Printed: 04/02/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norfolk Health Care Center	901 East Princess Anne Road Norfolk, VA 23504

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, and clinical record review the facility staff failed to provide needed durable medical equipment and home health services in a timely manner for 1 of 27 residents (Resident #115), in the survey sample. The findings included: Resident #115 was no longer a resident of the facility; therefore, a closed record review was conducted. Resident #115 was originally admitted to the facility 10/29/25. The diagnoses included; atherosclerotic heart disease of native coronary artery without angina pectoris, morbid obesity due to excess calories, end stage renal disease, and muscle weakness. The discharge Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/27/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #115's cognitive abilities for daily decision making were intact.On 1/13/26 at 12:08 PM an interview was conducted with Resident #115. Resident #115 stated that she was discharge from the facility to home on [DATE] and a physicians order was written for a bedside commode and a front-wheeled walker to be delivered to her home, as well as a physician's order for home health services which included nursing and physical therapy services. Resident #115 also stated that the bedside commode and the front-wheeled walker was not delivered to her home until 12/30/25 and home health services did not begin services until 1/3/26. Resident #115 further stated that she had to use a bedpan for 4 days and due to her limited mobility, it was very difficult on her body and mental state. Resident #115 lastly stated that due to not having home health services and physical therapy for a week after arriving home, her body became weaker and one of her legs became flaccid. On 1/14/26 at 11:05 AM an interview was conducted with the Director of Social Services. The Director of Social Services stated Resident #115 was discharged from the facility to home on [DATE]. The Director of Social Services also stated that the bedside commode and the front-wheeled walker did not arrive to Resident #115's home until 12/30/25 and home health services did not begin until 1/3/26. The Director of Social Services further stated, It is an issue them not delivering the DME (durable medical equipment) until 12/30/25 and the HH company not showing up until 1/3/26. It is not typical for this to occur.On 1/14/26 at 12:38 PM an interview was conducted with the Director of Rehabilitation. The Director of Rehabilitation stated that prior to Resident #115 being discharged from the facility to home, she gave Resident #115 a bedpan to go home with since the bedside commode was not going to be at the home prior to the resident's arrival home. The Director of Rehabilitation also stated that she went to Resident #115 home on [DATE] to set up the bedside commode due to the Durable Medical Equipment provider not being able to set the equipment up. The Director of Rehabilitation further stated that it was an issue that the bedside commode and the home health provider did not show up in a reasonable time frame, however this is not a normal occurrence. On 1/14/26 at 5:40 PM an interview was conducted with the Administrator. The Administrator stated that it was not acceptable that the bedside commode and the front-wheeled walker was delivered to (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #115's home on [DATE]. The Administrator also stated that it was not an acceptable time frame regarding the home health provider starting services a week after Resident #115 arrived home from the facility. Discharge Planning Progress Notes included the following notations: 12/30/2025 12:05 PM: Ms. [NAME] called stating that her DME has not been delivered and that the PCA company called her stating that per the Medicaid portal, it shows that Ms. [NAME] is on a spend down and they are no longer able to cover PCA services. SW reached out to adapt health and spoke with Ms. [NAME] regarding ETA for DME. Per Ms. [NAME] the BSC and rollator will now be arriving today between 11:35am - 1:35pm. 12/30/2025 5:08 PM: Ms. [NAME] informed SW that the DME was delivered, however they did not set up the BSC, SW called adapt health to see if they can send someone over to at least set it up, per adapt health rep they would not be able send any one over to set it up. SW notified IDT team. Rehab director stated she would stop by the house and set it up for her. SW asked Ms. [NAME] if it was okay for our rehab director to stop by to help set it up. Ms. [NAME] was grateful and stated yes that is fine. SW also informed Ms. [NAME] that due to her HH not returning her calls, SW will send out another HH referral to a different company. No other needs or concerns reported at this time. SW will continue to follow up. 12/31/2025 1:22 PM: SW sent HH referral to Enhabit, Interim, Westminister [NAME], Medi USA, Centerwell, Adoration, and Hope-in-Home. SW will follow up. Continue POC. 12/31/2025 4:29 PM: Ms. [NAME] contacted SW regarding her HH. Ms. [NAME] informed SW that Amedysis contacted her and informed her that they will begin services on Saturday, 1/3/26. On 1/14/26 at approximately 5:50 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional Director of Clinical Services, and [NAME] President of Operations. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0803

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observations, resident and staff interviews, and clinical record review, the facility staff failed to ensure that 3 of 28 residents (Residents #108, #107, and #124) in the survey sample had meals served that followed the menu and meal tickets. The findings included: 1. The facility's staff failed to serve food items according to the menu and meal ticket.

Resident #108 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included stroke, renal failure, and heart failure.

The annual Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 10/13/25, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated that Resident #108's cognitive abilities for daily decision-making were moderately impaired.

In section GG (Functional Abilities and Goals), the resident was coded as requiring setup or clean-up assistance with eating, dependent with oral hygiene, toileting hygiene, showers/bathes, upper body dressing, lower body dressing, putting on and taking off footwear, personal hygiene, rolling, and sit-to-lying.

On 1/13/25 at approximately 12:30 PM, an observation was made of Resident #108 during the lunch meal. The meal served was roasted pork with gravy, beets, mashed potatoes, a biscuit, and an apple dessert. The menu and the resident's personal meal ticket read that the resident was to receive cornbread, not a biscuit.

The resident's meal ticket dated 1/13/26 for the lunch meal read: fluids restricted to 1200 milliliters per day. A regular diet: Roasted pork 3 ounces, pork gravy 2 ounces, Harvard beets 1/2 cup, creamy mashed potatoes 4 ounces, corn bread 1 piece, margarine 1 each, apple crisp 1/2 cup, allowed one 8-ounce beverage.

On 1/14/26 at approximately 4:25 PM, an interview was conducted with the Dietary Manager (DM). The DM stated that he didn't have cornbread for the meal on 1/13/26 because the food delivery didn't occur when it was supposed to. He also said that the cornbread substitute was not updated on the menu or on residents' personal meal tickets to notify them of the change, due to the difficulties with the menu/meal ticket software.

On 1/14/26 at approximately 5:50 PM, a final interview was conducted with the Administrator, Director of Nursing, the Regional [NAME] President, and the Regional Nurse Consultant. An opportunity was provided for the facility to provide feedback, but they offered none.

2. The facility's staff failed to serve food items according to the menu and meal ticket to serve chopped meat to a resident on a mechanically advanced/chopped diet on 1/13/26.

Resident #107 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included tracheostomy, diabetes, PVD, and heart failure.

The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/25/25, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated that Resident #107's cognitive abilities for daily decision making were intact. The residents' meal ticket dated 1/13/26 read: mechanical advanced/chopped diabetic diet. Serve a mechanical advanced/chopped roasted pork loin 3 ounces, pork gravy 2 ounces, diced beets 1/2 cup, creamy mashed potatoes 4 ounces, a dinner roll, 1, margarine 1 each, apple crisp 1/4 of a cup, 2% milk 8 ounces, and hot coffee or hot tea 6 ounces. In section GG (Functional Abilities and Goals), the resident was coded as requiring setup or clean-up assistance with eating, substantial/maximal assistance with oral hygiene, was dependent with toileting hygiene, showers/bathes, upper body dressing, lower body dressing, putting on and taking off footwear, and personal hygiene. The resident also required partial/moderate assistance with rolling and sit-to-lying. On 1/13/25 at approximately 12:41 PM, an observation was made of Resident #107 during the lunch meal. The residents' meal consisted of a whole slice of roasted pork with gravy (this should have been chopped roasted pork per the meal ticket), diced beets, mashed potatoes, a biscuit (the menu and meal ticket read a dinner roll was to be served), and an apple dessert. On 1/14/26 at approximately 4:25 PM, an interview was conducted with the Dietary Manager (DM). The DM further stated that it was an error that the residents' pork loin was not chopped, and he would in-service the staff on the foodservice line to be more aware of what is on the meal tickets. The DM further stated that he didn't have dinner rolls for the lunch meal on 1/13/26 because the food delivery didn't occur when it was supposed to. He also said that the dinner roll substitute was not updated on the menu or on residents' personal meal tickets to notify them of the change, due to the difficulties with the menu/meal ticket software. On 1/14/26 at approximately 5:50 PM, a final interview was conducted with the Administrator, Director of Nursing, the Regional [NAME] President, and the Regional Nurse Consultant. An opportunity was provided for the facility to provide feedback, but they offered none. 3. The facility staff failed to serve portion of food listed on the menu. Resident #124 was originally admitted to the facility 3/03/17 from an acute care facility and re-admitted on [DATE]. The current diagnoses included; Dysphagia, Mechanically Altered PO Intake and Cerebral Palsy. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/03/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #124 cognitive abilities for daily decision making were intact. In Section GG (Functional Abilities and Goals) the resident was coded as using suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. On 1/13/26 at approximately 11:50 am., Resident #124 was observed sitting in his wheelchair outside of his room. The resident stated I want my food to get my weight back; I don't have enough fat on me. The resident was asked if he was getting extra portions of food, he said no and I ask all of the time. He also said, I want you to look at my tray when they bring it. On 1/13/26 at approximately 12:14 pm., an observation of the resident's meal and tray was conducted (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at lunch time. The residents' meal consisted of Roasted Pork Loin, Pork Gravy, Diced Harvard Beets, Creamy Mashed Potatoes, a Biscuit and Apple Crisp. The resident's meal ticket listed all of the above including Cornbread that was not present on the resident's tray but 1 biscuit was observed on the resident's tray instead. The resident said that it comes like that sometimes but I got to get my weight up. On 1/13/26 at approximately 3:20 pm., an end-of-day meeting was conducted with the Administrator and with the Director of Nursing (DON) concerning the above issues. The DON said that the meal ticket should be followed due to weight loss, the resident gets double portions. On 1/14/26 at approximately 11:30 am., Resident #124 said that he was going out to eat lunch today. On 1/14/26 at approximately 4:35 pm., an interview was conducted with the Dietary Manager (DM) concerning Resident #124. The DM said that there was no cornbread mix available, so the resident was served a biscuit instead. On 1/14/26 at approximately 5:45 pm., the above findings were shared with the Administrator, Director of Nursing, the Regional Nurse Consultant and the Regional [NAME] President. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0807

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observations, resident and staff interviews, and clinical record review, the facility staff failed to ensure that 4 of 28 residents (Residents #124, #122, #108, and #107) in the survey sample received fluids as listed on the menu, per their preferences, or as ordered. The findings included:

1.The facility staff failed to serve a beverage listed on the menu. Resident #124 was originally admitted to the facility 3/03/17 from an acute care facility and re-admitted on [DATE]. The current diagnoses included; Dysphagia, Mechanically Altered PO Intake and Cerebral Palsy.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/03/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #124 cognitive abilities for daily decision making were intact. In Section GG (Functional Abilities and Goals) the resident was coded as using suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.

On 1/13/26 at approximately 12:14 pm., an observation of the resident's meal ticket at lunch time read Hot Coffee or Hot Tea. Resident #124 overheard his roommate complaining to the nurse about not having anything to drink brought in with his lunch. Resident #124 said that he didn't get anything to drink either, holding up his water bottle, saying I can drink this.

On 1/13/26 at approximately 3:20 pm., an end-of-day meeting was conducted with the Administrator and with the Director of Nursing (DON) concerning the above issues. The DON said that the meal ticket should be followed.

On 1/14/26 at approximately 4:35 pm., an interview was conducted with the Dietary Manager (DM) concerning Resident #124. The DM said that beverages should have been available.

On 1/14/26 at approximately 5:45 pm., the above findings were shared with the Administrator, Director of Nursing, the Regional Nurse Consultant and the Regional [NAME] President. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

2.The facility staff failed to serve a beverage listed on the menu. Resident #122 was originally admitted to the facility 10/26/19 from an acute care facility and re-admitted on [DATE]. The current diagnoses includes: Moderate Protein Calorie Malnutrition.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/01/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #122 cognitive abilities for daily decision making were intact.

On 1/13/26 at approximately 12:00 pm., during rounds was approached by Resident #122 concerning the poor services he's receiving from the nursing and dietary staff.

On 1/13/26 at approximately 12:16 pm., an observation of the resident's meal and tray was

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F 0807

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

conducted at lunch time. The resident's meal ticket listed Hot tea or Coffee no beverage was observed on the resident's tray other than what he already had on his bedside table. The resident was overheard asking for his tea or coffee to LPN #2. LPN #2 was observed shrugging her shoulders, leaving the room but not returning with a beverage.

On 1/13/26 at approximately 3:20 pm., an end-of-day meeting was conducted with the Administrator and with the Director of Nursing (DON) concerning the above issues. The DON said that the meal ticket should be followed.

On 1/14/26 at approximately 4:35 pm., an interview was conducted with the Dietary Manager (DM) concerning Resident #122. The DM said that the resident's should have received their beverages.

On 1/14/26 at approximately 5:45 pm., the above findings were shared with the Administrator, Director of Nursing, the Regional Nurse Consultant and the Regional [NAME] President. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

3. The facility's staff failed to serve an 8 ounce beverage according to the menu and the residents' personalized meal ticket.

Resident #108 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included stroke, renal failure, and heart failure.

The annual Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 10/13/25, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated that Resident #108's cognitive abilities for daily decision-making were moderately impaired.

In section GG (Functional Abilities and Goals), the resident was coded as requiring setup or clean-up assistance with eating, dependent with oral hygiene, toileting hygiene, showers/bathes, upper body dressing, lower body dressing, putting on and taking off footwear, personal hygiene, rolling, and sit-to-lying.

On 1/13/25 at approximately 12:30 PM, an observation was made of Resident #108 during the lunch meal. The meal served was roasted pork with gravy, beets, mashed potatoes, a biscuit, and an apple dessert. No fluids were served.

An interview was conducted with the Certified Nursing Assistant (CNA) #1 at approximately 12:33 PM. She was observed in the hallway distributing trays and drinks. CNA #1 stated she did not provide the resident with a drink because he had a water pitcher at bedside. CNA #1 asked if I wanted the resident to have a glass of tea, and I responded that she should proceed according to the facility's protocol.

The menu stated that residents were to receive an 8-ounce and a 6-ounce beverage at lunch. Resident #108's beverages were restricted to 1200 milliliters per day, with an allowance of 8 ounces at lunch, which was not provided. The resident's lunch meal ticket read: allowed one 8-ounce beverage.

On 1/14/26 at approximately 12:25 PM, the resident was observed in bed with the lunch meal before him, and the Assistant Director of Nursing (ADON) was present. The meal consisted of a thick piece of

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breaded chicken, mixed vegetables, and rice. No fluids were served to him. The ADON stated that, based on the residents' meal ticket, he should have received an 8-ounce beverage with his lunch. The ADON further said she would ensure the resident received his beverage of choice. On 1/14/26 at approximately 4:25 PM, an interview was conducted with the Dietary Manager (DM). The DM stated that the resident was supposed to receive his meal as planned on the menu, with modifications based solely on his personal preferences and limitations, as ordered by the physician. The DM stated that drinks had been spilling onto the trays; therefore, a decision was made to send beverages up separately to avoid spills that ruined meals. He also stated that no one had raised concerns about the beverage distribution method, so he was unaware that not all residents were receiving beverages in accordance with the menu, preferences, and physician orders. The DM stated he would address the concern with the administrative team so they could strategize on a solution. On 1/14/26 at approximately 5:50 PM, a final interview was conducted with the Administrator, Director of Nursing, the Regional [NAME] President, and the Regional Nurse Consultant. An opportunity was provided for the facility to provide feedback, but they offered none. 4. The facility's staff failed to serve an 8 ounce beverage and a 6 ounce beverage to Resident #107, according to the menu and the residents' personalized meal ticket. Resident #107 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included tracheostomy, diabetes, PVD, and heart failure. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 11/25/25, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated that Resident #107's cognitive abilities for daily decision making were intact. In section GG (Functional Abilities and Goals), the resident was coded as requiring setup or clean-up assistance with eating, substantial/maximal assistance with oral hygiene, was dependent with toileting hygiene, showers/bathes, upper body dressing, lower body dressing, putting on and taking off footwear, and personal hygiene. The resident also required partial/moderate assistance with rolling and sit-to-lying. On 1/13/25 at approximately 12:41 PM, an observation was made of Resident #107 during the lunch meal. The residents' meal consisted of a whole slice of roasted pork with gravy (this should have been chopped per the meal ticket), diced beets, mashed potatoes, a biscuit, and an apple dessert. No fluids were served. The menu stated that residents were to receive an 8-ounce and a 6-ounce beverage at lunch. Resident #107's lunch meal ticket read: 2 percent milk, 8 ounces, and hot coffee or hot tea, 6 ounces. On 1/14/25 at approximately 12:37 PM, an observation was made with the ADON of Resident #107 during the lunch meal. The resident's meal consisted of chopped, breaded chicken, mixed vegetables, and rice. No fluids were served with the meal. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review, and review of facility documents, the facility's staff failed to ensure an enhanced barrier precaution sign was posted for 1 resident to prevent the spread of infection for 1 of 28 residents (Resident # 117), in the survey sample.The findings include: Resident #117 was originally admitted to the facility 10/23/25 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Tracheostomy Status. The discharge Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/17/25 coded the resident as having short-term memory loss which indicated Resident #117 cognitive abilities for daily decision making were moderately impaired. Section K (Swallowing/Nutritional Status) coded the resident as having a Feeding Tube. A review of the Physician's order Summary for December 2025 read Enhanced Precaution r/t Trach every shift. Active from 11/04/25. On 1/13/26 and during the initial tour of the facility at approximately, no Enhanced Barrier (EHB) signage was observed on Resident's door or wall before entering room [ROOM NUMBER] B.On 1/14/26 no EHB signage was observed on the resident's door or wall of room [ROOM NUMBER] B. The resident was observed resting quietly in bed with her eyes closed, Tracheostomy attached, enteral feeding observed at the bedsideOn 1/14/26 interviews were conducted at 11:45 am., with staff on unit 1, 2nd floor concerning EHB precautions. Certified Nursing Assistant # 3 (CNA) was asked to explain why some of the rooms on the unit displayed EHB signage on the wall before entering a residents room. CNA #3 said that they were in- serviced on EHB Precautions, and only residents with tracheostomies, feeding tubes, staff must follow the EHB signs on what to wear such as gowns, masks, gloves, providing ADL care, and changing briefs.On 1/14/26 at approximately 11:55 am., an interview was conducted with Registered Nurse #1 concerning EHB precaution signage. RN #1 said that if a resident has a PICC Line, Trach., or attends dialysis they should be on EHB Precautions. RN #1 was asked if Resident #117 should be under EHB precautions. RN #1 said yes, there should have been EHB signage on the door or wall. RN #1 also said because the resident was moved to another room yesterday, no signage was put up.Throughout the course of the survey EHB Precaution signs were observed on all floors. The signage read: STOP! Perform hand hygiene using soap and water and or alcohol-based hand rub before entering room and before exiting room. Wear gown and gloves when entering room to provide the following high-contact resident care activities: Dressing, Bathing/Showering, Transferring, Changing Linens, Providing hygiene, Changing briefs or assisting with toileting, Device care or use: central line urinary catheter, feeding tube, tracheostomy, wound care: any sin opening requiring a dressing, Bag linen and discard trash to prevent contamination of self, environment or outside bag.On 1/14/26 at approximately 5:45 pm., the above findings were shared with the Administrator, Director of Nursing, the Regional Nurse Consultant and the Regional [NAME] President. The DON said there was signage on the door of the resident's room (room [ROOM NUMBER] B). The DON was informed by the surveyor that no signage was observed on the resident's wall or door since rounds were conducted from 1/12/26 through 1/14/26. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norfolk Health Care Center	901 East Princess Anne Road Norfolk, VA 23504

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, staff interviews, and clinical record review, the facility staff failed to maintain a sanitary and comfortable environment for all.The findings included: 1. The facility staff failed to provide a sanitary and comfortable environment in the 200-unit. On 1/12/25, it took 12 minutes from the time the call button was activated until the elevator arrived at the front lobby. Upon arriving at the 200's unit on 1/12/24 at approximately 3:30 PM, the lower numeral corridor was observed to be littered with debris on the floor, had many dark spots on the floor that appeared to be uncleaned spills, and the corridor was cluttered with various medical equipment. In room [ROOM NUMBER], the floor was simply dirty, the trash can was without a liner, and a used glove was observed on the floor. The A bed resident had mats at the bedside with holes and a dark substance on them. Under the head of the bed, the floor space was filled with broken, useless items, a wheelchair leg rest, and a lot of dust and dirt. The room was also very cluttered. The resident in the B bed stated that the resident in the A bed had a television remote control that changed the television channels on his side of the room. In room [ROOM NUMBER], the room was dark and smelly, the floor was covered with dirt and debris, and the bathroom toilet was dirty and smelly. The corridor was also extremely odorous after passing room [ROOM NUMBER], and the odor didn't dissipate over time. An interview was conducted with the environmental services staff (EVS) on 1/13/25 at 12:27 PM. The EVS stated that she works extremely hard to keep the unit clean and that she had been complimented for her success in turning the unit around. The EVS stated that she moves nothing on the floor when she mops because she doesn't know what items are there, so she mops around them. She also said that she had scrubbed the fall mats on the floors, but she was unsuccessful in getting some of them clean. She stated that she records the information in her daily notes and then gives them to her supervisor. On 1/14/26 at approximately 5:50 PM, a final interview was conducted with the Administrator, Director of Nursing, the Regional [NAME] President, and the Regional Nurse Consultant. An opportunity was provided for the facility to provide feedback; they nodded that they agreed there were environmental concerns. 2.The facility staff failed to provide a sanitary and comfortable environment on the 400 floor. On 1/12/26 at approximately 4:05 pm., an initial tour was conducted on the 400 floor. A strong urine odor was detected in the hallways, the floors had dirt and debris. A housekeeper was observed standing near her cart. On 1/13/26 at approximately 2:10 pm., a tour of the 400 floor was conducted. The floors appeared clean and no odor was present. Several housekeeping staff were observed cleaning rooms and mopping floors. On 1/14/26 at approximately 12:40 pm., a brief tour was made of the 400 floor. A strong urine odor was present. Only a few Housekeepers were noticed on the unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER Norfolk Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 901 East Princess Anne Road Norfolk, VA 23504	

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/26 at approximately 5:45 pm, a final interview was conducted with the Administrator, Director of Nursing, the Regional [NAME] President, and the Regional Nurse Consultant.