STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. Building B. Wing	03/12/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility staff failed to implement the facility abuse policies for one Resident (Resident #1) of 2 residents in the survey sample.The findings included:The facility staff failed to implement their abuse policy and report an unusual occurrence that resulted in a missing person report being filed for Resident #1, who a Certified Nursing Assistant/Aide (CNA B) was not trained on LOA (leave of absence) permitted Resident #1 to leave the facility for approximately 3 days without family or nursing staff knowledge. The Resident was returned by his daughter/power of attorney (POA) approximately 72 hours after his departure with a cousin.Resident #1 was admitted on [DATE] with diagnoses including Stroke, hypertension, chronic systolic heart failure, left sided hemiparesis, and aphasia. The Resident's face sheet listed the Resident's daughter as his POA for financial and medical decision making. The Document was not derived until 3-10-26 upon his return to the facility. Prior to that he was his own decision maker. The Resident's most recent Minimum data set (MDS) federally mandated assessment was dated 2-25-26 and was a quarterly review. The Resident had a Brief Interview for Mental Status (BIMS) score of 7 of a possible 15 points indicating moderate cognitive impairment. The Resident also required assistance with all activities of daily living.On 3-12-26, facility staff and Resident #1 were interviewed, and the facility Administrator was asked for the full facility investigation into the incident. Those records and interviews revealed the following timeline of events in chronological order.On 3-7-26 at approximately 2:00 P.M. Resident #1 left the facility and was signed out for a LOA by a family member identified as a cousin by family, which was documented by her signature on the facility sign out sheets. Licensed Practical Nurse (LPN #1) recounted that Resident #1 went out with family for a cookout and would return at approximately 7:00 P.M. that same night. LPN #1 Stated she was told that by CNA #2. LPN #1 gave that report to the oncoming LPN and left the building at the end of her shift at 7:00 P.M The Director of Medical Records was the Manager on Duty (MOD) that day and stated she had also seen Resident #1 exit with the family member and they told her he was going out to a cookout and would be back later in the evening. She stated she asked them if he had been signed out, and both the cousin and the Resident stated yes. On Sunday 3-8-26 LPN #1 became concerned as the Resident was not yet back in the building to receive his medications, and so she called the Resident's daughter to find out when he would be returning, and that is when the daughter found out he was missing and the family actually had no idea he was missing and they had not removed him.An interview conducted with the Administrator on 3-12-26 @ 1:00 P.M. revealed that CNA #2 helped him leave, (which was an error). The Administrator further stated that CNA #2 was currently suspended and would be terminated. The Administrator went on to say that staff members have either resigned or been terminated with respect to their roles in this situation. On 3-8-26 the Administrator was made aware of the incident by LPN #2 (on call nurse manager) via a phone call, as she had been contacted by LPN #1 who was onsite with concerns. On 3-9-26 The daughter was made aware of the incident and was irate understandably according to the Administrator who also stated the daughter was made aware on the evening of 3-8-26, however, she did not come to the facility until 3-9-26. The Administrator also called local police and issued a missing person's complaint. The Administrator told the daughter the name of the individual who signed Resident #1 out, and the daughter calmed down (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after learning the name of the person who took the Resident out. The Daughter stated to the Administrator that she had a cousin by that name. On 3-9-26 at 3:38 P.M. the state agency received this anonymous complaint, 2 days after the incident occurred. The complaint has an addendum which stated that the Resident called in a report to the state agency when he found out he had been deemed a missing person and wished to discharge from the facility and called to say he was making his own decisions regarding discharge.No report to the state agency was ever made by the facility for this unusual occurrence as per the facility's abuse policy. The facility received the Resident back on 3-10-26 after the daughter was called and alerted by a near by Hospital that Resident #1 had been left there by the cousin in the emergency room. He was evaluated there and needed no care, so the daughter returned him to the facility.On 3-10-26 The daughter gave the facility 2 POA's (financial & medical) that were completed on that day and attested as signed by the Resident in front of a notary public, possibly at the hospital.The facility investigation was reviewed and included staff interviews, QAPI (quality assurance and process improvement) plan, and ongoing education with staff sign-in sheets on the LOA process which were being conducted. The Administrator stated the education on LOA would continue being conducted upon hire, and (since re-started on 3-10-26), would be conducted for all staff currently as they come to work until everyone has received it. The investigation was not complete and did not include statements from residents, nor all individuals involved in the incident, nor did it indicate the chronology of events that would lead to a conclusion for planning of comprehensive corrections to the failed LOA policy. Further, no initial report nor 5 day follow up report was ever sent to the state agency as mandated by law.The facility policy on abuse titled, Abuse/Neglect/Misappropriation/Crime- Administrative Reference Guide, with an effective date of 1/23/2020 was reviewed. The policy read in part, . 4. Centers are to report to teh State Survey Agency any unusual incidents or occurrences. Examples of unusual occurrences include: a. Any event involving a patient that is likely to result in legal action . h. Any unusual event involving a patient or patients that may result in media coverage or law enforcement involvement . With regard to reporting the abuse policy indicated that reports are to be made to the state agency but not later than 2 hours after the allegation is made if the allegation involves abuse or not later than 24 hours if the allegation does not involve abuse. The document revealed that a through investigation should be conducted and findings submitted to the state agency within 5 working days of the incident. On 3-12-26 The Resident had been in the facility since his return on 3-10-26 with no issues. The Resident was interviewed and wanted to go home, and had a good time while I was out, however, he has cognitive decline and hemiparesis due to a stroke and is unable to care for himself. His daughter is a college student and unable to care for her father, therefore no discharge plan has been initiated.Resident #1 was permitted to leave the facility with a family member incorrectly and unsafely, with no medications and no plan. The Resident was assisted by a staff member who was not trained to provide a safe LOA, however, as he was his own responsible party at the time he insisted and left. The Administrator and Director of Nursing (DON) were made aware of the findings at the end of day debriefing on 3-12-26. They both stated they had no further information to provide.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, Resident interview, clinical record review, and facility documentation review, the facility staff failed to maintain competency necessary to care for resident needs in Nursing Aide proficiency related to leaves of absence (LOA) for one Resident (Resident #1) of 2 Residents in the survey sample. The findings included:Certified Nursing Assistant/Aide (CNA B) was found to have not been trained on LOA which she provided to Resident #1 resulting in him leaving the facility for approximately 3 days without family or nursing staff knowledge. The Resident was returned by his daughter/power of attorney (POA) approximately 72 hours after his departure with a cousin.Resident #1 was admitted on [DATE] with diagnoses including Stroke, hypertension, chronic systolic heart failure, left sided hemiparesis, and aphasia. The Resident's face sheet listed the Resident's daughter as his POA for financial and medical decision making. The Document was not derived until 3-10-26 upon his return to the facility. Prior to that he was his own decision maker. The Resident's most recent Minimum data set (MDS) federally mandated assessment was dated 2-25-26 and was a quarterly review. The Resident had a Brief Interview for Mental Status (BIMS) score of 7 of a possible 15 points indicating moderate cognitive impairment. The Resident also required assistance with all activities of daily living.Staff and the Resident were interviewed, and the facility Administrator was asked for the full facility investigation into the incident. Those records and interviews revealed the following timeline of events in chronological order.On 3-7-26 at approximately 2:00 P.M. Resident #1 left the facility and was signed out for a LOA by a family member identified as a cousin by family, which was documented by her signature on the facility sign out sheets. Licensed Practical Nurse (LPN #1) recounted that Resident #1 went out with family for a cookout and would return at approximately 7:00 P.M. that same night. LPN #1 Stated she was told that by CNA #2. LPN #1 gave that report to the oncoming LPN and left the building at the end of her shift at 7:00 P.M The Director of Medical Records was the Manager on Duty (MOD) that day and stated she had also seen Resident #1 exit with the family member and they told her he was going out to a cookout and would be back later in the evening. She stated she asked them if he had been signed out, and both the cousin and the Resident stated yes. On Sunday 3-8-26 LPN #1 became concerned as the Resident was not yet back in the building to receive his medications, and so she called the Resident's daughter to find out when he would be returning, and that is when the daughter found out he was missing and the family actually had no idea he was missing and they had not removed him.An interview conducted with the Administrator on 3-12-26 @ 1:00 P.M. revealed that CNA #2 helped him leave, (which was an error). The Administrator further stated that CNA #2 was currently suspended and would be terminated. The Administrator went on to say that staff members have either resigned or been terminated with respect to their roles in this situation. On 3-8-26 the Administrator was made aware of the incident by LPN #2 (on call nurse manager) via a phone call, as she had been contacted by LPN #1 who was onsite with concerns. On 3-9-26 The daughter was made aware of the incident and was irate understandably according to the Administrator who also stated the daughter was made aware on the evening of 3-8-26, however, she did not come to the facility until 3-9-26. The Administrator also called local police and issued a missing person's complaint. The Administrator told the daughter the name of the individual who signed Resident #1 out, and the daughter calmed down after learning the name of the person who took the Resident out. The Daughter stated to the Administrator that she had a cousin by that name. On 3-9-26 at 3:38 P.M. the state agency received this anonymous complaint, 2 days after the incident occurred. The complaint has an addendum which stated that the Resident called in a report to the state agency when he found out he had been deemed a missing person and wished to discharge from the facility and called to say he was making his own decisions regarding discharge.No report to the state agency was ever made by the facility. The facility received the Resident back on (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3-10-26 after the daughter was called and alerted by a near by Hospital that Resident #1 had been left there by the cousin in the emergency room. He was evaluated there and needed no care, so the daughter returned him to the facility.On 3-10-26 The daughter gave the facility 2 POA's (financial & medical) that were completed on that day and attested as signed by the Resident in front of a notary public, possibly at the hospital.Other LOAs were reviewed in consideration of the allegations, and only 1 Resident was found to have used the LOA in 6 months (Resident #2). Those records were reviewed and followed the facility policy without incident. The facility investigation was reviewed and included staff interviews, QAPI (quality assurance and process improvement) plan, and ongoing education with staff sign-in sheets on the LOA process which were being conducted. The Administrator stated the education on LOA would continue being conducted upon hire, and (since re-started on 3-10-26), would be conducted for all staff currently as they come to work until everyone has received it. The investigation was not complete and did not include statements from residents, nor all individuals involved in the incident, nor did it indicate the chronology of events that would lead to a conclusion for planning of comprehensive corrections to the failed LOA policy. Further, no initial report nor 5 day follow up report was ever sent to the state agency as mandated by law.On 3-12-26 The Resident had been in the facility since his return on 3-10-26 with no issues. The Resident was interviewed and wanted to go home, and had a good time while I was out, however, he has cognitive decline and hemiparesis due to a stroke and is unable to care for himself. His daughter is a college student and unable to care for her father, therefore no discharge plan has been initiated.Review of the facility LOA policy revealed that the patient or Responsible party must notify a licensed nurse on the unit prior to leaving, and an estimated time of return to be included. The Resident will receive medications, and an LOA will be documented in the medical record. The policy goes on to say that the Administrator, or business office manager, or admissions director must be made aware if the Resident will not return the same day. The Resident left with a family member incorrectly and unsafely with no medications and no plan. The Resident was assisted by a staff member who was not trained to provide a safe LOA, however, as he was his own responsible party at the time he insisted and left. The Administrator and Director of Nursing (DON) were made aware of the findings at the end of day debriefing on 3-12-26. They both stated they had no further information to provide.