STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495215	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Grove Health & Rehab Center, LLC	776 Oak Grove Rd Chesapeake, VA 23320

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, observations, and interviews, the facility failed to ensure a splint was applied routinely for one out of one resident (Resident (R) 11) reviewed for position and mobility. The facility's failure to ensure R11's splint was routinely applied created the potential for this and other residents to experience avoidable decline in range of motion (ROM). A total of 31 residents were reviewed in the sample. Review of R11's Resident Face Sheet, dated 02/19/26 and found in the electronic medical record (EMR) under the Admissions tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included history of stroke and reduced mobility. Review of R11's Occupational Therapy Discharge summary, dated [DATE] and found in the EMR under the Documents tab, revealed facility staff had been trained to ensure the application of the resident's right upper extremity splint/brace for three hours daily. Review of R11's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/16/25 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment could not be completed due to the resident's poor cognition and inability to communicate. The assessment indicated the resident had limited range of motion (ROM) to his upper and lower extremities bilaterally and indicated a brace/splint was not being applied for the resident. Reviewed of R11's Splint/Brace Care Plan, dated 02/12/26 and found in the EMR under the Care Plan tab, revealed R11 required the use of a splint/brace to his right upper extremity for three hours per day to improve ROM to the extremity. The care plan indicated the resident's splint/brace was to be applied every day from 8:00 AM until 11:00 AM. Review of R11's Physician's Order Report, dated 02/19/26 and found in the EMR under the Orders tab, revealed no orders for the resident's use of a splint/brace.R11's record revealed no documentation to indicate his splint/brace was being applied per his plan of care.Observations of R11 lying in his bed or seated in his wheelchair conducted on 02/18/26 at 9:25 AM and 10:55 AM, and on 02/19/26 at 10:15 AM, revealed R11 did not have his care planned brace applied to his right upper extremity. R11 was observed along with Licensed Practical Nurse/Unit Manager (LPN/UM1) and the Director of Nursing (DON) on 02/19/26 at 11:17 AM. Both confirmed R11 was not wearing his care planned splint/brace and that they were not able to locate the brace. Both indicated R11 was expected to have the care planned splint/brace applied daily for three hours between 8:00 AM and 11:00 AM. During a follow-up interview with the DON on 02/19/26 at 12:16 PM, she confirmed that although R11 was expected to have had his care planned brace/splint applied, the application of the resident's brace had not been added to the resident's daily care documentation and so had never been applied. The DON confirmed R11 should have been wearing the splint/brace daily and stated education would be provided to staff to begin applying the splint/brace immediately. Review of the facility's policy titled, Splint Issuance Policy, dated last revised/reviewed on 03/24/25, indicated, Splints shall be issued or fabricated with a provider's order and therapist must evaluate patient to determine need for splint, fit and issuance and Patient splint schedule will be communicated to the multidisciplinary team and documented in the care plan.

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of facility policy, the facility failed to ensure consistent and comprehensive management of nutritional services for one out of 11 residents (Resident (R) 67) reviewed for nutrition. The facility's failure to ensure consistent nutritional interventions were provided for R67 created the potential for this and other residents to experience significant/unanticipated weight loss or nutritional deficits. A total of 31 residents were reviewed in the sample. Review of the Resident Face Sheet, dated 02/19/26 and found in the electronic medical record (EMR) under the Profile tab, revealed R67 was admitted to the facility on [DATE]. The resident's diagnoses included rheumatoid arthritis, history of stroke, and malnutrition. Review of R67's Physician's Order Report, dated 02/19/26 and found in the EMR under the Orders tab, revealed orders, with an initial order date of 12/12/25 for the resident to receive a regular mechanical soft diet with nectar thick liquids and an order with an original order date of 09/04/25, for the resident to receive fortified foods with breakfast and dinner and for the resident to receive a 2-Cal Nutritional Supplement twice daily. The orders did not include any specific frequency for monitoring the resident's weight. R67's Vital Signs Report, dated 02/19/26 and found in the EMR under the Vital Signs Tab, revealed the following weights (which indicated a significant weight loss of 20.9% in two months): 12/05/25: 102.4 poundsNo weight was recorded in January of 202602/04/26: 81.0 poundsThe record did not indicate anything to show a re-weight had ever been obtained for R67 after her significant weight loss was recorded on 02/04/26.Review of R67's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/04/26 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment could not be completed due to the resident's poor cognition. The assessment indicated the resident had short and long-term memory deficits. The assessment indicated the resident had not experienced significant weight loss or gain during the assessment reference period and indicated the resident was dependent on staff to eat her meals. Review of R67's Nutrition Note, dated 02/09/26 and found in the EMR under the Notes tab, revealed Nutrition Note: [R67] is a 90 y.o. [year old] female who remains at increased nutritional risk related to PMH [Past Medical History]: dysphagia [difficulty swallowing], protein-calorie malnutrition, HTN [hypertension], hypothyroidism, iron-deficiency anemia, dementia, metabolic encephalopathy, and anxiety. She continues with a regular, mech [mechanical] soft diet, nectar thick liquids with fortified foods at breakfast and dinner. Additionally she gets House 2 Cal Med Pass 180 mL [milliliters] twice daily (720 kcal [calories], 32 g [grams] protein). Her intake is good with > [greater than] 75% of most meals consumed, although she is noted with some varied intake. Today she did eat most of her breakfast as I observed her finishing her meal. She does do well with the ONS [supplement] although she is also noted to refuse that at times as well. Current weight: 81 lb [pounds] (02/04/26), previous weight: 102.4 lb (12/5/25), 98 lb (11/3/25), and 102.4 lb (8/5/25). This is noted for significant weight loss of 17% weight loss over previous 3 months and 20% weight loss over previous 6 months. Resident is noted to remain underweight during this admission. She is noted with a skin tear, but no pressure injury at this time. She was seen earlier this month for her quarterly review, but there was no monthly weight yet. Recommend to re-check resident's weight. Additionally recommend to increase fortified foods to be at all meals. Recommend to continue with regular, mech soft diet with nectar thick liquids. Continue with House 2 cal HN [supplement], 180 mL, twice daily. Recommend to check weight weekly x4 [four times]. If weight continues downward trend even with additional fortified foods recommend to increase House 2 cal HN, Med Pass to three times daily. Will continue to monitor intake, weight, labs, and skin integrity, and follow-up per protocol.R67's Nutrition/Hydration Risk Care Plan, dated 02/16/26 and found in the EMR under the Care Plan tab, indicated the resident was at risk for significant weight loss related to her history of stroke and rheumatoid arthritis and was receiving a calorie enhanced diet. Interventions included: provide diet (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	per physician's order, honor resident's dietary preferences, weigh per facility protocol, provide supplements as ordered, monitor dietary intake, and monitor need for increased nutritional intervention related to diagnosis, medications, and listed problems. Review of R67's Medication and Treatment Administration Records (MARs/TARS), dated 02/01/26 through 02/19/26 and found in the EMR under the Orders tab, revealed the resident received her supplement twice daily and fortified foods at meals twice daily.Review of R67's dietary meal cards revealed she received fortified foods at all three meals.Review of R67's record revealed nothing to indicate the resident had been re-weighed or that the resident's weight had been obtained weekly according to the recommendations in the 02/09/26 nutrition note. During an interview with the Registered Dietician (RD) on 02/18/26 at 12:58 PM, she indicated R67 should have been weighed in January, and she was unsure of why that had not been done. She indicated if the resident had refused to be weighed in January, the weight should have been re-attempted, and documentation should be in the resident's record to indicate a refusal/reason for the missed weight if the weight was not able to be obtained. The RD indicated a re-weight had been requested and should have been done after R67 was weighed on 02/04/26 and a significant weight loss had been recorded on that date. She stated her expectation was her nutritional recommendations would be followed.During an interview with the Director of Nursing (DON) on 02/19/26 at 12:27 PM, she confirmed R67 had not been weighed in January per facility protocol, and her expectation, and confirmed the resident's weights had not been increased to weekly per the RD's 02/09/26 recommendation. She stated she was not sure why these things had been missed. The DON further indicated a re-weight should have been obtained for R67 on 02/04/26 after the result indicated a significant loss of weight.Review of the facility's policy titled, Resident Weight Policy, dated last revised/reviewed on 03/23/25, indicated, Weights will be obtained routinely in order to monitor nutritional health over time.The facility's policies related to the maintenance of nutritional health were requested by the survey team on 02/19/26 at 10:00 AM; however, the policies were not received prior to survey exit on 02/19/26.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and review of facility policy, the facility failed to ensure a medication error rate of less than five percent. Two errors occurred during the administration of one Resident's (Resident (R) 134) medications out of 30 observed opportunities, resulting in an error rate was 6.67 percent. The facility's failure created the potential for R134 and other residents to experience negative physical and/or psychosocial effects related to improper medication administration. A total of 31 residents were reviewed in the sampleReview of R134's Resident Face Sheet, dated 02/19/26 and found in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included congestive heart failure and malnutrition. Review of R134's Physician's Order Report, dated 02/19/26 and found in the EMR under the Orders tab, revealed an order, with an original order date of 02/13/26, for the resident to receive MiraLAX (a stool softening medication) 17 grams by mouth daily and an order, with an original order date of 02/13/26, for the resident to receive a multivitamin one tablet daily for supplement. Review of R134's Medication Administration Record (MAR), dated 02/13/26 through 02/19/26 and found in the EMR under the Orders tab, revealed the resident was receiving her MiraLAX and multivitamin as ordered. Review of R134's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/19/26 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment score of three out of 15, which indicated the resident was severely cognitively impaired. R134 was observed receiving her medication administered by Registered Nurse (RN) 1 on 02/18/26 at 9:38 AM. The resident's MiraLAX was mixed and administered with approximately two to three ounces of water (less than the required four to eight ounces of fluid to ensure full effect of the medication) and a multivitamin with minerals was administered instead of the resident's ordered multivitamin (without added minerals). During an interview with RN1 on 02/18/26 at 9:43 AM, she stated she administered the multivitamin with minerals because it was the only form of the vitamin available in the facility and stated she thought MiraLAX was to be administered in about eight ounces of water. She stated she did not realize the cup used to mix the resident's MiraLAX in was only a four-ounce cup. No larger cups were available on the medication cart. During an interview with the Director of Nursing (DON) on 02/19/26 at 10:57 AM, she stated medication was expected to be administered in the correct form/dose, and MiraLAX was expected to be administered in at least four to eight ounces of fluid to ensure proper effect.Review of the facility's policy titled, Bowel Tracking Policy, dated 10/06/25, indicated, If 48 hours without a bowel movement: Step 1: Give Miralax 17 grams in 4 - 8 ounces liquid. Review of the facility's policy titled, General Dose and Preparation and Medication Administration Policy, dated 11/15/24, indicated, 3. Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 3.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident.