STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495237	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Virginia Beach Healthcare and Rehab Center	1801 Camelot Drive Virginia Beach, VA 23454

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to prevent the elopements for two (2) residents out of 24 residents. Resident #217 and Resident # 223, in the survey sample. The findings included: 1.Resident #217 eloped from the facility on 1/21/25 at 11:03 PM., The facility staff failed to report the elopement within the required time frame of 2 hours to the State Survey Agency. This behavior could have put the resident at risk for death, hypothermia and or being hit by a moving vehicle. Resident # 217 was originally admitted to the facility 10/16/18 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Suicidal Ideations and Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety. The admissions Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #217 cognitive abilities for daily decision making moderately impaired. In sectionGG(Functional Abilities Goals) the resident was coded as being independent with eating, oral hygiene, requires supervision or touch assistance when walking 150 feet. The Care Plan dated 12/30/24 read that Resident #217 is at risk for elopement. The goal for the resident was that he will not elope. The interventions for the resident were to check wander guard function, placement, elopement risk assessment. The facility synopsis of events dated 1/21/25 read that Resident #217 was observed by staff in the parking lot. Returned to the building, no injuries noted. Resident #217 elopement was not reported until 1/22/25. The fax confirmation to the State Reporting Agency was dated 1/22/25 at 4:06 PM.,which was a total of 16 hours and 3 minutes after the elopement occurred. According to the Health Status note and the Final Synopsis listed above. Resident #217's elopement wasn't reported to the State Agency and Adult Protective services until 16 hours and 3 minutes later. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 an interview was conducted with Resident #217 at approximately 4:10 PM., concerning his elopement. Resident #217 said that he left the building to check on his home. On 1/23/25 at approximately 4:30 PM., an interview was conducted with the DON concerning the above elopement. The DON said that the incident should have been reported within 2 hours, but it was reported later. 2. Resident #223. The facility staff failed to report his elopement to the State Survey Agency after resident eloped from the facility. Resident #223 was originally admitted to the facility 10/18/24 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Depression, Unspecified. The 5-day Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/20/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #223 cognitive abilities for daily decision making were moderately impaired. In sectionGG(Functional Abilities Goals) the resident was coded as requiring set-up assistance with eating and oral hygiene. Dependent with toileting hygiene and requires substantial maximal assistance with bathing/showering. The Care Plan dated 12/30/24 read that Resident #223 is at risk for elopement. The goal for the resident was that he will not elope. The interventions for the resident were to check wander guard function, placement, elopement risk assessment. A review of Resident #223's incident report completed on 12/29/24 at 2:00 PM., read that Resident #223's family observed resident sitting in his wheelchair in the parking lot. Resident said that he was going for a walk. No injuries were observed by staff. A Facility Synopsis of the event was not completed. On 1/23/25 at approximately 6:30 PM., an interview was conducted with the DON. The DON said that the family informed the staff that the resident was in the parking lot. The DON also mentioned that a report (Facility Synopsis) was not completed but an elopement incident report was completed. The Abuse/Neglect/Misappropriation/Crime Policy reads dated 10/17/23 reads: There is zero tolerance for abuse, neglect, misappropriation of property, or any crime against a patient of the Health and Rehabilitation Center. Procedure: Any suspected or witnessed incidents of patient abuse, neglect, theft against a patient should be reported to the administration, an internal investigation conducted, appropriate and timely reporting to the State Survey Agency and other legally designated agencies, as well as staff corrective action, suspension, and/or termination as necessary. Failure for an employee to report any suspected or witnessed incident of mistreatment, abuse, neglect against a patient will result in corrective action. Immediately upon notification of any alleged violations involving, abuse, neglect or exploitation the administrator will immediately report to the state agency, but no later than 2 hours after the allegation is made. On 1/23/25 at approximately 7:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Regional Nurse Consultant (RNC) said that the staff was re-educated on resident elopements and investigating.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to provide the necessary supervision to prevent an elopement for two (2) out of 24 residents. Resident #217 and Resident # 223, in the survey sample. The findings included: 1. Resident #217 eloped from the facility on 1/21/25 at 11:03 PM., in the snow to the facility parking lot where employees and visitors parked their vehicles. This behavior could have put the resident at risk for death, hypothermia and or being hit by a moving vehicle. Resident # 217 was originally admitted to the facility 10/16/18 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; suicidal Ideations and unspecified dementia, unspecified Severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. The admissions Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #217 cognitive abilities for daily decision making moderately impaired. In sectionGG(Functional Abilities Goals) the resident was coded as being independent with eating, oral hygiene, requires supervision or touch assistance when walking 150 feet. The Care Plan dated 12/30/24 read that Resident #217 is at risk for elopement. The goal for the resident was that he will not elope. The interventions for the resident were to check wander guard function, placement, elopement risk assessment. The December 2024 Physician Order Summary (POS) read: Check function of wander bracelet weekly every day shift every Monday for monitor placement. Active 12/29/2024. Check Wander Prevention Patient Band every shift. every shift Verbal Active 12/29/2024. A Health status noted dated 1/21/2025 at 11:03 PM., read that Resident #217 was found outside walking around the facility. Wander Guard did sound off and was alerted to the whole facility the Wander Guard was found on resident; door alarm did sound off and was alerted to the facility. No injuries found. A Health status noted dated 1/21/25 at 12:08 AM., read that the Medical Doctor (MD) was notified. Vital signs taken. Temperature=97.9, Pulse=83, Blood Pressure =143/80, Respirations = 18, Oxygen = O2 sat's 96% on Room Air (RA). No noted distress, injuries, discomfort or complaints of pain, skin is intact. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The final synopsis of events dated 1/21/25 read that Resident #217 was observed by staff in the parking lot. Returned to the building, no injuries noted. Resident #217 elopement was not reported until 1/22/25. The fax confirmation to the state reporting agency was dated 1/22/25 at 4:06 PM. According to the Health Status note and the Final Synopsis listed above. Resident #217's elopement wasn't reported to the State Agency and Adult Protective services until 16 hours and 3 minutes later. On 1/22/25 an interview was conducted with Resident #217 at approximately 4:10 PM., concerning his elopement. Resident #217 said that he left the building to check on his home. On 1/23/25 at approximately 11:00 AM., the Director of Nursing (DON) was given a list of three residents to check wander guard placement and function. Resident #217, Resident #218 and Resident #224. On 1/23/25 at approximately 11:55 AM., the wander guards on the above three residents were observed and tested for function by Licensed Practical Nurse (LPN) # 4. No issues were found. On 1/23/25 at approximately 4:30 PM., an interview was conducted with the DON concerning the above elopement. The DON said that the incident should have been reported within 2 hours, but it was reported later. Elopement Scoring: 0 - 7 =Low Risk 8 - 9 =At Risk for elopement/exit seeking 10 - above =High Risk for elopement/exit seeking The elopement Risk Tool assessment dated [DATE] at 8:38 PM., was reviewed. Resident #217 was assessed as scoring an 8 on the assessment which indicated that resident was at risk for elopement/exit seeking. On 01/23/25 at approximately 6:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Corporate Regional Consultant said that whenever a resident leaves the building without the staff knowing is considered an elopement. 2.Resident #223. The facility staff failed to keep him from eloping from the facility. Resident #223 was originally admitted to the facility 10/18/24 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; depression, unspecified. The 5-day Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/20/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #223 cognitive abilities for daily decision making were moderately impaired. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In sectionGG(Functional Abilities Goals) the resident was coded as requiring set-up assistance with eating and oral hygiene. Dependent with toileting hygiene and requires substantial maximal assistance with bathing/showering. The Care Plan dated 12/30/24 read that Resident #223 is at risk for elopement. The goal for the resident was that he will not elope. The interventions for the resident were to check wander guard function, placement, elopement risk assessment. Elopement Scoring: 0 - 7 =Low Risk 8 - 9 =At Risk for elopement/exit seeking 10 - above =High Risk for elopement/exit seeking The elopement Risk Tool assessment dated [DATE] at 7:14 PM., was reviewed. Resident #223 was assessed as scoring 9 on the assessment which indicated that resident was at risk for elopement/exit seeking. The December Physician Order Summary (POS) read: Check function of wander bracelet weekly every day shift every Saturday. Active 12/30/2024. Check Wander Prevention Patient Band every shift. every shift. Active 12/30/2024. A review of Resident #223's incident report completed on 12/29/24 at 2:00 PM., read that Resident #223's family observed resident sitting in his wheelchair in the parking lot. Resident said that he was going for a walk. No injuries were observed by staff. An interview was conducted on 1/22/25 at approximately 1:15 PM., with Resident #223. Resident #223 complained that the facility wouldn't let him leave at his own will by placing an ankle bracelet on his left ankle against his wishes. Resident #223 also said that he left Against Medical Advice (AMA) because he no longer wanted to stay at the facility. An interview was conducted on 1/22/25 at approximately 4:35 PM., with Registered Nurse (RN) #2. RN #2 said that the facility staff tried to talk him out of leaving the facility. RN #2 also mentioned that the resident wore a wander guard because he was exit seeking. He never mentioned that staff wasn't treating him right. RN #2 also said that she removed his wander guard from his ankle on his day of discharge. On 1/23/25 at approximately 6:30 PM., an interview was conducted with the Director of Nursing (DON). The DON said that the family informed the staff that the resident was in the parking lot. The DON also mentioned that a report (Facility Synopsis) was not completed but an elopement incident report was completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy, Elopement/Exit Seeking Behaviors dated 1/29/24 read: The Elopement Risk Tool Assessment will be used to evaluate a patient's risk of elopement/exit seeking behaviors. Procedure: Upon admission to the center, each patient will be assessed for elopement/exit seeking history and or behaviors using the elopement Risk Tool Assessment. If a patient is determined to be at risk, a wander guard will be placed for intervention. An order will be obtained from the provider, the Responsible Party will be notified. If the resident begins demonstrating unsafe exit seeking behaviors after the initial admission, the Elopement Risk Tool Assessment will be utilized. What is Nursing Home Elopement In nursing homes and other long-term care facilities, an elopement is a form of unsupervised wandering that leads to the resident leaving the facility. Elopement risk refers to the potential danger when a patient, often deemed too ill or impaired to make sound decisions, leaves a healthcare facility unauthorized, posing immediate threats to their health or safety. This endangers the resident immediately and can result in serious injury, or even death, depending on circumstances such as the location of the facility, the time of year, how long it takes staff to recognize the resident is missing, and how long it takes to find the resident. https://www.bbga.com/practice-areas/nursing-home-abuse/nursing-home-elopement/ On 1/23/25 at approximately 7:30 p.m., the above findings were shared with the Administrator, DON and Corporate Consultant. The Regional Nurse Consultant (RNC) said that the staff was re-educated on resident elopements and investigating.