<br><br>During the survey, LPNs and Certified Nursing Assistants (CNAs) were interviewed and stated that they did remember the two (2) Residents involved during these [DATE] incidents. They stated there were times when RNs were not present to help and admitted that they often felt inadequate to care for tracheostomy Residents. They further stated they were not always sure when those residents were exhibiting signs of distress or worsening conditions until the residents were seriously ill. None were able to answer what the safe strength of suctioning in millimeters of mercury was for the Residents.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The facility assessment was reviewed and revealed that the specialty care unit for tracheostomies would be staffed with RNs on every shift and every day, indicating that they were aware of the state and federal requirements for the specialty unit.<br><br>The Resident's care plan was reviewed and revealed current focuses for The Resident is at risk for complications secondary to a tracheostomy initiated on 5-15-25 after admission with interventions including observe for signs and symptoms of respiratory complications including infection and or respiratory blockage or mucus plug and notify MD (doctor) as indicated, suction as needed, tracheostomy care per order.<br><br>The Resident had other care plan interventions for a respiratory infection/pneumonia early on in his stay; however, they were discontinued as resolved on 6-24-25.<br><br>No oxygen with humidification therapy, inner cannula cleaning and replacement, nor size and location of spare cannulas, nebulizer treatments, strength of suction devices, nor trach support tie changes were ever placed on the care plan to guide care for nurses.<br><br>The combination of lapses in care planning, Registered Nursing insufficiency, and the lack of assessment and care contributed to the situation on the dedicated tracheostomy specialty unit. The result was that care was given improperly, and therapeutic interventions were potentially being omitted.<br><br>Resident #186 was eventually sent out by 911 to the hospital and did not recover.<br><br>On 9-11-25 at 3:00 P.M., both the Director of Nursing and the Administrator were identified as new employees of only a few days. The Corporate staff responded that they were aware Registered Nurses had not been dedicated to the tracheostomy unit on the specified days and times, and stated they had nothing further to provide as evidence. They were notified at this time that immediate jeopardy was a finding in the investigation and asked for a plan to remove the immediacy requirement principle, which infers that this could happen again with other Residents on this specialized nursing unit if not fixed immediately.<br><br>The facility staff supplied an immediacy removal plan which included the following.<br><br>The facility staff failed to provide Registered Nurse (RN) staffing on the specialized tracheostomy unit on the 3:00 P.M. to 11:00 P.M. shift on 8-12-25, 11P.M. to 7:00 A.M. shift on 8-16-25/8-17-25, and previously on 5-6-25 for another Resident causing adverse outcomes resulting in death.<br><br>Those included Resident #185, #186, and #190.<br><br>The Residents that could be affected included all with tracheostomies residing on the tracheostomy unit that are not afforded care/assessment by an RN trained in tracheostomy care<br><br>The actions the facility will take to prevent serious adverse outcomes from occurring or reoccurring, and when action will be complete follows below:<br><br>1. Effective 9-12-25 a Registered Nurse with documented tracheostomy competency training will be assigned to the tracheostomy unit every shift 7 days per week.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 2. Effective 9-12-25 Director of Nursing (DON) or designee will verify and document on assignment sheet the presence of an RN with documented tracheostomy training.<br><br>3. Effective 9-12-25 the Regional Director of Specialty Care or designee will ensure all RN staff scheduled to work on the tracheostomy unit have completed immediate reeducation and competency validation in care of tracheostomy patients, prior to assuming an assignment.<br><br>4. Effective 9-12-25 a roster of RN's will be maintained by the DON or designee and provided to staffing scheduler to ensure immediate coverage in the event of call-off.<br><br>The plan's credible evidence was evaluated by the survey team on 9-12-25 through observation, review of educational documents, direct interviews with staff, and staffing schedule reviews. The plan was accepted on 9-12-25 at 2:00 P.M. and was re-evaluated to ensure staff maintained the four points during the rest of the survey. Upon accepting the plan, the Immediate Jeopardy was lowered to a level 3 isolated (harm).<br><br>3. For Resident #190, the facility staff failed to have the required RN (Registered Nurse) assigned to work the tracheostomy unit during the 7:00 p.m. to 7:00 am shift on [DATE].<br><br>Resident #190 was admitted to the facility on [DATE] with diagnoses including but not limited to acute encephalopathy, anemia in chronic kidney disease stage 5, atherosclerosis of arteries, hypertension, chronic pain, continuous opioid dependence, dysphagia, end stage renal failure on dialysis, type 2 diabetes, anoxic brain damage, subclavian and axillary DVT (Deep Vein Thrombosis) chronic respiratory failure. Resident #190 had a tracheostomy and a g tube, was non-verbal, in a chronic vegetative state, and totally dependent on staff for all aspects of care. Resident #190 was coded as a DNR (Do Not Resuscitate) and on palliative care.<br><br>A review of the staffing worksheet revealed that RN #3 was scheduled to work the 7:00 p.m. – 7:00 a.m. shift on the 2nd floor tracheostomy unit on [DATE]. A review of the timecard punches revealed RN #3 clocked in at 6:59 p.m. and that she clocked out at 8:47 p.m.<br><br>On [DATE] at approximately 9:30 a.m., an interview was conducted with RN #3, who stated that she was scheduled for work on [DATE] and that she was a new RN and a new employee at the facility. She stated that she was still in training and that it would have been her first night working on the tracheostomy unit. She stated that after clocking in, she heard the staff discussing the people who had called out, including the RN supervisor. She stated that she suddenly realized she would be the only RN on the specialized tracheostomy unit responsible for the entire unit, which she had never worked before, and as a new nurse, she had not had much experience with tracheostomies. She stated that she began to get nervous about what could happen, and she called the supervisor, and they called the DON (Director of Nursing), who refused to come in. She stated that at that point, she was worried about what could happen if something went wrong. She stated that she did not feel comfortable taking the assignment, so she handed the keys over, clocked out, and went home at 8:47 pm.<br><br>A review of the facility records revealed that the DON did, in fact, refuse to come to the facility on the night of [DATE]. The DON was issued a Corrective Action form that read as follows:<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE], you failed to ensure there was adequate nurse coverage after being informed of the callouts on the unit. You were also instructed that a member from the nursing leadership needed to come into the center, and no one did.<br><br>A review of the staffing revealed that there was no RN coverage on the specialized tracheostomy unit when Resident #190 was found deceased . The RN from another floor had to be called down to pronounce Resident #190's death, as there were only LPNs working the specialized unit.<br><br>On [DATE], an interview was conducted with the Administrator, who stated that she was aware that a Registered Nurse was required to be scheduled on all shifts on the specialized tracheostomy unit.<br><br>On [DATE], during the end-of-day meeting, the Administrator was made aware of the concerns, and no further information was provided. |