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	05/07/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and facility documentation, the facility staff failed to protect the residents right to be free from abuse and neglect by facility staff for one resident (R4) in a survey sample of five Residents. This deficient practice resulted in the identification of Immediate Jeopardy (IJ), which constituted substandard quality of care. Following the verification of removal of the IJ, the scope and severity was lowered to a level three isolated. The findings included: For R4 the facility staff turned call light off from nurses' station, refused to come into the room, neglected to attend to resident needs and left resident in an unsafe position in the bed, which resulted in psychosocial harm for R4.R4 was admitted to the facility on [DATE] with diagnoses that included but were not limited to quadriplegia, due to gunshot wound to neck, epilepsy, neuromuscular disfunction of bladder, presence of suprapubic catheter, autonomic dysreflexia and PTSD (post-traumatic stress disorder). R4's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/20/26 coded R4 as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15, indicating no cognitive impairment. R4 was also coded as being totally dependent on staff for all aspects of care due to her quadriplegia. She can utilize a motorized wheelchair with mouth control (Also known as Sip and Puff Wheelchair- using mouth to control wheelchair with puff or sip of air). On 5/6/26 at approximately 3:00 p.m. R4 was escorted to the conference room where she requested to speak to the survey team. R4 stated that she had been in the facility for roughly two months and had been experiencing problems on the night shift. R4 stated that on the night shift she is ignored, her call bell is turned off before anyone comes into her room, she stated the staff stand outside of her room and talk about her loudly enough for her to hear. She stated she has been called Extra and that staff have stated they won't take care of her or need two people to go into her room. R4 stated that on 4/27/26, very early in the morning, before day shift arrived, it got so bad she called the non-emergency police number to get an officer to come and get her some help. She stated that the police responded to the building and came to investigate why she was calling for help from the facility. R4 proceeded to pull up a picture from 4/27/26 and stated that she made the day shift certified nursing assistant (CNA) take a picture of how she was found before moving her. The picture showed R4 with legs hanging over the side of the bed and torso on the bed. R4 stated this is how they left me in the bed. R4 proceeded to show the survey team three videos she had of staff turning off the call light without attending to resident needs, The video showed R4 recording herself hitting the call light for assistance, she could not turn around to see the call light box but you can clearly see in the video the box over the bed lit up red when the call light was pressed by R4. After approximately 15 minutes the light on the box went off and you could hear the R4 say The ringing has stopped, they turned the light off from the nurses station.In the second video nursing staff can be seen coming into the room turning off the call light telling R4 that someone will be in to take care of her, yet the video continued to show no one coming in for another 15-20 minutes. When staff arrived, she told R4 that she will not come in the room alone, she refused to provide care and then left. R4 engaged the light again and the staff member came in turned off the light and refusesd to provide care. The resident can (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	be heard asking If you don't want to take care of me who will? I still need care during the night. The last video shows R4 phoning the police to get some assistance. The police arrive and make staff leave the room because they are being argumentative and rude to R4. The police took a report and gave the resident a report number. R4 stated that she informed the Director of Nursing (DON) and the Unit Manager on the morning of 4/27/26 after she had called the police. R4 is a former victim of domestic violence who is unable to tend to any of her own basic needs and must rely on her care givers for all aspects of care. R4 stated I am now afraid to have them shut my door; they won't hear me if I scream. R4 stated I have PTSD and this is causing me a lot of fear and anxiety. R4 stated that she felt she could not trust the people that were supposed to look out for her. R4 was asked if she has counseling or psychiatry services and she stated that she would love to have some consistent therapy. R4 stated that she saw someone one time when she first arrived but not since then. This suggests that the facility staff were made aware of the abuse / neglect alleged by R4 on 4/27/26.A review of the clinical record revealed the admission Trauma Informed Screening was not completed until 5/6/26 at 4:44 p.m. (this document should be completed on or as soon after the admission as it is part of the admission Assessment Tool.) Further review of the clinical record revealed that there were no progress notes from psychiatric services.On the afternoon of 5/6/26 R4 showed the videos to Employee C, the Corporate Nurse. On 5/7/26 at approximately 9:00 a.m. an interview was conducted with CNA who wished to remain anonymous, the CNA confirmed that she did take the picture of the R4 hanging out of the bed but she stated I tried to put her in bed first but she insisted I take the picture so that she would have proof of how she had been treated.On 5/7/26 at approximately 12:00 PM an interview was conducted with the DON who stated that she was not aware of the alleged abuse and neglect of R4. The DON was asked if she was aware that the police were called and why on 4/27/26 and she stated that she was aware. The DON was asked if she was aware of who called the police she stated that she was aware. The DON admitted she was aware that an allegation of neglect was made by R4 on 4/27/26.A review of the Policy for Abuse Neglect and Misappropriation read as follows: Policy 701 - Effective 10/17/23. There is zero tolerance for mistreatment, abuse. neglect, misappropriation of property or any crime against a patient of the Health and Rehabilitation Center.3. All employees are responsible for immediately (but not later than 2 hours if the allegation involves abuse or results in serious bodily injury, not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury) reporting to the Administrator, or in their absence the Director of Nursing or their direct supervisor any and all suspected or witnessed incidents of abuse, neglect, theft, exploitation, and or mistreatment of a patient as well as any reasonable suspicion of a crime against a patient .According to the facility Policy titled, 703- Reporting Requirements Effective Date 2/5/23, it read in part, .1 Immediately upon notification of any alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours if the allegation involves abuse or results in serious bodily injury, not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily harm . 2 The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigative protocol will include but not be limited to, collecting the evidence, interviewing alleged victims, and witnesses, and involving other appropriate agents or authorities to assist in the process and determination.On 5/6/26 at 6:00 p.m., after consulting with the state agency supervisory team, immediate jeopardy was identified to have began 4/27/26. The facility was unable to provide an acceptable removal plan and R4 was assigned a 1:1 CNA to provide care overnight. The facility submitted the Immediacy Removal plan on the morning of 5/7/26, which was accepted. The removal plan read, 1. Immediate Corrective Actions: The facility immediately took the following actions to remove the Immediacy:Staff Education: All staff will be educated on facility abuse policies prior to next shift in addition to education on answering call lights and providing required services, (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	promptly.Medical Oversight: The attending physician and Medical Director were notified of the deficiencies.Resident Safety: Resident #4 was offered a room change and declined. Resident #4 was interviewed to determine preferred staff that will deliver her care.Resident will be offered Psychiatric evaluation and treatmentFacility reportable incident has been submitted to all appropriate State agencies to include OLC , regional ombudsman and office of Adult protective services .Interviews related to abuse and neglect will be conducted on all cognitively intact residents with BIMS scores greater than 12.Skin assessments will be completed on all cognitively impaired residents with BIMS scores less than 13.Staff members involved in the investigation will be suspended until the investigation is completed.Resident will be provided 1:1 monitoring.Plan Completion will be on 5/7/2026 at 1:00 PM.The Survey Team verified education by interviewing staff and questioning the staff about the education they received. Staff were able to answer questions and converse appropriately about the topic of abuse and neglect. The Survey Team went to the resident's room and found that she did have a 1:1 sitter throughout the night. The survey team verified that the facility did indeed offer the R4 a room change and psychological support services which were scheduled for that day. R4 was interviewed and stated that the facility did offer and she did give names of her preferred staff for care. Skin assessments reviewed and residents were interviewed and no further incidents of abuse and neglect were reported.All involved staff were marked as suspended pending investigation.After verification of the plan of immediate jeopardy removal and consultation with state agency supervisory staff, the immediate jeopardy was removed on 5/7/26 as of 1:00 p.m. at which time the facility administration was notified. Following the removal of the immediate jeopardy status, this deficiency was cited at level 3, isolated (harm).

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on interview, clinical record review and facility documentation, the facility staff failed to implement their abuse/neglect policy and take measures to protect a resident during an allegation of abuse/neglect, failed to report the allegation and failed to conduct a thorough investigation for one resident (Resident #4-R4) in a survey sample of five residents. This failure resulted in R4 sustaining psychosocial harm and the identification of immediate jeopardy (IJ) and resulted in substandard quality of care. The findings included:For R4 the facility staff failed to implement their abuse policy and take measures to protect the resident from alleged perpertrators, failed to investigate an incident of abuse and neglect, and failed to report the allegation of abuse and neglect, which resulted in psychosocial harm leaving R4 feeling anxious, and fearful of having her needs met, fearful of not being heard in the event of a medical emergency and refusing to allow staff to close the door at night.R4 was admitted to the facility on [DATE] with diagnoses that included but were not limited to quadriplegia, due to gunshot wound to neck, epilepsy, neuromuscular disfunction of bladder, presence of suprapubic catheter, autonomic dysreflexia and PTSD (post-traumatic stress disorder). R4's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/20/26 coded R4 as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15, indicating no cognitive impairment. R4 was also coded as being totally dependent on staff for all aspects of care due to her quadriplegia. She can utilize a motorized wheelchair with mouth control (Also known as Sip and Puff Wheelchair- using mouth to control wheelchair with puff or sip of air). On 5/6/26 at approximately 3:00 p.m. an interview was conducted with R4. R4 stated that she had been in the facility for roughly two months and had been experiencing problems on the night shift. R4 stated that on the night shift she is ignored and neglected, her call bell is turned off before anyone comes into her room, she stated the staff stand outside of her room and talk about her loudly enough for her to hear. She stated she has been called Extra and that staff have stated they won't take care of her or need two people to go into her room. R4 stated that on 4/27/26, very early in the morning, before day shift arrived, it got so bad she called the non-emergency police number to get an officer to come and get her some help. She stated that the police responded to the building and came to investigate why she was calling for help from the facility. During the interview R4 showed the survey team a picture on her phone from 4/27/26 and stated that she made the day shift CNA take a picture of how she was found before moving her. The picture showed R4 with legs hanging over the side of the bed and torso on the bed. R4 stated this is how they left me in the bed R4 proceeded to show the survey team three videos she had of staff neglecting to provide for her care needs and turning off the call light. The video showed R4 recording herself hitting the call light for assistance, she could not turn around to see the call light box but you can clearly see in the video the box over the bed lit up red when the call light was pressed by R4. After approximately 15 minutes the light on the box went off and you could hear the R4 say The ringing has stopped, they turned the light off from the nurses station.In the second video nursing staff can be seen coming into the room turning off the call light telling R4 that someone will be in to take care of her, yet the video continued to show no one coming in for another 15-20 minutes. When staff arrived, they told R4 that they will not come in the room alone, she refused to provide care and then left. R4 engaged the light again and the staff member came in turned off the light and refused to provide care. The resident could be heard asking If you don't want to take care of me who will? I still need care during the night. The last video shown to the survey team was R4 phoning the police to get some assistance. The police arrived and asked staff leave the room because they were being argumentative and rude to R4. The police took a report and gave the resident a report number. R4 stated that she informed the Director of Nursing (DON) and the Unit Manager on the morning of 4/27/26 after she had called the police. On 5/7/26 at approximately 12:00 PM an interview was conducted with the Director of Nursing (DON) who stated that she was not aware of the alleged abuse (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and neglect of R4. The DON was asked if she was aware that the police were called and asked why on 4/27/26. The DON confirmed she was aware. The DON admitted she was aware that an allegation of neglect was made by R4 on 4/27/26.The facility failed to have evidence that they implemented any measures to protect the resident from alleged perpetrators, failed to report the allegation to regulatory agencies, and failed to investigate the allegation of neglect. Resident #4 continued to have the same care givers assigned to her that neglected her and out of fear she refused to allow the staff to close her door and reported being fearful, which constituted psychosocial harm.A review of the Policy for Abuse Neglect and Misappropriation read as follows: Policy 701 - Effective 10/17/23. There is zero tolerance for mistreatment, abuse. neglect, misappropriation of property or any crime against a patient of the Health and Rehabilitation Center.3. All employees are responsible for immediately (but not later than 2 hours if the allegation involves abuse or results in serious bodily injury, not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury) reporting to the Administrator, or in their absence the Director of Nursing or their direct supervisor any and all suspected or witnessed incidents of abuse, neglect, theft, exploitation, and or mistreatment of a patient as well as any reasonable suspicion of a crime against a patient .According to the facility Policy titled, 703- Reporting Requirements Effective Date 2/5/23, it read in part, .1 Immediately upon notification of any alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours if the allegation involves abuse or results in serious bodily injury, not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily harm . 2. The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigative protocol will include but not be limited to, collecting the evidence, interviewing alleged victims, and witnesses, and involving other appropriate agents or authorities to assist in the process and determination.Immediate Jeopardy was identified and the facility notified on 5/6/26 at 6:00 p.m. after consulting with the state agency supervisory staff. After the facility was unable to provide an acceptable removal plan R4 was assigned a one to one certified nursing assistant overnight. On the morning of 5/7/26 an acceptable removal plan was received. The plan read, Immediate Corrective Actions. The facility immediately took the following actions to remove the Immediacy: Staff Education: All staff will be educated prior to next shift on abuse policy and procedures to include mandated reporting.Resident Safety:Resident #4 was offered a room change and declined. Resident #4 was interviewed to determine preferred staff that will deliver her care.Resident #4 will be provided with 1:1 monitoringResident will be offered psychiatric evaluation and treatment Facility reportable incident has been submitted to all appropriate state agencies to include OLC, regional ombudsman office, state office adult protective services.Begin thorough investigation process.Interviews related to abuse and neglect will be completed on all cognitively intact residents with BIMS greater than 12.Skin Assessments will be completed on cognitively impaired residents with BIMS less than 13.Plan Completion will be on 5/7/2026 at 1:00 PM.On 5/7/26, after verification of the plan of immediate jeopardy removal and consultation with state agency supervisory staff, the immediate jeopardy was determined to have been removed at 1:00 pm on 5/7/26. Following the removal of immediate jeopardy status, the deficiency was cited at level 3, isolated (harm).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility document review, and staff interview, facility staff failed to develop a comprehensive plan of care for Hemorrhoids with internal treatment with a medication for one Resident (Resident #1-R1) in a survey sample of five Residents.The findings included.Resident #1 [R1] was initially admitted to the facility on [DATE] and discharged on 4-12-26. R1's diagnoses included Breast Cancer current, osteoporosis with femur fracture and surgical repair current, Beta Thalassemia, chronic kidney disease stage 4 severe, Irritable Bowel Syndrome, Atrial fibrillation, Arteriosclerotic Cardiovascular disease, Chronic heart failure, high blood pressure, Rheumatoid Arthritis, Thrombocytopenia, PTSD, panic disorder, and depression.R1's most recent and only admission minimum data set [MDS] assessment with an ARD [assessment reference date] of 4-12-26 revealed that the Resident was her own responsible party and was cognitively independent.Review of the clinical record revealed physician's orders and Medication Administration Records [MARs] for all of R1's current medications and treatments. The records revealed the following order. Hydrocortisone external cream 2.5% Hydrocortisone (topical) insert 1 application rectally 2 times per day for hemorrhoids. Ordered by the physician on 4-10-26 at 4:25 PM, the corticosteroid was administered twice on 4-11-26. The Resident was discharged and expired on 4-12-26. It is unknown what the amount of insert 1 application rectally means, as no dosage nor quantity is reflected in the order. This reveals that a different amounts could have been administered each time as no standard dose measurement is directed in the order.References for this medication were reviewed to include National Institutes of Health [NIH] which indicated that this medication is to be applied in a thin layer externally and never taken internally.The nursing care plan was reviewed and revealed no care plan having been derived for the internal treatment of hemorrhoids which would require specific nursing knowledge of rectal insertion that carries a danger of perforating the bowel to an untrained staff member.Nursing and physician progress notes, and hospital records which indicated that on 4-12-26 at 5:23 AM R1's vital signs were Blood pressure 108/80, pulse 89, respirations 18, tympanic temperature 97.3, and pulse oximetry 97% on room air. During shift change, at approximately 7:05 AM, a Code Blue and Cardiopulmonary Resuscitation [CPR] was initiated using 30 compressions to 2 ventilations by nursing as the Resident was found unresponsive without a palpable pulse. An emergency rescue squad was called to respond and transport the Resident to the local hospital emergency room. The family was notified immediately of the incident and given information as to where the Resident had been sent for treatment.The Resident later expired in the hospital.On 5-7-26 at 11:00 AM the Administrator, and Director of Nursing were made aware of the findings. They stated they had nothing further to provide.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Clinical record review, facility document review, and staff interview, the facility staff failed to clarify a physician's order which was written without a specific dosage, and with a contraindicated route for a significant medication, for one Resident (Resident #1/R1) in a survey sample of five Residents.The findings included.Resident #1 [R1] was initially admitted to the facility on [DATE] and discharged on 4-12-26. R1's diagnoses included Breast Cancer current, osteoporosis with femur fracture and surgical repair current, Beta Thalassemia, chronic kidney disease stage 4 severe, Irritable Bowel Syndrome, Atrial fibrillation, Arteriosclerotic Cardiovascular disease, Chronic heart failure, high blood pressure, Rheumatoid Arthritis, Thrombocytopenia, PTSD, panic disorder, and depression.R1's most recent and only admission minimum data set [MDS] assessment with an ARD [assessment reference date] of 4-12-26 revealed that the Resident was her own responsible party and was cognitively independent.Review of the clinical record revealed physician's orders and Medication Administration Records [MARs] for all of R1's current medications and treatments. The records revealed the following order. Hydrocortisone external cream 2.5% Hydrocortisone (topical) insert 1 application rectally 2 times per day for hemorrhoids. Ordered by the physician on 4-10-26 at 4:25 PM, the corticosteroid was administered twice on 4-11-26. The Resident was discharged and expired on 4-12-26. It is unknown what the amount of insert 1 application rectally means, as no dosage nor quantity is reflected in the order. This reveals that a different amounts could have been administered each time as no standard dose measurement is directed in the order.References for this medication were reviewed to include National Institutes of Health [NIH] which indicated that this medication is to be applied in a thin layer externally and never taken internally.The nursing care plan was reviewed and revealed no care plan having been derived for the internal treatment of hemorrhoids which would require specific nursing knowledge of rectal insertion that carries a danger of perforating the bowel to an untrained staff member.nursing and physician progress notes, and hospital records which indicated that on 4-12-26 at 5:23 AM R1's vital signs were Blood pressure 108/80, pulse 89, respirations 18, tympanic temperature 97.3, and pulse oximetry 97% on room air. During shift change, at approximately 7:05 AM, a Code Blue and Cardiopulmonary Resuscitation [CPR] was initiated using 30 compressions to 2 ventilations by nursing as the Resident was found unresponsive without a palpable pulse. An emergency rescue squad was called to respond and transport the Resident to the local hospital emergency room. The family was notified immediately of the incident and given information as to where the Resident had been sent for treatment.The Resident later expired in the hospital.The DON was asked what nursing reference for care the facility used, and she stated [NAME], Mosby, and [NAME]/[NAME].[NAME] professional nursing standards. Guidance was given from [NAME], Fundamentals of Nursing, which reads: To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to these rights:1. The right medication2. The right dose3. The right patient4. The right route5. The right time6. The right documentationOn 5-7-26 at 11:00 AM the Administrator, and Director of Nursing [DON] were made aware of the findings. They stated they had nothing further to provide.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record reveiew and facility documentation, the facility staff failed to provide necessary services to maintain good grooming and personal hygiene for one resident, (Resident #5-R5) in a survey sample of five residents. The findings included:For R5 the facility staff failed to ensure proper bathing, and grooming to prevent body odor and maintain good personal hygeine.R5 was admitted to the facility on [DATE] with diagnoses that included but were not limited to unspecified severe protein-calorie malnutrition, hip pain (right), myalgia, stiff man syndrome, abnormal coagulation profile, and hypertension. The most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/24/26 R5 was coded as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15, indicating no cognitive impairment. R5 was also coded as requiring physical assistance from staff for all aspects of ADL care.On 5/6/26 at 9:00 a.m. surveyor was standing outside of R5 room and could smell a [NAME] scent of body odor. R5 was observed in a flat lying in bed with a sheet over his body, his feet were exposed. R5's feet were observed to be extremely dry with peeling dry/dead skin and long thick, discolored and mycotic toenails. The closer this surveyor got to the resident the stronger the odor became. R5 was resting in bed with his eyes closed. On 5/6/26 at approximately 2:00 p.m. an interview was conducted with R5 who stated that he did not like to get into the shower because it hurt to transfer in the lift and get on the shower stretcher. R5 stated that the certified nursing assistants (CNA's) give him a bed bath a couple of times a month. R5 stated that he did not get up out of the bed because of the transfer via the mechanical lift was painful due to his condition of Stiff Man Syndrome.On 5/7/26 at approximately 8:45 am an interview was conducted with certified nursing assistant #2 (CNA 2) who stated that R5 always refuses to shower. When asked if he allows a bed bath daily CNA 2 stated that the resident will allow a bed bath some times but not daily. On 5/7/26 at approximately 9:15 a.m. an interview was conducted with a licensed practical nurse (LPN 3) who stated that R5 was Care planned for refusal of showers. When asked what that meant, LPN 3 stated he refuses showers so its on his care plan that he refuses. LPN 3 stated that they have interventions on the care plan but they don't work. A review of the care plan revealed the following entry:FOCUS: R5 [name redacted] has behaviors *Refusing medications/ weights/ showers and bed baths at times- education has been provided and provider notified of refusals Created on: 08/09/2025 Revision on: 02/23/2026GOAL: the residents' behaviors will not cause them or other residents' distress thru the review periodCreated on: 08/09/2025 Target Date: 02/13/2026INTERVENTION: administer medications as ordered Created on: 08/18/2025assure the residents are safe if they become distressed Created on: 08/09/2025psych services referral as needed Created on: 08/09/2025redirect resident to subjects that matter to them when behaviors occur Created on: 08/09/2025. On 5/7/26 at approximately 10:00 a.m an interview was conducted with the DON who stated that the care plan directs the care of the resident. The DON stated that the care plan interventions should be periodically reviewed and revised if they are not effective, and new intrventions should be put in place. On 5/7/26 the Admistrator was made aware of the concerns and no further information was provided.

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	05/07/2026

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and clinical record review the facility staff failed to ensure residents received proper treatment and care to maintain good foot health for one resident in a survey sample of five residents, (Resident #5- R5).The findings included:For R5 the facility staff failed to ensure proper foot care to include exfoliation of dry / dead skin and care of mycotic toenails.R5 was admitted to the facility on [DATE] with diagnoses that included but were not limited to unspecified severe protein-calorie malnutrition, hip pain (right), myalgia, stiff man syndrome, abnormal coagulation profile, and hypertension. The most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/24/26 R5 was coded as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15, indicating no cognitive impairment. R5 was also coded as requiring physical assistance from staff for all aspects of ADL care.On 5/6/26 at 9:00 a.m. R5 was observed in a flat lying in bed with a sheet over his body, his feet were exposed. R5's feet were observed to be extremely dry with peeling dry/dead skin and long thick, discolored and mycotic toenails. R5 was resting in bed with his eyes closed.On 5/6/26 at approximately 3:00 p.m. an interview was conducted with R5 who stated that he does not walk due to his condition of stiff man syndrome. R5 says it hurts to move and transfer. R5 was asked if he had seen the podiatrist for foot care, and he stated that he had but it's been a long time. R5 said no one puts lotion on his skin and no one has tried to cut his toenails since the podiatrist visited a long time ago. When asked if he would like to see the podiatrist R5 said, Yes I would like that a lot.On 5/6/26 at 4:00 p.m. an interview was conducted with a licensed practical nurse (LPN B) who stated, I cannot put R5 on the list for podiatry until I have an order from the doctor. LPN B further stated she would get the order when the doctor or nurse practitioner made rounds.On 5/7/26 the Administrator was made aware of the concerns and no further information was provided.

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	05/07/2026

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

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview, clinical record review and facility documentation, the facility staff failed to ensure residents on four of four units had snacks available to them.The findings included: On 5/5/26 during initial tour on unit 1 CNA B was asked if there were snacks available to residents. CNA B opened the pantry refrigerator and pulled out a plastic bag containing 6 small individual cups of applesauce. CNA B was asked if the applesauce was the only snack that was available for the entire unit and she stated that they were. On 5/5/26 at approximately 11:15 am a tour of unit 2 was conducted CNA C was asked if snacks were available and she stated that they were not available. On 5/5/26 at approximately 11:25 am a tour of unit 3 was conducted and LPN B was asked if snacks were available to residents and she stated that they had a few containers of applesauce but if they wanted anything more substantial like a sandwich they would have to see if the kitchen would accommodate them. She stated that usually they could get something if a diabetic needed it. On 5/5/26 at approximately 11:40 am a tour of unit 4 was conducted and LPN C was asked if there were snacks available and she stated that there were no snacks available in general but if they needed something for diabetic residents they could go to the kitchen and get it. LPN C was asked what they would do in an off shift like nights she stated they would have to check all the units. She stated that they always have applesauce available for med pass. On 5/5/26 at 1:00 pm an interview was conducted with the dietary manager who stated that they do send sandwiches to the unit in the evening after dinner for the diabetics with orders. The dietary manager stated that they do not send cookies, crackers or fruit to the units for all residents; snacks are only sent for diabetics. On 5/5/26 at approximately 3:00 pm an interview was conducted with the Administrator who explained the facility would be taking over food service and the contracted company was no longer going to be in control of the dietary services. On 5/5/26 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.