

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Virginia Beach Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 40026 Based on interview, clinical record review and facility documentation the facility staff has failed to determine that Residents are clinically appropriate to self-self-administer medication for 1 Resident (#142) in a survey sample of 55 Residents. The findings included: For Resident #142 the facility staff allowed the Resident to self-administer the psychotropic medication, trazadone (an anti-depressant used to treat insomnia), without an assessment to determine if it was clinically appropriate for him to do so. On 10/7/24 at approximately 12:00 p.m. an interview was conducted with Resident #142 who stated that they used to let him keep his trazadone by his bedside and take it when he wants to. He stated that he now has to ask for it and it Takes an act of God to get it. When asked if he had any special lock box for it, he stated that he did not he used to keep it on his night table. On 10/8/24 a review of the clinical record revealed the following orders for trazadone: trazadone HCI Oral Tablet 100 MG Give 1.5 tablet by mouth at bedtime for insomnia MAY GIVE ANYHTIME BETWEEN 7PM AND 9PM -Order Date- 09/04/2024 -D/C Date-09/09/2024 trazadone HCI Oral Tablet 100 MG Give 1.5 tablet by mouth every 24 hours for insomnia unsupervised self-administration -Order Date-09/09/2024 -D/C Date-09/16/2024 trazadone HCI Oral Tablet 150 MG (Trazodone HCI) Give 1 tablet by mouth at bedtime related to INSOMNIA -Order Date-09/16/2024 -D/C Date-10/10/2024 A review of the MAR (Medication Administration Record) revealed that during the time from 9/9/24 through 9/16/24 the medication was signed in the MAR as SA (Self-Administer). (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 495237	Facility ID: 495237 If continuation sheet Page 1 of 117

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at approximately 2:00 p.m. LPN C was asked how it is determined if a Resident can self-administer medications, she stated that they must be screened for safety and cognitively able to do it, and they have to have a lock box for storage. On 10/11/24 at approximately 10 a.m. an interview was conducted with the Clinical Nurse Consultant and the DON who both stated that Residents who are clinically appropriate to self-administer medications must be screened and have a lock box to store medications. A review of the clinical record revealed that no screening was done for appropriateness of self - administration of meds was completed, and the order reverted back to facility administration on 9/16/24. A review of the document entitled Medication Administration Policy revealed the following excerpt: Page 5 13. Residents are permitted to self-administer medications when specifically authorized by the attending physician and in accordance with the procedures for self-administration of medications. During the end of day meeting the Administrator was made aware of the findings and no further information was provided.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on observation, Resident interview, staff interview and clinical record review, the facility staff failed to provide services in the facility with reasonable accommodation of resident needs and preferences, for 2 Residents (# 161 and # 107) in a survey sample of 55 Residents. The findings included: 1. For Resident # 161, the facility staff failed to ensure the clock on the bedroom wall was working. Resident # 161 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, Primary Osteoarthritis of the Knee, Septic Arthritis of the Knee, Heart Failure, and edema. The most recent Minimum Data Set (MDS) was an Admission Assessment with an Assessment Reference Date (ARD) of 9/10/2024. Resident # 161's BIMS (Brief Interview for Mental Status) Score was a 14 out of 15, indicating no cognitive impairment. Review of the clinical record was conducted on 10/9/2024-10/11/2024. During rounds on 10/9/2024 at 1:15 p.m., Resident # 161 was observed lying in the bed and watching television. Resident # 161 was alert, oriented and able to converse with the surveyor. When asked about any concerns, Resident # 161 stated she had only one complaint about the facility. Resident # 161 pointed to a clock on the wall and stated that clock is wrong and it's been wrong the whole time. It is driving me crazy. The time on the clock in Resident # 161's room was observed to have the time of 11:50. Resident # 161 stated she had told several people but it had not been corrected. Resident # 161 stated it was frustrating to see the clock was not working. She stated she would use the clock if it was correct. She stated she didn't want to keep complaining but she had told several staff members and it still wasn't fixed. On 10/9/2024 at 2:10 p.m., the clock had the time of 11:50. On 10/9/2024 at 2:45 p.m., the clock had the time of 11:50. Resident # 161 was observed sitting up in bed watching television. On 10/9/2024 at 3:10 p.m., the clock had the time of 11:50. Resident # 161 was lying in bed watching TV. On 10/9/2024 at 3:11 p.m., an interview was conducted with the Certified Nursing Assistant (CNA)-2 who stated Resident # 161 was alert and oriented. CNA-2 stated she was aware that the clock was wrong. She stated she needs a battery. We are waiting on maintenance. CNA-2 stated the battery was not working. CNA-2 stated she had put in two work orders previously to the Maintenance department but the clock had not been fixed. CNA-2 stated the clock had not been working for a long time. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/2024 at 3:15 p.m., an interview was conducted with Licensed Practical Nurse (LPN)-4 who stated it was important for the time on the clocks to be correct. She stated the correct time helped with the orientation of the residents. LPN-4 stated she was an agency staff member and did not know how to put a maintenance request in the computer but would tell someone verbally if she noticed a problem with a clock not working. LPN-4 stated she had not noticed the clock in Resident # 161's room was incorrect since she was not working in that particular area. LPN-4 stated staff should respond to the requests/complaints of the residents. The Regional Nurse Consultant (Corporate-1) went to Resident # 161's room with the surveyor, looked at the clock and stated the time showed 11:50. The Regional Nurse Consultant (Corporate-1) stated the clock in the room should have had the correct time because it was important for the orientation of the residents. She stated staff members should have observed the clock was wrong and should have corrected the issue. During the end of day debriefing on 10/9/2024, the Facility Administrator, the Regional [NAME] President of Operations-Acting Administrator, two Regional Nurse Consultants (Corporate-1 and Corporate-2) and Director of Nursing were informed of the findings. They all stated the clocks in residents' rooms should be accurate. No further information was provided. 2. For Resident # 107, the facility staff failed to ensure the clock on the bedroom wall was working. Resident # 107 was admitted to the facility with the diagnoses of, but not limited to: Metabolic Encephalopathy, Hypertension, and Chronic Kidney Disease, The most recent Minimum Data Set (MDS) was an Admission Assessment with an Assessment Reference Date (ARD) of 10/3/2024. The MDS for Resident # 107 was coded with a BIMS (Brief Interview for Mental Status) Score of 6 out of 15 indicating severe cognitive impairment. Review of the clinical record was conducted on 10/09/2024-10/10/2024. During rounds on 10/9/2024 at 1:45 p.m., Resident # 107 was observed sitting up in bed, eating lunch and watching television. Resident # 107 was able to converse with the surveyor. When the surveyor asked what time he received his lunch, Resident # 107 stated he did not know for sure because the clock was wrong but he had not been eating too long. The clock on the wall near the dresser in Resident # 107's room was observed to have the time of 4:50. Resident # 107 stated the clock had been that time every since I've been here. Resident # 107 stated he informed the facility staff that the clock was not correct but it had not been fixed. On 10/9/2024 at 2:40 p.m., the clock had the time of 4:50. The second hand was not moving. Staff persons were observed in the room picking up food trays, and delivering ice and water. No staff person addressed the issue of the clock having the wrong time. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Regional Nurse Consultant (Corporate-1) went to Resident # 107's room with the surveyor, looked at the clock and stated the time showed 4:50. The Regional Nurse Consultant (Corporate-1) stated the clock in the room should have had the correct time because it was important for the orientation of the residents. She stated staff members should have observed the clock was wrong and should have corrected the issue. During the end of day debriefing on 10/9/2024, the Facility Administrator, the Regional [NAME] President of Operations-Acting Administrator, Administrator in Training, two Regional Nurse Consultants (Corporate-1 and Corporate-2) and Director of Nursing were informed of the findings. They all stated the clocks in residents' rooms should be accurate. No further information was provided.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 34306 Based on information obtained during the Resident Group interview, observations, staff interviews, and Resident Group meeting minutes, the facility staff failed to demonstrate their response, action and/or a rationale for not taking action to the Resident Group grievances. The findings included: On 10/7/24 at 2:00 PM a Resident Group meeting was held with the President, [NAME] President, four resident who attends the group meeting regularly and one who does not attend the regularly. It was a consensus of all attending the meeting that their grievances are not acted upon even when they had been voiced multiple times. The groups stated they had never received communication from the administrative staff regarding any of their grievances. The group's President stated that the Activity's Director (AD) assists with the meeting and she ensures the departments are aware of their grievances but she has her assistant act as a liaison between the residents and the staff. A review of six months of the Resident Group minutes revealed that the residents voiced the following concerns multiple times; medication are not administration as ordered, linen are not changed as needed, unprofessional of nursing staff, a desire for a variety of foods for meals, meal portions are too small, resident shopping trips are desired, rooms/floors not getting cleaned, trash not removed from the rooms on the weekends, toilet paper not replenished, call bells not answered or just turned off, water bugs in rooms, ceiling tiles over resident beds wet as well as their personal belongings, showers not given, dinner in the dining room wanted, personal laundry not returned but receiving others persons laundry, and episodes of having only 1-2 Certified Nursing Assistants on the unit. An interview was conducted with the AD on 10/10/24 at approximately 12: 48 PM. The AD stated she does present the group grievances to the department heads during the morning meetings but she has never received feedback to their grievances to report back to the group. The AD also stated she was not aware a response, action and/or a rationale if applicable were requirements. On 10/11/24 at approximately 8:15 PM, a final interview was conducted with the Administrator, Interim Administrator, Director of Nursing and two regional Nurse Consultants. They had no comments and voiced no concerns regarding the above information.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on observations, resident interviews, staff interviews, facility document reviews, and review of the facility's policy, the facility staff failed to provide a sanitary, comfortable, and homelike environment on four of four units and some common areas, which resulted in Substandard Quality of Life. The findings included: 1. Upon entering the facility on 10/4/24 at approximately 10:20 AM, water was observed leaking from the ceiling in the lobby. During the initial tour of Unit one at approximately 11:15 AM, the corridor was with much debris, many dark spots and a bed near the rear exit door. room [ROOM NUMBER]'s floors were soiled, the trash can was without a liner and a used glove was observed on the floor. room [ROOM NUMBER] was with strong odors, straw papers, sugar packages and other debris was also observed on the floor. In room [ROOM NUMBER] pungent odors was in the room and the toilet was observed to be clogged. In room [ROOM NUMBER] soiled linen was observed beneath the sink and many black splatter marks were on the floor. In room [ROOM NUMBER] the privacy curtain for the A bed was fifty percent covered with a dark brown substance. On 10/7/24 at 2:00 PM a Resident Group meeting was held with the President, [NAME] President, four resident who attends the group meeting regularly and one who does not attend the regularly. It was a consensus of all attending the meeting that their home was not sanitary, comfortable, and homelike. A review of six months of the Resident Group minutes revealed that the residents voiced the following concerns multiple times regarding the call bells are not answered and often they are just turned off, their rooms/floors not getting cleaned, trash is not removed from the rooms on the weekends, toilet paper is not replenished, ceiling tiles over resident beds are frequently wet and sometimes their personal belongings become wet because of the wet tiles. Residents in the group meeting also stated roaches and water bugs were seen frequently in their rooms especially when the lights are turned off. Resident representative from units 1, 2 and 3 stated that the roaches are also seen climbing the walls and they fly onto the TV screens. One resident stated when she opened the Styrofoam box to consume her lunch on 10/8/24, a roach was observed crawling on the food and she shut the top and did not eat because of the abhorrence. The consensus of all of the resident were they are tired of it and their desire is for action to be taken immediately. An interview was conducted with Resident #6 on 10/9/24 at approximately 12:25 PM. Resident #6 stated often there are constant strong urine odors on unit 1, the trash can in her room is without liners and waste is seen falling onto the floor. Resident #6 further stated the bathrooms are not cleaned and the floors are not mopped daily. Resident #6 pointed to the dark areas on the floor in her room and in the corridor outside of her room. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/11/24 at approximately 8:15 PM, a final interview was conducted with the Administrator, Interim Administrator, Director of Nursing and two regional Nurse Consultants. They had no comments and voiced no concerns regarding the above information. 40026 2. The facility staff failed to provide a sanitary ice machine, adequate pest control, palatable meals, and timely laundry and linens to meet the needs of the Residents. On 10/7/24 during the kitchen inspection there were 2 dead roaches noted in the dry storage area and one in the kitchen near the 3-compartment sink, and the floor in the dry storage had paper trash and some food debris as well as needing to be mopped, there were visible stains on the floor. On 10/11/24 observation of the ice machine in closet across from the dining room revealed standing water on the floor, a rubber mat with live roaches (5-6 of them) crawling around and under it, the ice machine drainage pipe was dripping on the floor not in the drain. Under the ice machine was black slimy substance and wet paper trash as well. The entire area smelled of dampness and mildew. During the entire survey there were fruit flies as well as large flies noted on all units and in the common areas as well. A review of the pest control logs revealed that the facility is having pest control services come to the building on a monthly basis however the pests continue to be visible. On 10/7/24 at approximately 3:00 p.m. an interview was conducted with Resident #153 who stated that he had Mold and Mildew in his ceiling, and they keep just painting over it. He pointed out a spot on the ceiling that appeared freshly painted, however there were black spots bleeding through the painted area. Resident #153 that the ceiling leaks and then it dries and then when he complains of the black spots They just paint over it, that is not fixing the problem. Food temps on all units ranged between 80-100 degrees, Residents on 4/4 units complained of Lukewarm or Cold food. Many Residents stated that since they started using Styrofoam the food is cold. A review of the work orders and emails from maintenance to corporate revealed the dishwasher has been inoperable since 8/9/24. Residents on 4/4 units complained of lack of linens and personal clothing taking too long to come back from laundry, On 10/10/24 at 3:00 pm, an interview was conducted with the director of housekeeping who was asked why there was a shortage of linens, and the laundry was not getting done in a timely manner. She stated that they are doing the best they can with 1 washing machine. When asked if that is all the facility has for 180 beds, she stated that the other 2 washers are broken. She stated that they are working 7 days a week with the one washer they have to try and keep up with all the linens and facility laundry as well as Resident personal clothing. On 10/11/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	40711 3. Unit 1B During the initial tour on 10/01/24 at approximately 4:30 PM., on unit 1 B across from the laundry room in the hallway were 3 large trash bags on the floor, filled with clothing. A rolling laundry cart was also observed in the hallway with approximately 16 items hanging from it. The items observed hanging were shirts, pants and 1 coat. On 10/01/24 an interview was conducted on 10/01/24 at approximately 4:45 PM., with the House Keeping /Laundry aide (Other Staff Member/OSM) #11 concerning the above issue. OSM #11 said that they didn't have enough room inside the laundry room, so they were keeping additional laundry items on the hall. Unit 2B, room [ROOM NUMBER] On 10/08/24 at approximately 10:28 AM., an observation of room [ROOM NUMBER] on unit 2B was conducted. Ceiling tiles in the left corner of room appeared wet looking with brown stains. The roommate, Resident #3 said they changed the tiles on yesterday and it's staining already. Unit 1A, room [ROOM NUMBER]A On 10/07/24 at approximately 3:28 PM., an observation was made of room [ROOM NUMBER]A on unit 1A. Cobb webs were observed on the wall near the resident's bed, [NAME] stains were observed on 2 ceiling tiles, the curtains hanging at the window also had a brown substance on them. The resident appeared irritated and angry due to his room being nasty and filthy. Resident #371 also said that he's afraid to touch things due to the filth. He also said that They need to burn this place down. On 10/07/24 at approximately 3:35 PM., Registered Nurse (RN) #3 entered the resident's room. RN #3 reassured the resident concerning his room condition. On 10/07/24 at approximately 3:41 PM. The maintenance tech (Other Staff Members/OSM) #13, entered the resident's room with a ladder and started removing and replacing 2 ceiling tiles that had a black substance on them. OSM #13 said that the discoloration is coming from condensation of the chiller pipes from heating and air unit. On 10/11/2024 at approximately 6:00 p.m., the above findings were shared with the Acting Administrator in Training, Director of Nursing and the Regional Nurse Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. 49917 Surveyor: [NAME], [NAME] 4. Unit 3: (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. In room [ROOM NUMBER] small, flat black spots with a powdery texture was observed behind the bedroom door extending toward the bed. Resident #424 was observed in bed and an interview was conducted with her on 10/8/24 at 12:45 PM. The resident stated the black spots have been on the wall for a while. Resident #424 also stated she believes the black spots are the reason she is not feeling well and cannot get well. The resident's admission Minimum Data Set Assessment (MDS) dated [DATE] coded the resident Brief Interview for Mental Status (BIMS) score as 15 out of 15. This indicated her daily decision-making ability was intact. On 10/8/24 at 4:00 PM two maintenance personnel were observed cleaning the wall that was covered in small, flat black spots with a powdery texture in room [ROOM NUMBER]. b. On 10/4/24 at 12:18PM a live cockroach was observed outside of room [ROOM NUMBER] in the hallway on Unit 3. The Director of Nursing (DON) and Maintenance Director were notified. The Maintenance Director was observed catching the pest in a Styrofoam cup and disposing the pest.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 31199 Based on staff interviews, Resident interviews, clinical record reviews, and facility documentation review, the facility staff failed to prevent repeated willful abuse and neglect, failed to report the abuse to the state agency, failed to fully investigate the abuse, failed to protect the victims during the investigation, and further failed to implement their abuse and neglect policies for four known Residents (Residents #68, #20 and #521,) in a survey sample size of 55 residents. The findings included: The facility failures described above resulted in the willful abuse of Residents #68, #20, and a third unknown Resident victim as perpetrated by Resident #521. Resident #68 (victim 1) was admitted to the facility on [DATE]. Diagnoses included but were not limited to: heart failure, hypertension, high cholesterol, malnutrition, peripheral venous insufficiency, hypothyroidism, rheumatoid arthritis, scoliosis, rhabdomyolysis, and foot pain. Resident #68's most recent Minimum Data Set with an Assessment Reference Date of 8-2-24 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and her own responsible party. The Resident required extensive assistance from one staff member for hygiene and bathing. The Resident had no aberrant behaviors documented, and had no complaints against any other staff or situations since her admission on 11-14-19. Resident #20 (victim 2) was admitted to the facility on [DATE]. Diagnoses included but were not limited to chronic ischemic heart disease, stroke with hemiplegia right side, anemia, diabetes, chronic hepatic failure, neck fracture, chronic kidney disease, depression, and femur fracture. Resident #20's most recent Minimum Data Set was a quarterly assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and her own responsible party. The Resident was independent for transferring and used a motorized wheel chair to leave the building for shopping trips to walmart using a van. The Resident had no aberrant behaviors documented, and had no complaints against any other staff or situations since her admission on 7-18-23. Resident #521 (perpetrator of 1 and 2) was admitted to the facility on [DATE]. Hospital discharge records indicated that the Resident was alert and oriented to person, place and time, and was ambulatory at the time of discharge. Diagnoses included but were not limited to: Heart failure, hypertension, Gastro Esophageal reflux disease, renal insufficiency, diabetes, thyroid disorder, dementia, malnutrition, and asthma. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Virginia Beach Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Minimal harm or potential for actual harm Residents Affected - Some	Resident #521's most recent Minimum Data Set with an Assessment Reference Date of 9-5-24 after one day in the facility was coded as an admission assessment. The Brief Interview for Mental Status was coded as 12 out of a possible 15 points which indicated mild cognitive impairment, however, the language barrier may have contributed to a false lower score. The Resident was her own responsible party. The Resident spoke only Spanish. The Resident required extensive assistance from one staff member for hygiene and bathing. On 10-1-24, the first day of survey, Resident #521 went out to a medical appointment and lost consciousness while there. She was sent directly to the hospital, and did not return during the remainder of the survey. While on continued tour of the facility on 10-4-24, Resident #68 was interviewed and asked if any person in the facility had abused her or if she had ever witnessed abuse. She stated yes that her former room mate (Resident #521) had kicked her, thrown fruit at her, hit her, and had spit on her. She stated that Resident #521 had also cursed and yelled at her, gotten in her bed, held her wheel chair so she could not leave the room for help, and had stood over her while she was laying in bed menacing her. She stated that she had been bruised by the kick and punch, but luckily suffered no other injuries. She further stated that she had complained to staff repeatedly but they did nothing until 9-20-24 when Resident #521 punched her in the arm and the Assistant Director of Nursing saw it. She went on to say that they moved her that day. The Resident was asked if she was still afraid and she stated no, she's gone now. On 10-7-24 the clinical records of Resident's #68, and #521 were reviewed. Those reviews contained the following information in chronological order; On 9-20-24 at 3:42 PM the records indicated that Resident #521 had been moved to another room for Safety. No other descriptions about the allegations of abuse on Resident #68 were documented. On 9-20-24 Resident #521's progress notes documented she was moved to the room containing Resident #20. On 9-21-24 at 12:47 AM (7.5 hours later) after the move, progress note review indicated that Resident #521 was observed to throw a cup of water across the room and spit on her new room mates charger for her electric wheel chair. On 9-21-24 at 8:41 PM, Later the same day, documents record Resident #521 hit Resident #20 and it was witnessed by staff. There was no mention of the scratches to Resident #20 inflicted by Resident #521. On 9-22-24 at 1:34 AM (5 hours later) progress notes go on to describe that Resident #521 was moved to a private room. (Victim #3 unknown name) On 9-22-24 at 2:54 AM, (1.5 hours after move) another note describes Resident #521 as standing next to her neighbors bed (unknown which neighboring room to the private room or which Resident this involved) staring at her (the neighbor of Resident #521) while sleeping and threatened anger aggressive behavior. On 9-23-24 a psychiatric consultation was ordered. It was never obtained. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9-25-24 the Physician's Assistant (PA) described in a note that (Resident #521) Patient assault on room mate multiple times, resident denied, on alternate location at this time. On 10-7-24 Resident #20 was interviewed and stated that Resident #521 was placed in her room and almost immediately began to yell at her, spit at her, and throw things at her. She went on to state that Resident #521 finally came over to her side of the room after dinner sometime and lashed out at her hitting her, causing several small scratches on her hand. She stated she was fending off the blows with her arm raised. and Resident #521's fingernails scratched her. She went on to state that the staff saw it and moved her out of the room until they could find a place for Resident #521. She stated that Resident #521 was moved Sometime late that night around midnight. Resident #20 was asked if she was afraid of Resident #521, and she stated no, she went to the hospital and I don't think she's ever coming back. Nursing staff on the units where Resident #521 was housed were interviewed and stated they remembered Resident #521, and her aggressive behaviors, however, those working during survey interviews were not present during the abuses. They stated they were aware of the incidents, however, most of the staff were from a staffing agency and did not work there every day. During interview and review of the clinical record, it was found that the Social Worker/Discharge Planner (SWDP) was only involved with Resident #521 on 3 occasions. Those instances follow below: 1. Nine days after admission on 9-13-24 for a Trauma Informed Care assessment which was negative for trauma experienced by the Resident. 2. After the first abuse on 9-20-24 to Resident #68, to notify Resident #521's son of the first room change. 3. Finally, at the first Interdisciplinary care plan meeting on 9-26-24 with only the SWDP and the Activity Assistant present. A copy of all Facility Reported Incidents (FRI's) for the prior 6 months were requested. 10 were provided by the Administrator, and 9 of the 10 followed the standardized format and documentation was provided for notification of the state agency the Virginia Department of Health Office of Licensure and Certification (VDH/OLC), the state Long Term Care Ombudsman, and Adult Protective Services (APS). The 9 completed FRI's were all prior to 9-20-24. The tenth alleged FRI involving Resident #68, and Resident #521 was incomplete and contained 7 documents. The documents included four statements from staff alleging abuse to Resident #68. One of the staff statements alleged repeated abuse allegations documented from 9-17-24 through 9-20-24 and for over a week. Also included was a fifth documented statement from the Resident alleging verbal and physical abuse. The sixth document was a written synopsis by the Administrator which was not signed, and only described the initial abuse allegation for Resident #68. It did not include Resident #20's abuse by Resident #521, the room changes, nor the incident with the unknown neighbor after being installed in the third room. The seventh document was a response from APS stating that the report to them did not meet validity criteria required to initiate an APS investigation. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator's synopsis stated that Resident #68 was asked what was triggering Resident #521's behavior, which implies that the victim is the causative factor, or that the victim is able to psychologically assess her room mate who only spoke Spanish, and Resident #68 only spoke English. The synopsis also stated that Resident #521 would be moved to a room with someone more compatible. The Administrator's synopsis goes on to describe Resident #521 as having a BIMS score of 3 points out of a possible 15 points indicating severe dementia, which was incorrect. The Resident's BIMS score was 12. The state agency VDH/OLC did not receive the fax sent by the Administrator and review of the fax number revealed it to be in error. All of the documents were completed on 9-20-24, the initial day of assault reporting on Resident #68, and #521. There was no report, investigation, nor protections for Resident #20 after her multiple assaults on 9-21-24, nor for the unknown Resident on 9-22-24 after a third room was inhabited by Resident #521 in less than 48 hours. The Administrator was interviewed on 10-8-24, and was asked why the document from 9-20-24 was not completed as the other FRI's were, his response was that he had only been here 4 weeks, and I am not required by law to use the FRI document, and I have all of the investigation, and here it is, this is the initial and 5 day follow up all in one. The synopsis was simple typed document on a clean white unlined sheet of copy paper, and did not state that it was an initial FRI, nor a 5 day follow up, and it was not signed. Included in the packet were 3 copies of a fax cover sheet To: VDH/APS/[NAME] From: (first name & last name first letter only) the Administrator, documenting that the fax contained 2 pages. The fax was sent on 9-20-24, at 2:24 PM, 2:26 PM, 2:27 PM respectively. The Administrator stated he wrote the synopsis, and sent the fax, and that in error he didn't sign it. This indicates the only 2 sheets allegedly sent were the fax cover sheet and the synopsis which was not signed, and did not state it was an initial FRI, nor a 5 day follow up. At that time the Administrator was informed that the investigation was incomplete as no FRI was ever received at the state agency VDH/OLC for the first allegation of abuse. The other 2 Resident's who were later involved were not protected from abuse and added to the initial investigation, and a 5 day follow up as required by law would have captured them as well. The Administrator was made aware that no second FRI and investigation was ever conducted after further abuse from Resident #521 on Resident #20, and the unknown Resident. Residents were not protected from a known abuser. Further they had not implemented their policies on abuse. The facility staff provided a copy of their Abuse policy, and the policy review revealed that all allegations of abuse will be investigated, Residents will be protected and prevented from further abuse, reports will be sent initially to the State agency VDH/OLC (and other agencies) within 24 hours or within 2 hours if serious injury occurs, and a follow up report will be sent in 5 days to include findings and corrections. Resident #68 reported abuse for days before staff observed the abuse and moved Resident #521. Resident #521 was then placed with Resident #20 who was not protected and was abused. Resident #521 was moved again and went to a third unknown Resident's room to abuse. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The allegations were never reported to the state agency. Residents were not protected from a known abuser. Abuse was not investigated fully, and the facility policy was not implemented for the protections of Residents from abuse. Further, there was never any added staff supervision for Resident #521 to prevent the abuse from continuing. No staff ever noted the suspicion of a crime, so no police report was ever filed. The first alleged report by the Administrator was never signed and had errors in information giving the appearance of a severely demented alleged abuser to APS in a single occurrence resulting in no investigation opened by them. On 10-9-24 at approximately 5:30 p.m., the facility Administrator, Corporate Registered Nurse, and Corporate Administrator were notified of the findings. They stated they had no further information or documentation to offer.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interviews, Resident interviews, clinical record reviews, and facility documentation review, the facility staff failed to implement their abuse policies to prevent repeated willful abuse and neglect, in so doing, failed to report the abuse to the state agency, failed to fully investigate the abuse, and further failed to protect the victims during the investigation, for four known Residents (Residents #68, #20, #521, and #325) in a survey sample size of 55 residents. The findings included: The facility failures described above resulted in the willful abuse of Residents #68, #20, and a third unknown Resident victim as perpetrated by Resident #521. Resident #68 (victim 1) was admitted to the facility on [DATE]. Diagnoses included but were not limited to: heart failure, hypertension, high cholesterol, malnutrition, peripheral venous insufficiency, hypothyroidism, rheumatoid arthritis, scoliosis, rhabdomyolysis, and foot pain. Resident #68's most recent Minimum Data Set with an Assessment Reference Date of 8-2-24 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and her own responsible party. The Resident required extensive assistance from one staff member for hygiene and bathing. The Resident had no aberrant behaviors documented, and had no complaints against any other staff or situations since her admission on 11-14-19. Resident #20 (victim 2) was admitted to the facility on [DATE]. Diagnoses included but were not limited to chronic ischemic heart disease, stroke with hemiplegia right side, anemia, diabetes, chronic hepatic failure, neck fracture, chronic kidney disease, depression, and femur fracture. Resident #20's most recent Minimum Data Set was a quarterly assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and her own responsible party. The Resident was independent for transferring and used a motorized wheel chair to leave the building for shopping trips to walmart using a van. The Resident had no aberrant behaviors documented, and had no complaints against any other staff or situations since her admission on 7-18-23. Resident #521 (perpetrator of 1 and 2) was admitted to the facility on [DATE]. Hospital discharge records indicated that the Resident was alert and oriented to person, place and time, and was ambulatory at the time of discharge. Diagnoses included but were not limited to: Heart failure, hypertension, Gastro Esophageal reflux disease, renal insufficiency, diabetes, thyroid disorder, dementia, malnutrition, and asthma. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #521's most recent Minimum Data Set with an Assessment Reference Date of 9-5-24 after one day in the facility was coded as an admission assessment. The Brief Interview for Mental Status was coded as 12 out of a possible 15 points which indicated mild cognitive impairment, however, the language barrier may have contributed to a false lower score. The Resident was her own responsible party. The Resident spoke only Spanish. The Resident required extensive assistance from one staff member for hygiene and bathing. On 10-1-24, the first day of survey, Resident #521 went out to a medical appointment and lost consciousness while there. She was sent directly to the hospital, and did not return during the remainder of the survey. While on continued tour of the facility on 10-4-24, Resident #68 was interviewed and asked if any person in the facility had abused her or if she had ever witnessed abuse. She stated yes that her former room mate (Resident #521) had kicked her, thrown fruit at her, hit her, and had spit on her. She stated that Resident #521 had also cursed and yelled at her, gotten in her bed, held her wheel chair so she could not leave the room for help, and had stood over her while she was laying in bed menacing her. She stated that she had been bruised by the kick and punch, but luckily suffered no other injuries. She further stated that she had complained to staff repeatedly but they did nothing until 9-20-24 when Resident #521 punched her in the arm and the Assistant Director of Nursing saw it. She went on to say that they moved her that day. The Resident was asked if she was still afraid and she stated no, she's gone now. On 10-7-24 the clinical records of Resident's #68, and #521 were reviewed. Those reviews contained the following information in chronological order; On 9-20-24 at 3:42 PM the records indicated that Resident #521 had been moved to another room for Safety. No other descriptions about the allegations of abuse on Resident #68 were documented. On 9-20-24 Resident #521's progress notes documented she was moved to the room containing Resident #20. On 9-21-24 at 12:47 AM (7.5 hours later) after the move, progress note review indicated that Resident #521 was observed to throw a cup of water across the room and spit on her new room mates charger for her electric wheel chair. On 9-21-24 at 8:41 PM, Later the same day, documents record Resident #521 hit Resident #20 and it was witnessed by staff. There was no mention of the scratches to Resident #20 inflicted by Resident #521. On 9-22-24 at 1:34 AM (5 hours later) progress notes go on to describe that Resident #521 was moved to a private room. (Victim #3 unknown name) On 9-22-24 at 2:54 AM, (1.5 hours after move) another note describes Resident #521 as standing next to her neighbors bed (unknown which neighboring room to the private room or which Resident this involved) staring at her (the neighbor of Resident #521) while sleeping and threatened anger aggressive behavior. On 9-23-24 a psychiatric consultation was ordered. It was never obtained. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9-25-24 the Physician's Assistant (PA) described in a note that (Resident #521) Patient assault on room mate multiple times, resident denied, on alternate location at this time. On 10-7-24 Resident #20 was interviewed and stated that Resident #521 was placed in her room and almost immediately began to yell at her, spit at her, and throw things at her. She went on to state that Resident #521 finally came over to her side of the room after dinner sometime and lashed out at her hitting her, causing several small scratches on her hand. She stated she was fending off the blows with her arm raised. and Resident #521's fingernails scratched her. She went on to state that the staff saw it and moved her out of the room until they could find a place for Resident #521. She stated that Resident #521 was moved Sometime late that night around midnight. Resident #20 was asked if she was afraid of Resident #521, and she stated no, she went to the hospital and I don't think she's ever coming back. Nursing staff on the units where Resident #521 was housed were interviewed and stated they remembered Resident #521, and her aggressive behaviors, however, those working during survey interviews were not present during the abuses. They stated they were aware of the incidents, however, most of the staff were from a staffing agency and did not work there every day. During interview and review of the clinical record, it was found that the Social Worker/Discharge Planner (SWDP) was only involved with Resident #521 on 3 occasions. Those instances follow below: 1. Nine days after admission on 9-13-24 for a Trauma Informed Care assessment which was negative for trauma experienced by the Resident. 2. After the first abuse on 9-20-24 to Resident #68, to notify Resident #521's son of the first room change. 3. Finally, at the first Interdisciplinary care plan meeting on 9-26-24 with only the SWDP and the Activity Assistant present. A copy of all Facility Reported Incidents (FRI's) for the prior 6 months were requested. 10 were provided by the Administrator, and 9 of the 10 followed the standardized format and documentation was provided for notification of the state agency the Virginia Department of Health Office of Licensure and Certification (VDH/OLC), the state Long Term Care Ombudsman, and Adult Protective Services (APS). The 9 completed FRI's were all prior to 9-20-24. The tenth alleged FRI involving Resident #68, and Resident #521 was incomplete and contained 7 documents. The documents included four statements from staff alleging abuse to Resident #68. One of the staff statements alleged repeated abuse allegations documented from 9-17-24 through 9-20-24 and for over a week. Also included was a fifth documented statement from the Resident alleging verbal and physical abuse. The sixth document was a written synopsis by the Administrator which was not signed, and only described the initial abuse allegation for Resident #68. It did not include Resident #20's abuse by Resident #521, the room changes, nor the incident with the unknown neighbor after being installed in the third room. The seventh document was a response from APS stating that the report to them did not meet validity criteria required to initiate an APS investigation. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator's synopsis stated that Resident #68 was asked what was triggering Resident #521's behavior, which implies that the victim is the causative factor, or that the victim is able to psychologically assess her room mate who only spoke Spanish, and Resident #68 only spoke English. The synopsis also stated that Resident #521 would be moved to a room with someone more compatible. The Administrator's synopsis goes on to describe Resident #521 as having a BIMS score of 3 points out of a possible 15 points indicating severe dementia, which was incorrect. The Resident's BIMS score was 12. The state agency VDH/OLC did not receive the fax sent by the Administrator and review of the fax number revealed it to be in error. All of the documents were completed on 9-20-24, the initial day of assault reporting on Resident #68, and #521. There was no report, investigation, nor protections for Resident #20 after her multiple assaults on 9-21-24, nor for the unknown Resident on 9-22-24 after a third room was inhabited by Resident #521 in less than 48 hours. The Administrator was interviewed on 10-8-24, and was asked why the document from 9-20-24 was not completed as the other FRI's were, his response was that he had only been here 4 weeks, and I am not required by law to use the FRI document, and I have all of the investigation, and here it is, this is the initial and 5 day follow up all in one. The synopsis was simple typed document on a clean white unlined sheet of copy paper, and did not state that it was an initial FRI, nor a 5 day follow up, and it was not signed. Included in the packet were 3 copies of a fax cover sheet To: VDH/APS/[NAME] From: (first name & last name first letter only) the Administrator, documenting that the fax contained 2 pages. The fax was sent on 9-20-24, at 2:24 PM, 2:26 PM, 2:27 PM respectively. The Administrator stated he wrote the synopsis, and sent the fax, and that in error he didn't sign it. This indicates the only 2 sheets allegedly sent were the fax cover sheet and the synopsis which was not signed, and did not state it was an initial FRI, nor a 5 day follow up. At that time the Administrator was informed that the investigation was incomplete as no FRI was ever received at the state agency VDH/OLC for the first allegation of abuse. The other 2 Resident's who were later involved were not protected from abuse and added to the initial investigation, and a 5 day follow up as required by law would have captured them as well. The Administrator was made aware that no second FRI and investigation was ever conducted after further abuse from Resident #521 on Resident #20, and the unknown Resident. Residents were not protected from a known abuser. Further they had not implemented their policies on abuse. The facility staff provided a copy of their Abuse policy, and the policy review revealed that all allegations of abuse will be investigated, Residents will be protected and prevented from further abuse, reports will be sent initially to the State agency VDH/OLC (and other agencies) within 24 hours or within 2 hours if serious injury occurs, and a follow up report will be sent in 5 days to include findings and corrections. Resident #68 reported abuse for days before staff observed the abuse and moved Resident #521. Resident #521 was then placed with Resident #20 who was not protected and was abused. Resident #521 was moved again and went to a third unknown Resident's room to abuse. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The allegations were never reported to the state agency. Residents were not protected from a known abuser. Abuse was not investigated fully, and the facility policy was not implemented for the protections of Residents from abuse. Further, there was never any added staff supervision for Resident #521 to prevent the abuse from continuing. No staff ever noted the suspicion of a crime, so no police report was ever filed. The first alleged report by the Administrator was never signed and had errors in information giving the appearance of a severely demented alleged abuser to APS in a single occurrence resulting in no investigation opened by them. On 10-9-24 at approximately 5:30 p.m., the facility Administrator, Corporate Registered Nurse, and Corporate Administrator were notified of the findings. They stated they had no further information or documentation to offer.		

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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 - Some	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** 31199 Based on staff interviews, Resident interviews, clinical record reviews, and facility documentation review, the facility staff failed to prevent repeated willful abuse and neglect, failed to report the abuse to the state agency, failed to fully investigate the abuse, failed to protect the victims during the investigation, and further failed to implement their abuse and neglect policies for four known Residents (Residents #68, #20, #521, and #325) in a survey sample size of 55 residents. The findings included: The facility failures described above resulted in the willful abuse of Residents #68, #20, and a third unknown Resident victim as perpetrated by Resident #521. Resident #68 (victim 1) was admitted to the facility on [DATE]. Diagnoses included but were not limited to: heart failure, hypertension, high cholesterol, malnutrition, peripheral venous insufficiency, hypothyroidism, rheumatoid arthritis, scoliosis, rhabdomyolysis, and foot pain. Resident #68's most recent Minimum Data Set with an Assessment Reference Date of 8-2-24 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and her own responsible party. The Resident required extensive assistance from one staff member for hygiene and bathing. The Resident had no aberrant behaviors documented, and had no complaints against any other staff or situations since her admission on 11-14-19. Resident #20 (victim 2) was admitted to the facility on [DATE]. Diagnoses included but were not limited to chronic ischemic heart disease, stroke with hemiplegia right side, anemia, diabetes, chronic hepatic failure, neck fracture, chronic kidney disease, depression, and femur fracture. Resident #20's most recent Minimum Data Set was a quarterly assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and her own responsible party. The Resident was independent for transferring and used a motorized wheel chair to leave the building for shopping trips to walmart using a van. The Resident had no aberrant behaviors documented, and had no complaints against any other staff or situations since her admission on 7-18-23. Resident #521 (perpetrator of 1 and 2) was admitted to the facility on [DATE]. Hospital discharge records indicated that the Resident was alert and oriented to person, place and time, and was ambulatory at the time of discharge. Diagnoses included but were not limited to: Heart failure, hypertension, Gastro Esophageal reflux disease, renal insufficiency, diabetes, thyroid disorder, dementia, malnutrition, and asthma. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
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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 - Some	Resident #521's most recent Minimum Data Set with an Assessment Reference Date of 9-5-24 after one day in the facility was coded as an admission assessment. The Brief Interview for Mental Status was coded as 12 out of a possible 15 points which indicated mild cognitive impairment, however, the language barrier may have contributed to a false lower score. The Resident was her own responsible party. The Resident spoke only Spanish. The Resident required extensive assistance from one staff member for hygiene and bathing. On 10-1-24, the first day of survey, Resident #521 went out to a medical appointment and lost consciousness while there. She was sent directly to the hospital, and did not return during the remainder of the survey. While on continued tour of the facility on 10-4-24, Resident #68 was interviewed and asked if any person in the facility had abused her or if she had ever witnessed abuse. She stated yes that her former room mate (Resident #521) had kicked her, thrown fruit at her, hit her, and had spit on her. She stated that Resident #521 had also cursed and yelled at her, gotten in her bed, held her wheel chair so she could not leave the room for help, and had stood over her while she was laying in bed menacing her. She stated that she had been bruised by the kick and punch, but luckily suffered no other injuries. She further stated that she had complained to staff repeatedly but they did nothing until 9-20-24 when Resident #521 punched her in the arm and the Assistant Director of Nursing saw it. She went on to say that they moved her that day. The Resident was asked if she was still afraid and she stated no, she's gone now. On 10-7-24 the clinical records of Resident's #68, and #521 were reviewed. Those reviews contained the following information in chronological order; On 9-20-24 at 3:42 PM the records indicated that Resident #521 had been moved to another room for Safety. No other descriptions about the allegations of abuse on Resident #68 were documented. On 9-20-24 Resident #521's progress notes documented she was moved to the room containing Resident #20. On 9-21-24 at 12:47 AM (7.5 hours later) after the move, progress note review indicated that Resident #521 was observed to throw a cup of water across the room and spit on her new room mates charger for her electric wheel chair. On 9-21-24 at 8:41 PM, Later the same day, documents record Resident #521 hit Resident #20 and it was witnessed by staff. There was no mention of the scratches to Resident #20 inflicted by Resident #521. On 9-22-24 at 1:34 AM (5 hours later) progress notes go on to describe that Resident #521 was moved to a private room. (Victim #3 unknown name) On 9-22-24 at 2:54 AM, (1.5 hours after move) another note describes Resident #521 as standing next to her neighbors bed (unknown which neighboring room to the private room or which Resident this involved) staring at her (the neighbor of Resident #521) while sleeping and threatened anger aggressive behavior. On 9-23-24 a psychiatric consultation was ordered. It was never obtained. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9-25-24 the Physician's Assistant (PA) described in a note that (Resident #521) Patient assault on room mate multiple times, resident denied, on alternate location at this time. On 10-7-24 Resident #20 was interviewed and stated that Resident #521 was placed in her room and almost immediately began to yell at her, spit at her, and throw things at her. She went on to state that Resident #521 finally came over to her side of the room after dinner sometime and lashed out at her hitting her, causing several small scratches on her hand. She stated she was fending off the blows with her arm raised. and Resident #521's fingernails scratched her. She went on to state that the staff saw it and moved her out of the room until they could find a place for Resident #521. She stated that Resident #521 was moved Sometime late that night around midnight. Resident #20 was asked if she was afraid of Resident #521, and she stated no, she went to the hospital and I don't think she's ever coming back. Nursing staff on the units where Resident #521 was housed were interviewed and stated they remembered Resident #521, and her aggressive behaviors, however, those working during survey interviews were not present during the abuses. They stated they were aware of the incidents, however, most of the staff were from a staffing agency and did not work there every day. During interview and review of the clinical record, it was found that the Social Worker/Discharge Planner (SWDP) was only involved with Resident #521 on 3 occasions. Those instances follow below: 1. Nine days after admission on 9-13-24 for a Trauma Informed Care assessment which was negative for trauma experienced by the Resident. 2. After the first abuse on 9-20-24 to Resident #68, to notify Resident #521's son of the first room change. 3. Finally, at the first Interdisciplinary care plan meeting on 9-26-24 with only the SWDP and the Activity Assistant present. A copy of all Facility Reported Incidents (FRI's) for the prior 6 months were requested. 10 were provided by the Administrator, and 9 of the 10 followed the standardized format and documentation was provided for notification of the state agency the Virginia Department of Health Office of Licensure and Certification (VDH/OLC), the state Long Term Care Ombudsman, and Adult Protective Services (APS). The 9 completed FRI's were all prior to 9-20-24. The tenth alleged FRI involving Resident #68, and Resident #521 was incomplete and contained 7 documents. The documents included four statements from staff alleging abuse to Resident #68. One of the staff statements alleged repeated abuse allegations documented from 9-17-24 through 9-20-24 and for over a week. Also included was a fifth documented statement from the Resident alleging verbal and physical abuse. The sixth document was a written synopsis by the Administrator which was not signed, and only described the initial abuse allegation for Resident #68. It did not include Resident #20's abuse by Resident #521, the room changes, nor the incident with the unknown neighbor after being installed in the third room. The seventh document was a response from APS stating that the report to them did not meet validity criteria required to initiate an APS investigation. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator's synopsis stated that Resident #68 was asked what was triggering Resident #521's behavior, which implies that the victim is the causative factor, or that the victim is able to psychologically assess her room mate who only spoke Spanish, and Resident #68 only spoke English. The synopsis also stated that Resident #521 would be moved to a room with someone more compatible. The Administrator's synopsis goes on to describe Resident #521 as having a BIMS score of 3 points out of a possible 15 points indicating severe dementia, which was incorrect. The Resident's BIMS score was 12. The state agency VDH/OLC did not receive the fax sent by the Administrator and review of the fax number revealed it to be in error. All of the documents were completed on 9-20-24, the initial day of assault reporting on Resident #68, and #521. There was no report, investigation, nor protections for Resident #20 after her multiple assaults on 9-21-24, nor for the unknown Resident on 9-22-24 after a third room was inhabited by Resident #521 in less than 48 hours. The Administrator was interviewed on 10-8-24, and was asked why the document from 9-20-24 was not completed as the other FRI's were, his response was that he had only been here 4 weeks, and I am not required by law to use the FRI document, and I have all of the investigation, and here it is, this is the initial and 5 day follow up all in one. The synopsis was simple typed document on a clean white unlined sheet of copy paper, and did not state that it was an initial FRI, nor a 5 day follow up, and it was not signed. Included in the packet were 3 copies of a fax cover sheet To: VDH/APS/[NAME] From: (first name & last name first letter only) the Administrator, documenting that the fax contained 2 pages. The fax was sent on 9-20-24, at 2:24 PM, 2:26 PM, 2:27 PM respectively. The Administrator stated he wrote the synopsis, and sent the fax, and that in error he didn't sign it. This indicates the only 2 sheets allegedly sent were the fax cover sheet and the synopsis which was not signed, and did not state it was an initial FRI, nor a 5 day follow up. At that time the Administrator was informed that the investigation was incomplete as no FRI was ever received at the state agency VDH/OLC for the first allegation of abuse. The other 2 Resident's who were later involved were not protected from abuse and added to the initial investigation, and a 5 day follow up as required by law would have captured them as well. The Administrator was made aware that no second FRI and investigation was ever conducted after further abuse from Resident #521 on Resident #20, and the unknown Resident. Residents were not protected from a known abuser. Further they had not implemented their policies on abuse. The facility staff provided a copy of their Abuse policy, and the policy review revealed that all allegations of abuse will be investigated, Residents will be protected and prevented from further abuse, reports will be sent initially to the State agency VDH/OLC (and other agencies) within 24 hours or within 2 hours if serious injury occurs, and a follow up report will be sent in 5 days to include findings and corrections. Resident #68 reported abuse for days before staff observed the abuse and moved Resident #521. Resident #521 was then placed with Resident #20 who was not protected and was abused. Resident #521 was moved again and went to a third unknown Resident's room to abuse. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The allegations were never reported to the state agency. Residents were not protected from a known abuser. Abuse was not investigated fully, and the facility policy was not implemented for the protections of Residents from abuse. Further, there was never any added staff supervision for Resident #521 to prevent the abuse from continuing. No staff ever noted the suspicion of a crime, so no police report was ever filed. The first alleged report by the Administrator was never signed and had errors in information giving the appearance of a severely demented alleged abuser to APS in a single occurrence resulting in no investigation opened by them. On 10-9-24 at approximately 5:30 p.m., the facility Administrator, Corporate Registered Nurse, and Corporate Administrator were notified of the findings. They stated they had no further information or documentation to offer.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interviews, Resident interviews, clinical record reviews, and facility documentation review, the facility staff failed to prevent repeated willful abuse and neglect, failed to fully investigate the abuse, failed to report the abuse to the state agency, failed to protect the victims during the investigation, and further failed to implement their abuse and neglect policies for four known Residents (Residents #68, #20, #521, and #325) in a survey sample size of 55 residents. The findings included: The facility failures described above resulted in the willful abuse of Residents #68, #20, and a third unknown Resident victim as perpetrated by Resident #521. Resident #68 (victim 1) was admitted to the facility on [DATE]. Diagnoses included but were not limited to: heart failure, hypertension, high cholesterol, malnutrition, peripheral venous insufficiency, hypothyroidism, rheumatoid arthritis, scoliosis, rhabdomyolysis, and foot pain. Resident #68's most recent Minimum Data Set with an Assessment Reference Date of 8-2-24 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and her own responsible party. The Resident required extensive assistance from one staff member for hygiene and bathing. The Resident had no aberrant behaviors documented, and had no complaints against any other staff or situations since her admission on 11-14-19. Resident #20 (victim 2) was admitted to the facility on [DATE]. Diagnoses included but were not limited to chronic ischemic heart disease, stroke with hemiplegia right side, anemia, diabetes, chronic hepatic failure, neck fracture, chronic kidney disease, depression, and femur fracture. Resident #20's most recent Minimum Data Set was a quarterly assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and her own responsible party. The Resident was independent for transferring and used a motorized wheel chair to leave the building for shopping trips to walmart using a van. The Resident had no aberrant behaviors documented, and had no complaints against any other staff or situations since her admission on 7-18-23. Resident #521 (perpetrator of 1 and 2) was admitted to the facility on [DATE]. Hospital discharge records indicated that the Resident was alert and oriented to person, place and time, and was ambulatory at the time of discharge. Diagnoses included but were not limited to: Heart failure, hypertension, Gastro Esophageal reflux disease, renal insufficiency, diabetes, thyroid disorder, dementia, malnutrition, and asthma. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #521's most recent Minimum Data Set with an Assessment Reference Date of 9-5-24 after one day in the facility was coded as an admission assessment. The Brief Interview for Mental Status was coded as 12 out of a possible 15 points which indicated mild cognitive impairment, however, the language barrier may have contributed to a false lower score. The Resident was her own responsible party. The Resident spoke only Spanish. The Resident required extensive assistance from one staff member for hygiene and bathing. On 10-1-24, the first day of survey, Resident #521 went out to a medical appointment and lost consciousness while there. She was sent directly to the hospital, and did not return during the remainder of the survey. While on continued tour of the facility on 10-4-24, Resident #68 was interviewed and asked if any person in the facility had abused her or if she had ever witnessed abuse. She stated yes that her former room mate (Resident #521) had kicked her, thrown fruit at her, hit her, and had spit on her. She stated that Resident #521 had also cursed and yelled at her, gotten in her bed, held her wheel chair so she could not leave the room for help, and had stood over her while she was laying in bed menacing her. She stated that she had been bruised by the kick and punch, but luckily suffered no other injuries. She further stated that she had complained to staff repeatedly but they did nothing until 9-20-24 when Resident #521 punched her in the arm and the Assistant Director of Nursing saw it. She went on to say that they moved her that day. The Resident was asked if she was still afraid and she stated no, she's gone now. On 10-7-24 the clinical records of Resident's #68, and #521 were reviewed. Those reviews contained the following information in chronological order; On 9-20-24 at 3:42 PM the records indicated that Resident #521 had been moved to another room for Safety. No other descriptions about the allegations of abuse on Resident #68 were documented. On 9-20-24 Resident #521's progress notes documented she was moved to the room containing Resident #20. On 9-21-24 at 12:47 AM (7.5 hours later) after the move, progress note review indicated that Resident #521 was observed to throw a cup of water across the room and spit on her new room mates charger for her electric wheel chair. On 9-21-24 at 8:41 PM, Later the same day, documents record Resident #521 hit Resident #20 and it was witnessed by staff. There was no mention of the scratches to Resident #20 inflicted by Resident #521. On 9-22-24 at 1:34 AM (5 hours later) progress notes go on to describe that Resident #521 was moved to a private room. (Victim #3 unknown name) On 9-22-24 at 2:54 AM, (1.5 hours after move) another note describes Resident #521 as standing next to her neighbors bed (unknown which neighboring room to the private room or which Resident this involved) staring at her (the neighbor of Resident #521) while sleeping and threatened anger aggressive behavior. On 9-23-24 a psychiatric consultation was ordered. It was never obtained. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9-25-24 the Physician's Assistant (PA) described in a note that (Resident #521) Patient assault on room mate multiple times, resident denied, on alternate location at this time. On 10-7-24 Resident #20 was interviewed and stated that Resident #521 was placed in her room and almost immediately began to yell at her, spit at her, and throw things at her. She went on to state that Resident #521 finally came over to her side of the room after dinner sometime and lashed out at her hitting her, causing several small scratches on her hand. She stated she was fending off the blows with her arm raised. and Resident #521's fingernails scratched her. She went on to state that the staff saw it and moved her out of the room until they could find a place for Resident #521. She stated that Resident #521 was moved Sometime late that night around midnight. Resident #20 was asked if she was afraid of Resident #521, and she stated no, she went to the hospital and I don't think she's ever coming back. Nursing staff on the units where Resident #521 was housed were interviewed and stated they remembered Resident #521, and her aggressive behaviors, however, those working during survey interviews were not present during the abuses. They stated they were aware of the incidents, however, most of the staff were from a staffing agency and did not work there every day. During interview and review of the clinical record, it was found that the Social Worker/Discharge Planner (SWDP) was only involved with Resident #521 on 3 occasions. Those instances follow below: 1. Nine days after admission on 9-13-24 for a Trauma Informed Care assessment which was negative for trauma experienced by the Resident. 2. After the first abuse on 9-20-24 to Resident #68, to notify Resident #521's son of the first room change. 3. Finally, at the first Interdisciplinary care plan meeting on 9-26-24 with only the SWDP and the Activity Assistant present. A copy of all Facility Reported Incidents (FRI's) for the prior 6 months were requested. 10 were provided by the Administrator, and 9 of the 10 followed the standardized format and documentation was provided for notification of the state agency the Virginia Department of Health Office of Licensure and Certification (VDH/OLC), the state Long Term Care Ombudsman, and Adult Protective Services (APS). The 9 completed FRI's were all prior to 9-20-24. The tenth alleged FRI involving Resident #68, and Resident #521 was incomplete and contained 7 documents. The documents included four statements from staff alleging abuse to Resident #68. One of the staff statements alleged repeated abuse allegations documented from 9-17-24 through 9-20-24 and for over a week. Also included was a fifth documented statement from the Resident alleging verbal and physical abuse. The sixth document was a written synopsis by the Administrator which was not signed, and only described the initial abuse allegation for Resident #68. It did not include Resident #20's abuse by Resident #521, the room changes, nor the incident with the unknown neighbor after being installed in the third room. The seventh document was a response from APS stating that the report to them did not meet validity criteria required to initiate an APS investigation. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator's synopsis stated that Resident #68 was asked what was triggering Resident #521's behavior, which implies that the victim is the causative factor, or that the victim is able to psychologically assess her room mate who only spoke Spanish, and Resident #68 only spoke English. The synopsis also stated that Resident #521 would be moved to a room with someone more compatible. The Administrator's synopsis goes on to describe Resident #521 as having a BIMS score of 3 points out of a possible 15 points indicating severe dementia, which was incorrect. The Resident's BIMS score was 12. The state agency VDH/OLC did not receive the fax sent by the Administrator and review of the fax number revealed it to be in error. All of the documents were completed on 9-20-24, the initial day of assault reporting on Resident #68, and #521. There was no report, investigation, nor protections for Resident #20 after her multiple assaults on 9-21-24, nor for the unknown Resident on 9-22-24 after a third room was inhabited by Resident #521 in less than 48 hours. The Administrator was interviewed on 10-8-24, and was asked why the document from 9-20-24 was not completed as the other FRI's were, his response was that he had only been here 4 weeks, and I am not required by law to use the FRI document, and I have all of the investigation, and here it is, this is the initial and 5 day follow up all in one. The synopsis was simple typed document on a clean white unlined sheet of copy paper, and did not state that it was an initial FRI, nor a 5 day follow up, and it was not signed. Included in the packet were 3 copies of a fax cover sheet To: VDH/APS/[NAME] From: (first name & last name first letter only) the Administrator, documenting that the fax contained 2 pages. The fax was sent on 9-20-24, at 2:24 PM, 2:26 PM, 2:27 PM respectively. The Administrator stated he wrote the synopsis, and sent the fax, and that in error he didn't sign it. This indicates the only 2 sheets allegedly sent were the fax cover sheet and the synopsis which was not signed, and did not state it was an initial FRI, nor a 5 day follow up. At that time the Administrator was informed that the investigation was incomplete as no FRI was ever received at the state agency VDH/OLC for the first allegation of abuse. The other 2 Resident's who were later involved were not protected from abuse and added to the initial investigation, and a 5 day follow up as required by law would have captured them as well. The Administrator was made aware that no second FRI and investigation was ever conducted after further abuse from Resident #521 on Resident #20, and the unknown Resident. Residents were not protected from a known abuser. Further they had not implemented their policies on abuse. The facility staff provided a copy of their Abuse policy, and the policy review revealed that all allegations of abuse will be investigated, Residents will be protected and prevented from further abuse, reports will be sent initially to the State agency VDH/OLC (and other agencies) within 24 hours or within 2 hours if serious injury occurs, and a follow up report will be sent in 5 days to include findings and corrections. Resident #68 reported abuse for days before staff observed the abuse and moved Resident #521. Resident #521 was then placed with Resident #20 who was not protected and was abused. Resident #521 was moved again and went to a third unknown Resident's room to abuse. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The allegations were never reported to the state agency. Residents were not protected from a known abuser. Abuse was not investigated fully, and the facility policy was not implemented for the protections of Residents from abuse. Further, there was never any added staff supervision for Resident #521 to prevent the abuse from continuing. No staff ever noted the suspicion of a crime, so no police report was ever filed. The first alleged report by the Administrator was never signed and had errors in information giving the appearance of a severely demented alleged abuser to APS in a single occurrence resulting in no investigation opened by them. On 10-9-24 at approximately 5:30 p.m., the facility Administrator, Corporate Registered Nurse, and Corporate Administrator were notified of the findings. They stated they had no further information or documentation to offer.		

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NAME OF PROVIDER OR SUPPLIER Virginia Beach Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 Camelot Drive Virginia Beach, VA 23454	
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on a clinical record review and staff interview the facility staff failed to thoroughly and accurately complete the Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability (PASARR) for 2 of 55 residents (Resident #56 and #28), in the survey sample. The findings included: 1. The facility staff failed to code Resident #56's PASARR assessment for a current serious mental illness. Resident #56 was originally admitted to the facility 6/1/24 and readmitted [DATE] after an acute care hospital stay. The resident's current diagnoses included Post Traumatic Stress Disorder (PTSD), an anxiety disorder, ODC, personality hysterical and a major depressive disorder with recurrent, severe psychotic symptoms. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/2/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #56's cognitive abilities for daily decision making were intact. The resident's current care plan had a problem which stated the resident has signs and symptoms of depression and is at risk for adverse reactions. The goal read the resident will not have any adverse effects from depressive symptoms through 12/16/24. The intervention included administer medications as ordered and referral to psych services. The Physician's Order Summary included orders for Trazodone HCl Oral Tablet 150 MG - administer one (1) tablet by mouth at bedtime for a major depressive disorder, ordered 9/4/2024. Clomipramine HCl Oral Capsule 50 MG - administer three (3) capsule by mouth one time a day for a major depressive disorder, ordered 9/4/2024. Resident #56 received mental health services on 9/27/24, 9/6/24, 8/16/24 and 7/29/24. A review of Resident #56's PASAAR assessment completed on 9/4/24 revealed that she was not coded as having a current serious mental illness. A review of the resident's most recent mental health assessment dated [DATE] stated she was being treated for depression and an anxiety disorder and she continues to benefit without adverse effects from her current psychotropic medication regimen. The recommendation was to continue the medication regime as prescribed for the resident was stable at the current dose and a dose reduction attempt would cause decompensation of the resident. On 10/9/24 at 1:40 PM an interview was conducted with the Social Worker (SW). The SW stated the PASARR was not coded for a serious major mental illness diagnosis because the resident had not been treated for a mental health disorder in two years. In July 2024 the resident PHQ-9 was positive for signs of depression and she continued to remain on a medication regimen for depression and an anxiety disorder. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Family Member (FM) #4 on 10/7/24 at 5:46 PM. FM #2 stated the resident had a long history of mental health concerns and she was followed in the community by the community services board. FM #4 stated that the resident's long history of mental health concerns was why she did not have children and it had impacted her entire life. On 10/11/24 at approximately 8:15 PM, a final interview was conducted with the Administrator, Interim Administrator, Director of Nursing and two regional Nurse Consultants. They had no comments and voiced no concerns regarding the above information. 40711		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 31199 Based on Resident staff interview, facility documentation review, and clinical record review, the facility staff failed to provide a comprehensive care plan for care and services to maintain the highest practicable well being for two residents, (Resident #73, and #521) in a survey sample of 55 residents. The findings included: 1. Resident #73 had contractures with splints and palm guards required to prevent further contracture and maintain skin integrity. No care plan was ever devised for the palm guards and the splinting care plan was not individualized nor Resident centered. Resident #73, with contracted fingers of the left hand, experienced a pressure sore injury from his fingernails pressing into his palm. The pressure sore became infected resulting in cellulitis, which led to the identification of the pressure sore injury in the facility. The pressure sore and resulting infection caused the Resident to be sent out to the hospital for treatment with IV (intravenous) antibiotics for 10 days. The facility staff were unaware of the wound prior to the infection, and had not been applying the Residents hand splint (palm guard) to prevent the wound. Resident #73 was originally admitted to the facility on [DATE], was hospitalized on [DATE] for a pressure sore injury with infection and cellulitis, and returned 10 days later on 6-1-24. Diagnoses included; acute infection/cellulitis of upper left limb, stroke with left hemiplegia, dementia, contractures of left side limbs, dysphagia, epilepsy, hypertension, hypernatremia, and vitamin D deficiency. Resident #73's most recent Minimum Data Set assessment was a Significant change assessment with an assessment reference date of 7-29-24. Resident #73 had a Brief Interview of Mental Status score of 99 indicating severe cognitive impairment. He required extensive to total assistance with eating, bathing and personal hygiene. He was coded to have impaired Range of Motion on both upper extremities, and one lower extremity. He was coded with no behaviors, no swallowing difficulty, and had a mechanically altered regular pureed diet. On 10-4-24 at approximately 12:00 PM, during continued tour of the facility, Resident #73 was observed eating lunch and being fed by a Certified Nursing Assistant (CNA). The Resident's hands were both contracted. He was not observed to be wearing a palm guard nor any other type of equipment in the upper extremities. Physician and Nursing progress notes were reviewed for information on the Resident's contractures, left palm pressure wound, and splint usage. That review revealed that From 5-1-24 through 5-19-24 the Resident had no skin wounds. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5-20-24 at 2:20 PM, the Physicians Assistant (PA) documented Patient seen today for nursing reports of wound to the left palm. Left hand is contracted. Drainage, erythema and swelling noted. Patient says ouch when I touch his hand. Comments; one centimeter wound to the left palm with surrounding erythema and swelling that extends into his middle finger. Hand is warm to touch. Hand is contracted so range of motion is limited. Pain states ouch when I move his hand. Assessment and plan; Cellulitis secondary to wound of the left hand. Wound appears to have been caused by (finger) nail of contracted hand being dug into his palm. Palm guard present at bedside but it is unclear how often it is actually being placed on the patient's hand. Swelling and erythema extends into middle finger and dorsal aspect of the hand. Wound cleaned with DWC (Dakin's wound Cleanser) and bandaged. Palm guard placed. Plan: Wound care - Left hand palm cleanse with wound cleanser, pat dry with gauze, then apply antibiotic ointment to wound bed, cover with dry dressing daily and as needed. Apply palm guard, only remove when eating. Start Keflex 500 mg 4 times per day for 7 days. Monitor closely, if wound worsens consider labs and additional antibiotics emergency room visit if warranted. The Resident's care plan was reviewed and interventions revealed a focus for refusing to wear splint to (bilateral upper extremities/bilateral lower extremities - Bean Bag.) Cellulitis resolved 7-6-24. There was never a care plan devised for the application of palm guards. Progress notes review revealed no refusals for splint (palm guards) nor bean bag placement, and no other aberrant behaviors nor refusals were documented for this Resident. The Resident's Kardex which is used by CNA's as a care plan to guide specific care for each resident need, was reviewed and revealed bean bag splints as tolerated with no other instruction on use, nor location of use, and no mention of the palm guards. Staff were unaware of the palm guard need. Palm guards were not used consistently, which resulted in a pressure sore injury to the Resident's left palm. 2. Resident #521 abused 3 Residents in the facility and exhibited aggressive behaviors and signs of distress which were never assessed and care planned. For Resident #521 the facility staff failed to obtain a physician ordered psychiatric consult timely, failed to conduct behavior monitoring, failed to provide a comprehensive care plan for emotion regulation, failed to identify stressors and responses such as language barrier and supervision, to those stressors, which resulted in aggressive behaviors aimed at and impacting other residents. The facility failures described above resulted in the willful abuse of Residents #68, #20, and a third unknown Resident victim as perpetrated by Resident #521. Resident #521 was not receiving any psychotropic medications, to include antidepressants. Resident #68 (victim 1) was admitted to the facility on [DATE]. Diagnoses included but were not limited to: heart failure, hypertension, high cholesterol, malnutrition, peripheral venous insufficiency, hypothyroidism, rheumatoid arthritis, scoliosis, rhabdomyolysis, and foot pain. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #68's most recent Minimum Data Set with an Assessment Reference Date of 8-2-24 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and her own responsible party. The Resident required extensive assistance from one staff member for hygiene and bathing. The Resident had no aberrant behaviors documented, and had no complaints against any other staff or situations since her admission on 11-14-19. Resident #20 (victim 2) was admitted to the facility on [DATE]. Diagnoses included but were not limited to chronic ischemic heart disease, stroke with hemiplegia right side, anemia, diabetes, chronic hepatic failure, neck fracture, chronic kidney disease, depression, and femur fracture. Resident #20's most recent Minimum Data Set was a quarterly assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and her own responsible party. The Resident was independent for transferring and used a motorized wheel chair to leave the building for shopping trips to walmart using a van. The Resident had no aberrant behaviors documented, and had no complaints against any other staff or situations since her admission on 7-18-23. Resident #521 (perpetrator of 1 and 2) was admitted to the facility on [DATE], went back out to the hospital for syncope on 9-5-24, and returned on 9-8-24. Hospital discharge records indicated that the Resident was alert and oriented to person, place and time, and was ambulatory at the time of discharge. Diagnoses included but were not limited to: Heart failure, hypertension, Gastro Esophageal reflux disease, renal insufficiency, diabetes, thyroid disorder, dementia, malnutrition, and asthma. Resident #521's most recent Minimum Data Set with an Assessment Reference Date of 9-5-24 after one day in the facility was coded as an admission assessment. The Brief Interview for Mental Status was coded as 12 out of a possible 15 points which indicated mild cognitive impairment, however, the language barrier may have contributed to a false lower score. The Resident was her own responsible party. The Resident spoke only Spanish. The Resident required extensive assistance from one staff member for hygiene and bathing. On 10-1-24, the first day of survey, Resident #521 went out to a medical appointment and lost consciousness while there. She was sent directly to the hospital, and did not return during the remainder of the survey. While on continued tour of the facility on 10-4-24, Resident #68 was interviewed and asked if any person in the facility had abused her or if she had ever witnessed abuse. She stated yes that her former room mate (Resident #521) had kicked her, thrown fruit at her, hit her, and had spit on her. She stated that Resident #521 had also cursed and yelled at her, gotten in her bed, held her wheel chair so she could not leave the room for help, and had stood over her while she was laying in bed menacing her. She stated that she had been bruised by the kick and punch, but luckily suffered no other injuries. She further stated that she had complained to staff repeatedly but they did nothing until 9-20-24 when Resident #521 punched her in the arm and the Assistant Director of Nursing saw it. She went on to say that they moved her that day. The Resident was asked if she was still afraid and she stated no, she's gone now. On 10-7-24 the clinical records of Resident's #68, and #521 were reviewed. Those reviews contained the following information in chronological order; (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Virginia Beach Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 Camelot Drive Virginia Beach, VA 23454	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9-20-24 at 3:42 PM the records indicated that Resident #521 had been moved to another room for Safety. No other descriptions about the allegations of abuse on Resident #68 were documented. On 9-20-24 Resident #521's progress notes documented she was moved to the room containing Resident #20. On 9-21-24 at 12:47 AM (7.5 hours later) after the move, progress note review indicated that Resident #521 was observed to throw a cup of water across the room and spit on her new room mates charger for her electric wheel chair. On 9-21-24 at 8:41 PM, Later the same day, documents record Resident #521 hit Resident #20 and it was witnessed by staff. There was no mention of the scratches to Resident #20 inflicted by Resident #521. On 9-22-24 at 1:34 AM (5 hours later) progress notes go on to describe that Resident #521 was moved to a private room. (Victim #3 unknown name) On 9-22-24 at 2:54 AM, (1.5 hours after move) another note describes Resident #521 as standing next to her neighbors bed (unknown which neighboring room to the private room or which Resident this involved) staring at her (the neighbor of Resident #521) while sleeping and threatened anger aggressive behavior. On 9-23-24 a psychiatric consultation was ordered. It was never obtained. On 9-25-24 the Physician's Assistant (PA) described in a note that (Resident #521) Patient assault on room mate multiple times, resident denied, on alternate location at this time. On 10-7-24 Resident #20 was interviewed and stated that Resident #521 was placed in her room and almost immediately began to yell at her, spit at her, and throw things at her. She went on to state that Resident #521 finally came over to her side of the room after dinner sometime and lashed out at her hitting her, causing several small scratches on her hand. She stated she was fending off the blows with her arm raised. and Resident #521's fingernails scratched her. She went on to state that the staff saw it and moved her out of the room until they could find a place for Resident #521. She stated that Resident #521 was moved Sometime late that night around midnight. Resident #20 was asked if she was afraid of Resident #521, and she stated no, she went to the hospital and I don't think she's ever coming back. Nursing staff on the units where Resident #521 was housed were interviewed and stated they remembered Resident #521, and her aggressive behaviors, however, those working during survey interviews were not present during the abuses. They stated they were aware of the incidents, however, most of the staff were from a staffing agency and did not work there every day. During interview and review of the clinical record, it was found that the Social Worker/Discharge Planner (SWDP) was only involved with Resident #521 on 3 occasions. Those instances follow below: 1. Nine days after admission on 9-13-24 for a Trauma Informed Care assessment which was negative for trauma experienced by the Resident. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. After the first abuse on 9-20-24 to Resident #68, to notify Resident #521's son of the first room change. 3. Finally, at the first Interdisciplinary care plan meeting on 9-26-24 with only the SWDP and the Activity Assistant present. The facility staff provided a copy of their Abuse policy, and the policy review revealed that all allegations of abuse will be investigated, Residents will be protected and prevented from further abuse, reports will be sent initially to the State agency VDH/OLC (and other agencies) within 24 hours or within 2 hours if serious injury occurs, and a follow up report will be sent in 5 days to include findings and corrections. Resident #68 reported abuse for days before staff observed the abuse and moved Resident #521. Resident #521 was then placed with Resident #20 who was not protected and was abused. Resident #521 was moved again and went to a third unknown Resident's room to abuse. The allegations of abuse were never reported to the state agency. Residents were not protected from a known abuser. Abuse was not investigated fully, and the facility policy was not implemented for the protections of Residents from abuse. Further, there was never any added staff supervision for Resident #521 to prevent the abuse from continuing. No staff ever noted the suspicion of a crime, so no police report was ever filed. The first alleged report by the Administrator was never signed and had errors in information giving the appearance of a severely demented alleged abuser to APS in a single occurrence resulting in no investigation opened by them. Resident #521's nursing and physician progress notes were reviewed and revealed the following: 9-8-24 nurses documented Resident with language barrier (speaks only Spanish) states frustration with interpreter. 9-11-24 the physician documented Plan: - The patient has had a diagnosis of depression or has had a diagnosis of Bipolar Disorder. 9-12-24 nurses documented refused, wants to be left alone to therapy, refused weight yelling in Spanish 9-19-24 nurses documented Google translator only means of translation in the facility. 9-20-24 nurses documented room change for safety. 9-21-24 12:47 AM nurses documented woke from nap anxious, stating dead bodies everywhere, resident extremely restless and gestures for sleep but will not stay in bed more than 15-20 minutes at a time. 9-21-24 10:41 PM nurses documented Aggression and hitting roommate, removed from room. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9-22-24 1:34 AM nursing notes documented another room change to a private room. 9-22-24 2:54 AM nursing notes Aggressive behavior standing over sleeping neighbor threatening neighbor room. 9-23-24 2:45 PM nursing note Psyche consult placed in psyche referral book. 9-23-24 11:12 PM nursing note difficulty communicating with Resident. 9-25-24 physician documented resident's roommate spoke up about Resident #521 laying hands on her multiple times. Staff made aware, management involved, room changed. That reveals that the physician was only aware of one abuse victim, and not the other two. Resident #521's frustration was identified on day 1, and no plan was implemented to improve communication between staff and residents for this Resident. The psychiatric evaluation was put in a book at the nursing station awaiting the next visit from psyche professionals to see other residents before they knew Resident #521 needed services. This was revealed during interview at the nursing station when the consult book was requested, on 10-7-24 they stated that's our procedure. From 9-4-24 through 10-1-24 (28 days), no psychosocial nor behavioral services were ever afforded a disturbed Resident #521 even after 3 abuses of other Residents and aggression toward staff. Resident #521's care plan was reviewed and revealed no focus nor interventions for dementia, language barrier, nor behaviors was ever derived nor implemented before or after the abuses occurred. Resident #521's physician's orders and progress notes were reviewed and revealed On 9-8-24 Geriatric psyche consult (as needed) PRN. No other assessments nor orders for behavioral health support were ever obtained. On 10-9-24 at approximately 5:30 p.m., the facility Administrator, Corporate Registered Nurse, and Corporate Administrator were notified of the findings. They stated they had no further information or documentation to offer.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on observations, Resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to follow the professional standards of nursing practice for 2 residents, (Residents #89, and #161) in a survey sample of 55 residents. The Findings Included: 1. For resident #89 the facility staff failed to apply a Cardiac Monitor, to the Resident for the required time frame to capture and diagnose the cause of repeated syncopal episodes from suspected heart arrhythmias (irregular heart beats). Resident #89 was admitted to the facility on [DATE], and readmitted on [DATE], after a 6 day hospitalization . Diagnoses included; Chronic Kidney disease, sick sinus syndrome after syncope and collapse on 7-12-24, dementia, hypertension, malnutrition, stroke, and anemia. Resident #89's most recent Minimum Data set assessment was a quarterly assessment with an assessment reference date (ARD) of 8-1-24. Resident #89 was coded with a Brief Interview of Mental Status score of 3 indicating severe cognitive impairment. Resident #89 required extensive to total assistance from one to two staff members, with all activities of daily living. Resident #89's clinical record was reviewed on 10-7-24. The Resident's Medication Administration and Treatment Administration Records (MAR's/TAR's) and Physician's Orders revealed an order for Change cardiac monitor patch every 7 days starting 7-25-24. Discontinue patch and mail back (monitor) on 8-18-24 at 11:59 PM. Clinical hospital records indicate that the Cardiac monitoring was initiated in the hospital just prior to discharge on 7-18-24. The first change for the patch would have been completed 7 days later on 7-25-24, and then every 7 days after that on: 8-1-24, 8-8-24, 8-15-24, and finally removed on 8-18-24 after monitoring for 30 days (4 weeks). The monitor would have then been mailed back to the physician who ordered it, or the company which supplied it who would provide a report to the cardiology doctor. The TAR review revealed that the monitor/patches were not signed off as completed as ordered, and the monitor was discontinued 14 days early on 8-4-24, after only 2 weeks. Review of nursing and physician progress notes do not indicate a reason for the early discontinuance. On 8-19-24 (2 weeks after early discontinuance) the Physician's Assistant (PA) documented the following in the Physician progress notes; In the past 60 days the treatment plan has been closely monitored and adjusted when necessary to provide the patient with the best optimal health possible to prevent injury, prevent hospitalization , and improve quality of life. Cardiac monitor end date 8-18-24. Need to follow up with nursing to ensure this was mailed back. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The above note written by the PA revealed that the physicians treating in the facility were unaware that the monitor had been discontinued halfway through the ordered monitoring. The Resident's care plan was reviewed and documented an intervention for the cardiac monitoring to end on 8-18-24 and send the patch monitor by mail as ordered. On 10-8-24 at 11:00 a.m., 11:30 a.m., and 1:30 p.m., observations of Resident #89 were conducted. The Resident was alert, pleasant, talkative, and oriented to person, place, and time of day. The Resident stated she had enjoyed her lunch and her food tray was noted to be empty with only smears of what she had eaten 100% of for the meal. She stated I'm still hungry it wasn't much, can you get me a sandwich or something. The Resident was asked if she remembered going to the hospital and wearing the patch on her chest which was a heart monitor. She stated she did not remember it. On 10-8-24 at 3:00 PM, the current Assistant Director of Nursing ADON was interviewed, and stated that the Administrator had only been in the building for a month, the Director of Nursing had just started this week, and she (ADON) had no recollection of the cardiac monitor for that Resident. The PA which had been involved in the Resident's care was called via cellular phone, however, could not be contacted. Nursing staff on the Resident's nursing unit were interviewed and only 1 of 3 stated they did remember the monitor, however, the nurse was from an agency and worked there sporadically so had little contact with the Resident stating maybe twice during August. On 10-9-24 at 4:30 p.m., in the conference room with surveyors, the Administrator stated he was not in the building during that time, and they had 4 Directors of Nursing (DON's) in less than 1 year. He was made aware by surveyors that the Resident did not receive the cardiac monitoring as ordered for Resident #89, and also that the constant turn over in facility staff, and the daily presence of off site agency nursing staff, has been known to result in poor continuity of care. The Registered Nurse Corporate Consultant stated [NAME] as their nursing reference for their standards of practice. [NAME] Fundamentals of Nursing, provides the following guidance regarding physicians' orders, Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients. The facility Administrator and DON stated that they had no further information to provide. 34894 2. For Resident # 161. the facility staff failed to ensure antibiotics were administered as ordered by the physician. Resident # 161 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, Primary Osteoarthritis of the Knee, Septic Arthritis of the Knee, Heart Failure, and Edema. The most recent Minimum Data Set (MDS) was an Admission Assessment with an Assessment Reference Date (ARD) of 9/10/2024. Resident # 161's BIMS (Brief Interview for Mental Status) Score was a 14 out of 15, indicating no cognitive impairment. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Virginia Beach Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 Camelot Drive Virginia Beach, VA 23454	
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record was conducted on 10/9/2024-10/11/2024. Review revealed that on admission, Resident # 161 had a PICC (Peripherally inserted Central Catheter) and an order for Cephalexin Intravenously for 17 days and was being followed by an Infectious Disease Physician. Resident # 161 was seen by the Infectious Disease Physician on 9/18/2024 and the antibiotic was changed to an oral antibiotic to be given for 14 days. Review of the Physicians Orders revealed an order for: Amoxicillin Oral Capsule 500 mg (milligrams) Give 2 capsules by mouth three times a day related to Arthritis due to other bacteria, left knee, for 14 Days. Give with food. Order Date-09/18/2024 0833 Review of the September 2024 Medication Administration Record revealed he medication was scheduled for administration at 9:00 a.m., 2:00 p.m., and 9:00 p.m. and to stop on 10/1/2024 at 9:00 p.m. Further review revealed there were six doses not administered during the course of treatment. Amoxicillin was not administered on: 9/21/2024 at 9:00 p.m. 9/28/2024 at 9:00 p.m. -medication on order 9/29/2024 at 9:00 a.m. -on order ok to hold per provider 9/29/2024 at 2:00 p.m. -on order ok to hold per provider 9/29/2024 at 9:00 p.m. -on order 10/1/2024 at 9:00 a.m.-NONE AVAILABLE, PA (Physician Assistant) MADE AWARE. RX-(Pharmacy) CONTACTED On 10/11/2024 during clinical record review, it was noted that Resident # 161's order for Amoxicillin was supposed to be administered for 14 days. The Medication Administration Record revealed there had been 6 doses missed during the prescribed course of treatment. Four consecutive doses were missed from 9/28/2024 at 9:00 p.m. to 9/29/2024 at 9:00 p.m. The six missed doses equated to a total of two full days of missed doses. There was no indication that the antibiotic was extended to additional days to cover the missed doses. There was no documentation that the Infectious Disease Physician was notified of the missed doses. On 10/11/2024 at 1:10 p.m., an interview was conducted with the Regional Nurse Consultant (Corporate-2). She was asked if antibiotics should be continued as ordered. She stated it was very important. When asked why it was important to continue the antibiotics as prescribed, Corporate-2 stated that it was important because the antibiotics were prescribed to kill the bacteria. She also stated that taking all of the antibiotic as prescribed would prevent the bacteria from growing and becoming antibiotic resistant. Corporate -2 stated she had reviewed Resident # 161's record and noted the resident was seen by the Infectious Disease Physician who discontinued the IV antibiotics and changed to oral Amoxicillin 500 milligrams two capsules by mouth three times per day for 14 days. Corporate-2 stated the nurses should have administered the Antibiotic to Resident # 161 as ordered. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/2024 at approximately 3:20 p.m., another interview was conducted with the Regional Nurse Consultant (Corporate-2) who stated the Pharmacy was responsible for delivery of medications. Corporate-2 stated the nurses had access to medications that were delivered to the facility. If a medication was not available at the time of scheduled administration, the nurses should go to the Omnicell (on-site Stat box) to see if the medication was available in that stock. Corporate-2 stated if the medication was not in the Omnicell, the nurse was expected to inform the physician to see if there was another medication order or if the doctor would give the approval for the medication to be started later when available from the Pharmacy. Corporate-2 stated Resident # 161 should not have had any missed doses since the blister pack should have been received on the first day the medication was ordered. Corporate-2 also stated it was important for the antibiotics to be given timely and four consecutive doses should not have been missed. Review of the Omnicell STAT box contents revealed the medication, Amoxicillin 250 milligrams, was on hand. There was a quantity of 10 tablets in the box. The nurses could have retrieved the medication from the Omnicell STAT box. According to the Mayo Clinic, antibiotics are important drugs that can successfully treat infections caused by bacteria. Antibiotics can prevent the spread of disease. The way drugs are used affects how quickly and to what degree resistance occurs. It also stated: You need to to take the full treatment to kill the disease-causing bacteria. If you do not take an antibiotic as prescribed, you may need to start treatment again later. If you stop taking it, it can also promote the spread of antibiotic-resistant properties among harmful bacteria. The article also stated that Drug resistant infections can cause many problems including: More-serious illness, longer recovery, more-frequent or longer hospital stays, more health care provider visits and more-expensive treatments. Complete the entire treatment. According to Lippincott Nursing Procedures, Eighth Edition, Chapter 2, Standards of Care, Ethical and Legal Issues, on page 17 read, Common Departures from the Standards of Nursing Care. Claims most frequently made against professional nurses include failure to make appropriate assessments, follow physician orders, follow appropriate nursing measures, communicate information about the patient, follow facility policy and procedures, document appropriate information in the medical record . Guidance from the National Institutes of Health in the article The nurses medication day stated that Nurses serve as a barrier, protecting residents from potential hazards. Calls were also common to request 'missing meds' (medications) followed by waits until they were delivered. Waiting reflected system failures ncbi.nlm.nih.gov accessed 10/15/2024. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the end of day debriefing on 10/11/2024, the Facility's Acting Administrator, Administrator in Training, Regional Nurse Consultant (Corporate-2) and Director of Nursing were informed of the findings. The nurses failed to ensure the antibiotics were administered as prescribed by the Physician. No further information was provided.		

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on family interview, staff interviews, and clinical record review, the facility staff failed to have an ongoing discharge planning process which focused on the resident's/resident representative discharge goals for 1 of 31 residents (Resident #119), in the survey sample. The findings included: Resident #119 was originally admitted to the facility 2/17/23 and readmitted [DATE] after an acute care hospital stay. The resident's current diagnoses included intellectual disability, aphasia and a history of cancer of the colon which required a hemicolectomy and resulted in an ileostomy. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/3/24 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making abilities. The resident was admitted on [DATE] to the nursing facility after surgery for colon cancer. The resident was to receive rehabilitation services and surgical wound care while in the nursing facility because the Intermediate Care Facility (ICF) could not manage the surgical wound care. A review of the resident's person centered care plan dated 2/21/23, revealed the resident/resident representative preference was discharge from the facility and return to the ICF. An interview was conducted on 12/4/24 at approximately 2:20 PM with the Family Member (FM) #2. FM #2 stated that it was always their goal for Resident #119 to return to the ICF. FM #2 stated the barrier was the staff inability to heal the residents skin around the ileostomy and the stoma. FM #2 stated the resident's skin problems continued because the nurses used the wrong size stoma wafer, they frequently allow the ileostomy bag to become too full before they emptied it and they don't provide ileostomy care as frequently as necessary. FM #2 further stated the facility's lack of proper care resulted in stoma and skin irritation which has prevented him from transitioning back into the community. FM #2 stated the resident's skin has been healed approximately 2 months and the opportunity for the resident to transfer back into the community was now, but the staff is not working towards the goal of discharging him from the nursing facility to an ICF. On 12/4/24 at approximately 2:55 PM, an interview was conducted with the Discharge Planner (DP). The DP stated the resident's medical record had a progress note which read after the surgical wound was healed the resident would be transferred back to the ICF. The DCP stated that Resident #119's last day of covered rehabilitation services was 5/27/23 and the wound was not healed therefore the ICF would not accept the resident because of the unhealed surgical wound. The DCP stated when the payer source changed on 5/28/23 the resident remained in the facility as a long term care resident and his discharge status changed to long term care (LTC) the discharge status also changed from discharge to the community to LTC. (continued on next page)		

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing and two regional Nurse Consultants. The Administrator stated they had begun seeking appropriate placement for Resident #119 in the community.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 31199 Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to ensure two Residents (Resident #89 and #68) received ADL (activities of daily living) care to include hygiene and showers in a survey sample of 55 residents. The findings included: 1. For Resident #89 her fingernails were long and dirty/encrusted with a brown substance, and the resident did not receive twice weekly showers. Resident #89 was admitted to the facility on [DATE], and readmitted on [DATE], after a 6 day hospitalization . Diagnoses included; Chronic Kidney disease, sick sinus syndrome after syncope and collapse on 7-12-24, dementia, hypertension, malnutrition, stroke, and anemia. Resident #89's most recent Minimum Data set assessment was a quarterly assessment with an assessment reference date (ARD) of 8-1-24. Resident #89 was coded with a Brief Interview of Mental Status score of 3 indicating severe cognitive impairment. Resident #89 required extensive to total assistance from one to two staff members, with all activities of daily living. Resident #89's clinical record was reviewed on 10-8-24. ADL (Activities of Daily Living) care records revealed from 9-8-24 through 10-7-24 (30 days) the Resident received only 2 baths. The record indicated a refusal one day, however, it was the only refusal in 30 days. Review of the facility's policy regarding general ADL care included the fact that nursing personnel would provide basic nursing care and services following accepted standards of practice guidelines, and the fact that resident specific care activities will be reflected in the resident plan of care. The Resident's care plan was reviewed and revealed no bathing care plan for this Resident who was completely dependant on staff. On 10-8-24 at 11:00 a.m., 11:30 a.m., and 1:30 p.m., observations of Resident #89 were conducted. The Resident was alert, pleasant, talkative, and oriented to person, place, and time of day. The Resident was in a reclined side sitting position facing the window and stated she had enjoyed her lunch and her food tray was noted to be empty with only smears of what she had eaten 100% of, for the meal. She stated I'm still hungry it wasn't much, can you get me a sandwich or something. The Resident's finger nails were approximately 1/2 inch long, jagged and completely encrusted underneath with a hard dry tan substance. The surveyor told her she might need to wipe her hands that she had what looked like food under her nails, and she stated she had a stroke and could not do it. She was asked if she would enjoy having a bath and her nails cleaned and groomed, and she replied oh! that sounds wonderful. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10-8-24 at 2:00 PM, the nursing staff on the Resident's nursing unit were interviewed and only 1 of 3 stated they knew her, however, the nurse was from an agency and worked there sporadically so had little contact with the Resident stating she had taken care of the Resident maybe twice during August. An interview with CNA (certified nursing assistant) on the hall of the Resident stated I work mostly on the other unit but I am just helping get someone else up with the hoyer lift. She went on to state she knew Resident #89 and stated, On shower days, she is gotten up with a Hoyer lift. We do look at their nails while they are being bathed. Both staff members stated the expectation for baths is 2 per week or more if necessary and nail care every day. On 10-9-24 at 12:00 PM the Director of Nursing (DON) was interviewed and asked what the expectation was for bathing residents and she stated 2 times per week minimum and more as needed. She was made aware at that time that Resident #89 had only had two baths in 30 days. On 10-9-24 at 4:30 p.m., in the conference room with surveyors, the Administrator stated he had only been in the building for 4 weeks, and they had 5 Directors of Nursing (DON's) in less than 1 year. He was made aware by surveyors that the Resident had only received bathing twice in the last 30 days, and that she had not been afforded sufficient hygiene/nail care. A discussion ensued regarding the fact that the constant turn over in facility staff, and the daily presence of off site agency nursing staff, has been known to result in poor continuity of care. The facility Administrator and DON stated that they had no further information to provide. 2. For Resident #68 the resident complained of not receiving twice weekly showers, even after requesting them. Resident #68 was admitted to the facility on [DATE]. Diagnoses included but were not limited to: heart failure, hypertension, high cholesterol, malnutrition, peripheral venous insufficiency, hypothyroidism, rheumatoid arthritis, scoliosis, rhabdomyolysis, and foot pain. Resident #68's most recent Minimum Data Set with an Assessment Reference Date of 8-2-24 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and her own responsible party. The Resident required extensive assistance from one staff member for hygiene and bathing. The Resident had no aberrant behaviors documented. While on continued tour of the facility on 10-4-24, Resident #68 was interviewed and had several areas of concern reported to the surveyor. The area of greatest concern was the fact that she could not get baths twice per week. She stated staff constantly told her they were short when she asked for a bath, and she stated it helped her back pain from a spinal fracture and scoliosis. She went on to say staff is always out with smokers and didn't ask her until 9 PM or 10 PM, after she was in bed, on one occasion. She stated she had only one bath in the last month. Bathing records were reviewed on 10-9-24 at 11:00 AM and revealed that the Resident's bathing schedule was to be on Mondays and Thursdays, on the 3:00 PM to 11:00 PM shift. Documentation by staff indicated that from 9-8-24 she received a bath on Thursday 9-19-24. The Resident had no other baths through 10-9-24. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Certified Nursing Assistants (CNA's) on the Resident's unit were interviewed and stated that the Resident was a 3-11 PM bath, and no one had told them that her bath had been skipped, or they would have helped her on the 7:00 AM -3:00 PM shift. On 10-9-24 at 12:00 PM the Director of Nursing (DON) was interviewed and asked what the expectation was for bathing residents and she stated 2 times per week minimum and more as needed. She was made aware at that time that Resident #68 had only had one bath in 30 days. On 10-9-24 at 4:30 p.m., in the conference room with surveyors, the Administrator stated he had only been in the building for 4 weeks, and they had 5 Directors of Nursing (DON's) in less than 1 year. He was made aware by surveyors that the Resident had only received bathing once in the last 30 days, and that she had not been afforded sufficient ADL care. A discussion ensued regarding the fact that the constant turn over in facility staff, and the daily presence of off site agency nursing staff, has been known to result in poor continuity of care. The facility Administrator and DON stated that they had no further information to provide.		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on observation, staff interview, facility documentation review, and clinical record review the facility staff failed to prevent, assess, identify and treat an avoidable pressure ulcer resulting in harm for one Resident (Resident #73) in a survey sample of 55 Residents. The findings included: Resident #73, with contracted fingers of the left hand, experienced a pressure sore injury from his fingernails pressing into his palm. The pressure sore became infected resulting in cellulitis, which led to the identification of the pressure sore injury in the facility. The pressure sore and resulting infection caused the Resident to be sent out to the hospital for treatment with IV (intravenous) antibiotics for 10 days. The facility staff were unaware of the wound prior to the infection, and had not been applying the Residents hand splint (palm guard) to prevent the wound. Further the Resident was suffering from significant weight loss and malnutrition, increasing debility, and inability to heal. Resident #73 was originally admitted to the facility on [DATE], was hospitalized on [DATE] for a pressure sore injury with infection and cellulitis, and returned 10 days later on 6-1-24. Diagnoses included; acute infection/cellulitis of upper left limb, stroke with left hemiplegia, dementia, contractures of left side limbs, dysphagia, epilepsy, hypertension, hypernatremia, and vitamin D deficiency. Resident #73's most recent Minimum Data Set assessment was a Significant change assessment with an assessment reference date of 7-29-24. Resident #73 had a Brief Interview of Mental Status score of 99 indicating severe cognitive impairment. He required extensive to total assistance with eating, bathing and personal hygiene. He was coded to have impaired Range of Motion on both upper extremities, and one lower extremity. He was coded with no behaviors, no swallowing difficulty, and had a mechanically altered regular pureed diet. Before hospitalization and after hospitalization the Resident's diet remained the same. Regular diet, Dysphagia pureed texture, honey thick liquids consistency. On 10-4-24 at approximately 12:00 PM, during continued tour of the facility, Resident #73 was observed eating lunch and being fed by a Certified Nursing Assistant (CNA). The Resident's hands were both contracted. He was not observed to be wearing a palm guard nor any other type of equipment in the upper extremities. The CNA was interviewed and stated Yes he eats really well, and usually finishes 100% of his meals. She was asked why the servings were so small, she stated yeah it doesn't look like enough, but it's pureed so that's what he gets. When asked why the items listed on the tray ticket were missing, she stated They must have missed the other stuff in the kitchen. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Resident had just begun eating from 3 scoops of pureed food each scoop was approximately 2 inches long by 2 inches wide scoop circles (resembling a scoop of ice cream) and approximately 1 inch high. one scoop was gray and semi solid, one scoop was light tan/white and had a grainy pudding consistency, and the third scoop was a white smooth pudding consistency. There was also a clear plastic container with a lid containing approximately 90 milliliters of green liquefied gelatin which smelled like lime, and a cup with approximately 120 milliliters of thickened brown liquid described by the CNA as thickened tea. The Resident consumed all of the meal. The tray ticket menu and preparation instructions for quantity was reviewed and revealed it should have contained; Pureed turkey meatloaf 6 ounces with brown gravy 2 ounces, Pureed buttered diced carrots 8 ounces, Mashed potatoes with gravy 1 cup, Pureed dinner roll with 1 margarine, Fortified pudding 8 ounces, Pureed soft peanut butter cookie 8 ounces, Hot coffee or hot tea, honey thick 16 ounces. In American apothecary measurements and standardized metric medication measurements, 30 milliliters are equal to one ounce. One cup is equal to 8 fluid ounces. The 3 Pureed food servings on Resident #73's meal tray would have totaled approximately 3 ounces each, the gelatin was approximately 3 ounces, and thickened tea would have been approximately 4 ounces. There was half of the pureed meatloaf ordered, no gravy, no carrots, less than half of the potatoes, no gravy, no fortified pudding, no pureed cookie, and half of the thickened tea. The gelatin did not appear on the tray ticket. The meal did not contain all of the menu items nor was it quantity sufficient. Resident #73 was addressed in greeting and did not respond. The CNA stated he's not verbal. 2 hand splints were noted on a chair in the room against the wall at the foot of the bed. The CNA was asked are those splints for this Resident or his room mate. The CNA replied I'm not sure I will check and get back to you. The CNA was asked if the Resident lashed out or refused care, and she stated no, he doesn't ever do any of that, he can't. The CNA was unaware of the splint use and did not apply them as a result. On 10-4-24 at 1:30 PM, Kitchen staff were interviewed and told about the small quantity of food on Resident #73's tray, and the fact that all of the items were not on the tray and they responded that they were out of the pudding, and they didn't get magic cup in because it was too expensive so they substituted the Jello. They also stated that someone had made a mistake and left items off. When asked to see what the pureed cookie looked like, they stated all of the food was gone and they had none left. On 10-7-24 at approximately 12:00 PM Resident #73 was again observed during the lunch meal being fed to him by a staff member. The tray portions were unchanged and insufficient as before, the Resident ate 100%, and no house fortified pudding was on the tray. Resident #73's clinical record was reviewed. Weight documents all completed by mechanical Hoyer lift revealed the following; 5-01-24 - 118.0 pounds prior to the pressure sore injury and cellulitis. 5-20-24 - A nursing note documented Hoyer lift scale not working. 5-22-24 - The Resident went to the hospital with cellulitis after pressure sore injury. (continued on next page)		

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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 0686 Level of Harm - Actual harm Residents Affected - Few	6-10-24 - 125.2 pounds after hospitalization for cellulitis, after gaining 7 pounds in 10 days while hospitalized . 6-24-24 - 108.5 pounds 8-09-24 - 109.0 pounds 9-11-24 - 107.6 pounds 10-8-24 - 97.0 pounds taken during survey with 2 CNA's & surveyor. On 10-8-24 Two CNA's on 3 PM-11 PM shift weighed the Resident at the request of the surveyor by way of the Hoyer mechanical lift correctly zeroing out the scale prior to lift. The Resident did not seem to mind the jostling and placing on the sling nor lifting in the sling and had no facial nor physical response to the experience. The Resident's weight was found to be 97.0 pounds. The CNA's were asked if he refused care or splinting and both stated no, he never fights me over anything. Malnutrition Universal Screening (MUST) Tools were reviewed and revealed an assessment on 6-6-24 upon readmission after the 6-1-24 hospital discharge which documented low risk for malnutrition. The same (MUST) assessment was completed again on 7-24-24 and documented high Risk for malnutrition, weight of 108.5 which had been obtained a month earlier on 6-24-24. The 7-24-24 (MUST) assessment occurred after another full month of continued significant weight loss greater than 10% in less than 2 months. The downward trend continued through 9-11-24 which was the last facility obtained weight documented in the clinical record until the time of survey. On 10-8-24 when surveyors obtained a weight, no weight had been taken by facility staff for another month. The Registered Dietician (RD) was called via cellular phone for interview and was unable to be contacted. A message was left on voicemail, however, surveyors received no call back. RD notes were reviewed and revealed continued weight loss until hospitalization , with no change in recommendations. While the Resident was hospitalized for the Pressure sore injury and cellulitis a 7 pound weight gain was experienced. Then after the readmission to the facility the weight loss began again, and continued through survey without any change to recommendations, with the exception of the 5 following items; 1. 7-25-24 Discontinuance of the vitamin C. 2. The Resident never received the magic cups. 3. 9-26-24 pro-stat liquid (protein for healing) for 3 days then discontinued 9-29-24. 4. 9-18-24 the Vitamin C restarted 2 months after discontinuance. 5. 10-4-24 the house fortified pudding was added, instead of the magic cup, which was observed as not received. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The weekly weights which were recommended by the RD were never obtained. The Resident did not receive meals in the quantity/caloric intake that was ordered, nor was the ordered diet followed. Review of Physician's orders revealed only the following order for the left hand contracture and pressure wound injury with cellulitis; 1. Devices were ordered by the physician on 6-1-24 and again on 9-26-24. That device was Bean bag splints to left upper and left lower extremities as tolerated. No order for, nor directions for, use of palm guards was found in the clinical record. Physician and Nursing progress notes were reviewed for information on the Resident's contractures, left palm pressure wound, and splint usage. That review revealed that From 5-1-24 through 5-19-24 the Resident had no skin wounds. On 5-20-24 at 2:20 PM, the Physicians Assistant (PA) documented Patient seen today for nursing reports of wound to the left palm. Left hand is contracted. Drainage, erythema and swelling noted. Patient says ouch when I touch his hand. Comments; one centimeter wound to the left palm with surrounding erythema and swelling that extends into his middle finger. Hand is warm to touch. Hand is contracted so range of motion is limited. Pain states ouch when I move his hand. Assessment and plan; Cellulitis secondary to wound of the left hand. Wound appears to have been caused by (finger) nail of contracted hand being dug into his palm. Palm guard present at bedside but it is unclear how often it is actually being placed on the patient's hand. Swelling and erythema extends into middle finger and dorsal aspect of the hand. Wound cleaned with DWC (Dakin's wound Cleanser) and bandaged. Palm guard placed. Plan: Wound care - Left hand palm cleanse with wound cleanser, pat dry with gauze, then apply antibiotic ointment to wound bed, cover with dry dressing daily and as needed. Apply palm guard, only remove when eating. Start Keflex 500 mg 4 times per day for 7 days. Monitor closely, if wound worsens consider labs and additional antibiotics emergency room visit if warranted. The Keflex order was changed later that same day to a renal dose of 500 mg twice per day instead of 4 times. The Keflex antibiotic ordered on 5-20-24 at 2:20 PM was not obtained and administered until the afternoon of 5-21-24, which was 24 hours after the cellulitis was identified. It is notable to mention that the Keflex (Cefalexin 500 mg) 15 doses, was available for administration immediately in the facility, in the Omnicell stat box. The purpose of the Omnicell stat box is for staff to have on hand, and available, at all times, needed medications while waiting for the pharmacy to deliver the order, so as not to delay treatment. That was not done. On 5-20-24 at 9:33 PM the Resident was again seen by the same PA, with no changes made. On 5-21-24 at 1:38 AM nursing states notification received that the Resident will be starting the antibiotic treatment by mouth. On 5-21-24 at 10:17 AM the PA documents seeing the Resident again for the cellulitis, stating the cellulitis resulted from the Resident's fingernail digging into his chronically contracted hand and it seemed that his palm guard had not been consistently applied daily, she had been made aware of the wound on 5-20-24, and was still waiting on the pharmacy to deliver the antibiotic to begin treatment. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5-22-24 at 8:47 AM the PA again assessed the Resident documenting worsening cellulitis. Further documenting only 3 doses of the oral antibiotic Keflex had been administered, and the hand continued to become more swollen and extended throughout the entire hand and into the wrist. Cellulitis progressing rapidly and has not responded to oral antibiotics, given the swift advancement of erythema and swelling she was sending the Resident to the hospital for evaluation and possible IV (intravenous) antibiotics. There was concern by the PA that the tendon may have become infected, as a wound in the palm of the hand tissue which is shallow in depth, could reach underlying structures easily. On 5-22-24 at 4:43 PM nursing notes indicate the order was received to send the Resident out to the hospital non-emergently, and at 5:08, that the Resident was sent non-emergently after 24 hours without antibiotics after the order, and 2 days after the infected pressure wound with symptoms was identified. The Resident remained in the hospital for 10 days before returning with orders to continue Amoxicillin oral antibiotics twice per day for the cellulitis for 7 more days after receiving IV Zosyn, and IV Vancomycin in the hospital. The Resident's care plan was reviewed and interventions revealed a focus for refusing to wear splint to (bilateral upper extremities/bilateral lower extremities - Bean Bag.) Cellulitis resolved 7-6-24. There was never a care plan devised for the palm guards. Progress notes review revealed no refusals for splint nor bean bag placement, and no other aberrant behaviors nor refusals were documented for this Resident. The Resident's Kardex which is used by CNA's to guide specific care for each resident need was reviewed and revealed bean bag splints as tolerated with no other instruction on use, nor location of use, and no mention of the palm guards. Staff were unaware of the palm guard need. Facility policies and procedures were reviewed. The policy titled Skin assessments stated that skin assessments would be conducted by nursing weekly and daily with ADL care. Resident #73 experienced an avoidable pressure sore injury which was not identified until a cellulitis infection was present. The Resident was at risk for skin breakdown after a stroke and immobility with contractures, and was experiencing continued significant weight loss. The contracted left palm required palm guards to be implemented to protect the skin from wounds, however, they were not being used consistently. The pressure sore injury was identified only after it became infected requiring hospitalization . The pressure sore injury risk should have been identified during ADL care of the contracted hand prior to the actual wound opening and forming, which led to infection and hospitalization . The wound healed with care. On 10-9-24 at 11:15 a.m., the Administrator, Director of Nursing, and Corporate Nurse were notified that the survey team was considering a harm level deficiency. The facility staff was given the opportunity to provide any further information or explanation. They stated they had no further information.		

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, family interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to apply the correct size Ostomy appliance and failed to provide care to an ostomy according to the physician's order for 1 of 31 residents in the survey sample. The findings included: Resident #119 was originally admitted to the facility 02/17/23 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Ileostomy Status, Autistic Disorder and Malignant Neoplasm of Sigmoid Colon. The quarterly Revision Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/03/24 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired for daily decision making. In sectionGG(Functional Abilities Goal) the resident was coded as being independent with eating, Substantial/ maximal with toileting and personal hygiene. Resident was coded as refusing Tub/Shower transfers. In section H (Bladder and Bowel) the resident was coded under Appliances as having an Ostomy to include an Ileostomy. The December 2024 Physician's Order Summary (POS) reads: Abdominal wound (near ostomy) Gently cleanse wound with Dove soap that was provided by family Apply zinc oxide cream Daily and PRN every day shift for wound Treatment. -Order Date- 09/16/2024 3:23 PM. discharged (DC) Date- 12/05/2024 11:08 AM. Change Ostomy wafer and pouch. Wafer 1 3/4 and prn every day shift every 3 day(s) for (continued on next page)		

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ostomy change scheduled Q3 days & PRN Order Date- 09/16/2024 3:45 PM Check patient's colostomy bag q4h and empty if it is more than 1/2 full. every 4 hours for reduce stool exposure to adjacent open wound related to ILEOSTOMY STATUS -Order Date- 07/16/2024 10:41 AM. The person-centered Care Plan dated 07/22/24 read that Resident #119 has an Ileostomy of the Right Lower Quadrant. The Goals for the resident will be the Ostomy will be free from complications thru 1/05/25. The interventions will be to administer medications for loose stools, change bag as indicated, change wafer and provide site care as ordered, observed Ostomy and surrounding skin for signs of breakdown, irritation, infection or breakdown and notify MD as indicated and perform treatment as ordered to the surgical incision. An ileostomy is an opening in the belly (abdominal wall) that's made during surgery. It's usually needed because a problem is causing the ileum to not work properly, or a disease is affecting that part of the colon and it needs to be removed. The end of the ileum (the lowest part of the small intestine) is brought through this opening to form a stoma, usually on the lower right side of the abdomen. An ileostomy may only be needed for a short time (temporary), maybe for 3 to 6 months, because that part of the colon needs time to rest and heal from a problem or disease. But sometimes a disease, such as cancer, is more serious and an ileostomy may be needed for the rest of a person's life (permanent). After the colon and rectum are removed or bypassed, waste no longer comes out of the body through the rectum and anus. Digestive contents now leave the body through the stoma. The drainage is collected in a pouch that sticks to the skin around the stoma. The pouch is fitted to you personally. It's worn at all times and can be emptied as needed. Ileostomy output will be liquid to pasty, depending on what you eat, your medicines, and other factors. Because the output is constant, you'll need to empty the pouch 5 to 8 times a day. https://www.cancer.org/cancer/managing-cancer/treatment-types/surgery/ostomies/ileostomy/what-is-ileostomy.html#:~:text=An%20ileostomy%20is%20an%20opening,it%20needs%20to%20be%20removed. An interview was conducted on 12/04/24 at approximately 2:20 PM. With the Resident's Sister (Family Member/FM) #2. FM #2 said that the staff is using the wronged size wafer, It should be 1 3/4 cm. FM #2 also said that it used to take the staff up to 6 hours to change the resident's colostomy bag when it gets full which causes irritation to the resident's skin. Permission was received from FM #2 to observed Resident's stoma. The call bell was used by FM #2 to notify nurse. (continued on next page)		

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/04/24 at approximately 2:52 PM., Licensed Practical Nurse (LPN) #2 entered the resident's room to observed the resident's colostomy and stoma. LPN #2 removed the ostomy bag and said, This is the wrong size wafer. too much of the resident's skin was being exposed and the wafer was cut too large. FM #2 said it (wafer) should be 1 3/4 cm. LPN #2 said that she would return with supplies. The stoma was observed on the Resident's Right lower Abdomen, appeared, pinkish/reddish in color, no discharge or discoloration was observed. Shortly thereafter, resident was noted to have a moderate amount of yellow thin stool. LPN #2 said that the stoma was smaller but the wafer needed to be cut smaller. Ostomy care was provided by LPN #2 without difficulty. Resident tolerated procedure well. A final interview was conducted on 12/04/24 at approximately 5:15 PM., with the Corporate Nurse Consultant (CNC), Director of Nursing and the Administrator. The CCN said that the Ostomy wafer size for Resident #119 should be 1 3/4 cm, the nursing staff have been educated.		

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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** 31199 Based on observation, staff interview, facility documentation review, and clinical record review the facility staff failed to prevent significant weight loss and malnutrition for one Resident (Resident #73) in a survey sample of 55 Residents. The findings included: Resident #73, suffered significant weight loss and malnutrition, increasing debility, and promoting an inability to heal from a new pressure sore injury which became infected leading to cellulitis and required hospitalization . Resident #73 was originally admitted to the facility on [DATE], was hospitalized on [DATE] for a pressure sore injury with infection and cellulitis and returned 10 days later on 6-1-24. Diagnoses included: Acute infection/cellulitis of upper left limb, stroke with left hemiplegia, dementia, contractures of left side limbs, dysphagia, epilepsy, hypertension, hypernatremia, and vitamin D deficiency. Resident #73's most recent Minimum Data Set assessment was a significant change assessment with an assessment reference date of 7-29-24. Resident #73 had a Brief Interview of Mental Status score of 99 indicating severe cognitive impairment. He required extensive to total assistance with eating, bathing and personal hygiene. He was coded to have impaired Range of Motion on both upper extremities, and one lower extremity. He was coded with no behaviors, no swallowing difficulty, and had a mechanically altered regular pureed diet. Before hospitalization and after hospitalization the Resident's diet remained the same. Regular diet, Dysphagia pureed texture, honey thick liquids consistency. On 10-4-24 at approximately 12:00 PM, during continued tour of the facility, Resident #73 was observed eating lunch and being fed by a Certified Nursing Assistant (CNA). The Resident's hands were both contracted. He was not observed to be wearing a palm guard nor any other type of equipment in the upper extremities. The CNA was interviewed and stated Yes he eats really well, and usually finishes 100% of his meals. She was asked why the servings were so small, she stated yeah it doesn't look like enough, but it's pureed so that's what he gets. When asked why the items listed on the tray ticket were missing, she stated They must have missed the other stuff in the kitchen. The Resident had just begun eating from 3 scoops of pureed food each scoop was approximately 2 inches long by 2 inches wide scoop circles (resembling a scoop of ice cream) and approximately 1 inch high. one scoop was gray and semi solid, one scoop was light tan/white and had a grainy pudding consistency, and the third scoop was a white smooth pudding consistency. There was also a clear plastic container with a lid containing approximately 90 milliliters of green liquefied gelatin which smelled like lime, and a cup with approximately 120 milliliters of thickened brown liquid described by the CNA as thickened tea. The Resident consumed all of the meal. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The tray ticket menu and preparation instructions for quantity was reviewed and revealed it should have contained; Pureed turkey meatloaf 6 ounces with brown gravy 2 ounces, Pureed buttered diced carrots 8 ounces, Mashed potatoes with gravy 1 cup, Pureed dinner roll with 1 margarine, Fortified pudding 8 ounces, Pureed soft peanut butter cookie 8 ounces, Hot coffee or hot tea, honey thick 16 ounces. In American apothecary measurements and standardized metric medication measurements, 30 milliliters are equal to one ounce. One cup is equal to 8 fluid ounces. The 3 Pureed food servings on Resident #73's meal tray would have totaled approximately 3 ounces each, the gelatin was approximately 3 ounces, and thickened tea would have been approximately 4 ounces. There was half of the pureed meatloaf ordered, no gravy, no carrots, less than half of the potatoes, no gravy, no fortified pudding, no pureed cookie, and half of the thickened tea. The gelatin did not appear on the tray ticket. The meal did not contain all of the menu items nor was it quantity sufficient. Resident #73 was addressed in greeting and did not respond. The CNA stated he's not verbal. 2 hand splints were noted on a chair in the room against the wall at the foot of the bed. The CNA was asked are those splints for this Resident or his roommate. The CNA replied I'm not sure I will check and get back to you. The CNA was asked if the Resident lashed out or refused care, and she stated no, he doesn't ever do any of that, he can't. The CNA was unaware of the splint use and did not apply them as a result. On 10-4-24 at 1:30 PM, Kitchen staff were interviewed and talked about the small quantity of food on Resident #73's tray, and the fact that all of the items were not on the tray and they responded that they were out of the pudding, and they didn't get magic cup in because it was too expensive so they substituted the Jello. They also stated that someone had made a mistake and left items off. When asked to see what the pureed cookie looked like, they stated all of the food was gone and they had none left. On 10-7-24 at approximately 12:00 PM Resident #73 was again observed during the lunch meal being fed to him by a staff member. The tray portions were unchanged and insufficient as before, the Resident ate 100%, and no house fortified pudding was on the tray. Resident #73's clinical record was reviewed. Weight documents all completed by mechanical Hoyer lift revealed the following: 5-01-24 - 118.0 pounds prior to the pressure sore injury and cellulitis. 5-20-24 - A nursing note documented Hoyer lift scale not working. 5-22-24 - The Resident went to the hospital with cellulitis after pressure sore injury. 6-10-24 - 125.2 pounds after hospitalization for cellulitis, after gaining 7 pounds in 10 days while hospitalized . 6-24-24 - 108.5 pounds 8-09-24 - 109.0 pounds (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9-11-24 - 107.6 pounds 10-8-24 - 97.0 pounds taken during survey with 2 CNA's & surveyor. On 10-8-24 Two CNA's on 3 PM-11 PM shift weighed the Resident at the request of the surveyor by way of the Hoyer mechanical lift correctly zeroing out the scale prior to lift. The Resident did not seem to mind the jostling and placing on the sling nor lifting in the sling and had no facial nor physical response to the experience. The Resident's weight was found to be 97.0 pounds. The CNAs were asked if he refused care or splinting and both stated no, he never fights me over anything. Malnutrition Universal Screening (MUST) Tools were reviewed and revealed an assessment on 6-6-24 upon readmission after the 6-1-24 hospital discharge which documented low risk for malnutrition. The same (MUST) assessment was completed again on 7-24-24 and documented high Risk for malnutrition, weight of 108.5 which had been obtained a month earlier on 6-24-24. The 7-24-24 (MUST) assessment occurred after another full month of continued significant weight loss greater than 10% in less than 2 months. The downward trend continued through 9-11-24 which was the last facility obtained weight documented in the clinical record until the time of survey. On 10-8-24 when surveyors obtained a weight, no weight had been taken by facility staff for another month. Physician order reviews revealed only Vitamin C, a Multi vitamin, and 10 doses of Pro-stat for the Significant weight loss, those 3 follow below: 1. Ordered 9-18-24 Ascorbic Acid tablet (vit C) 500 mg (milligrams) 1 tablet at 9:00 AM for malnutrition and wound healing 2. Ordered 7-24-24 Multi vitamin 1 tablet at 9:00 Am for malnutrition and wound healing. 3. Ordered 9-26-24 - Pro-stat AWC oral liquid 30 ml (milliliters) by mouth 3 times per day for malnutrition and wound healing give at 9 AM, 2 PM, and 9 PM, discontinued 9-29-24 (only 10 doses given) in 3 days. The Registered Dietician (RD) was called via cellular phone for interview and was unable to be contacted. A message was left on voicemail; however, surveyors received no call back. RD notes were reviewed and revealed that the RD evaluated the Resident on the following dates. 5-03-24 - Weight warning, weight change, 10% loss, large portions, magic cup with meals, intake 75-100%, clinically insignificant weight loss, 10.6% in 141 days, weigh weekly, RD to monitor. 6-06-24 - Malnutrition screening done, low risk, Weight warning, weight increase (after hospitalization). 6-10-24 - Weight warning, weight loss, reweigh and RD to follow up after reweighing. 6-28-24 - Weight warning, weight loss, weekly weight through 7-1-24, defer to nursing to determine baseline weight. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7-24-24 - Malnutrition screen done, high risk, weight loss, kept same orders, obtain updated weight. 8-09-24 - Weight warning, change note, weight loss, 99.2, do reweigh to verify. 8-14-24 - Significant weight change, weight loss, Vitamin C discontinued 7-25-24 by nursing, weigh weekly. 9-18-24 - Significant weight change, weight loss, restart Vitamin C, weigh weekly. 9-29-24 - Discontinue pro-stat secondary to it not being ordered to be honey thickened. 10-4-24 - was the last entry - Change magic cup (which was not provided) to house fortified pudding. The RD notes reveal continued weight loss until hospitalization , with no change in recommendations. While the Resident was hospitalized a 7-pound weight gain was experienced, and then after the readmission to the facility the weight loss began again, and continued through survey without any change to recommendations, with the exception of the 5 following items; 1. 7-25-24 Discontinuance of the vitamin C. 2. The Resident never received the magic cups. 3. 9-26-24 pro-stat liquid (protein for healing) for 3 days then discontinued 9-29-24. 4. 9-18-24 the Vitamin C was discontinued, then restarted 2 months later. 5. 10-4-24 the house fortified pudding was added, instead of the magic cup, which was observed as not received. The weekly weights which were recommended by the RD were never obtained. The Resident did not receive meals in the quantity/caloric intake that was ordered, nor was the ordered diet followed. Review of Physician's orders revealed only the following order for the left-hand contracture and pressure wound injury with cellulitis. 1. Devices were ordered by the physician on 6-1-24 and again on 9-26-24. That device was Bean bag splints to left upper and left lower extremities as tolerated. No order for, nor directions for, use of palm guards was found in the clinical record. Physician and Nursing progress notes were reviewed for information on the Resident's contractures, left palm pressure wound, and splint usage. That review revealed that from 5-1-24 through 5-19-24 the Resident had no skin wounds. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5-20-24 at 2:20 PM, the Physician's Assistant (PA) documented Patient seen today for nursing reports of wound to the left palm. Left hand is contracted. Drainage, erythema and swelling noted. Patient says ouch when I touch his hand. Comments; one centimeter wound to the left palm with surrounding erythema and swelling that extends into his middle finger. Hand is warm to touch. Hand is contracted so range of motion is limited. Pain states ouch when I move his hand. Assessment and plan; Cellulitis secondary to wound of the left hand. Wound appears to have been caused by (finger) nail of contracted hand being dug into his palm. Palm guard present at bedside but it is unclear how often it is actually being placed on the patient's hand. Swelling and erythema extends into middle finger and dorsal aspect of the hand. Wound cleaned with DWC (Dakin's wound Cleanser) and bandaged. Palm guard placed. Plan: Wound care - Left hand palm cleanse with wound cleanser, pat dry with gauze, then apply antibiotic ointment to wound bed, cover with dry dressing daily and as needed. Apply palm guard, only remove when eating. Start Keflex 500 mg 4 times per day for 7 days. Monitor closely, if wound worsens consider labs and additional antibiotics emergency room visit if warranted. Resident #73 experienced continued significant weight loss and malnutrition without intervention and was not weighed weekly and monitored as recommended by the RD. The Resident did not receive the correct diet nor caloric intake need, and developed an avoidable pressure sore injury which was not identified until a cellulitis infection was present, and hospitalization was required. On 10-9-24 at 11:15 a.m., the Administrator, Director of Nursing, and Corporate Nurse were notified of the above findings and given the opportunity to provide any further information or explanation. They stated they had no further information.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Virginia Beach Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 Camelot Drive Virginia Beach, VA 23454	
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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 40711 Based on information obtained during the as worked nursing schedule nursing staff, the facility staff failed to staff a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week which could potentially affect all residents. The facility staff failed to staff a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. The findings included; A review of the as worked schedule from 11/19/24 through 12/05/24. The facility staff was unable to verify 8 consecutive hours a day of RN coverage for at least 2 days on the following dates: 11/30/24 and 12/01/24. The above dates were verified by the Corporate Nurse Consultant (CNC) #2 on 12/03/24 at approximately 4:40 PM. The CNC #2 said there was no RN coverage, but there should have been coverage on 11/30/24 and 12/01/24. A final interview was conducted on 12/04/24 at approximately 5:45 PM., with the Corporate Nurse Consultant (CNC) #2. The CNC #2 said that RN coverage should have been provided on the above dates.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on Resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to identify and address necessary behavioral health services, and failed to devise and implement a comprehensive person centered care plan for identified responses to stressors for one Resident with non-Alzheimer's type dementia with a language barrier (Resident #521) in a survey sample of 55 Residents. The findings included: For Resident #521 the facility staff failed to obtain a physician ordered psychiatric consult timely, failed to conduct behavior monitoring, failed to provide a comprehensive care plan for emotion regulation, failed to identify stressors and responses such as language barrier and supervision, to those stressors, which resulted in aggressive behaviors aimed at and impacting other residents. The facility failures described above resulted in the willful abuse of Residents #68, #20, and a third unknown Resident victim as perpetrated by Resident #521. Resident #521 was not receiving any psychotropic medications, to include antidepressants. Resident #68 (victim 1) was admitted to the facility on [DATE]. Diagnoses included but were not limited to: heart failure, hypertension, high cholesterol, malnutrition, peripheral venous insufficiency, hypothyroidism, rheumatoid arthritis, scoliosis, rhabdomyolysis, and foot pain. Resident #68's most recent Minimum Data Set with an Assessment Reference Date of 8-2-24 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and her own responsible party. The Resident required extensive assistance from one staff member for hygiene and bathing. The Resident had no aberrant behaviors documented, and had no complaints against any other staff or situations since her admission on 11-14-19. Resident #20 (victim 2) was admitted to the facility on [DATE]. Diagnoses included but were not limited to chronic ischemic heart disease, stroke with hemiplegia right side, anemia, diabetes, chronic hepatic failure, neck fracture, chronic kidney disease, depression, and femur fracture. Resident #20's most recent Minimum Data Set was a quarterly assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and her own responsible party. The Resident was independent for transferring and used a motorized wheel chair to leave the building for shopping trips to walmart using a van. The Resident had no aberrant behaviors documented, and had no complaints against any other staff or situations since her admission on 7-18-23. (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #521 (perpetrator of 1 and 2) was admitted to the facility on [DATE], went back out to the hospital for syncope on 9-5-24, and returned on 9-8-24. Hospital discharge records indicated that the Resident was alert and oriented to person, place and time, and was ambulatory at the time of discharge. Diagnoses included but were not limited to: Heart failure, hypertension, Gastro Esophageal reflux disease, renal insufficiency, diabetes, thyroid disorder, dementia, malnutrition, and asthma. Resident #521's most recent Minimum Data Set with an Assessment Reference Date of 9-5-24 after one day in the facility was coded as an admission assessment. The Brief Interview for Mental Status was coded as 12 out of a possible 15 points which indicated mild cognitive impairment, however, the language barrier may have contributed to a false lower score. The Resident was her own responsible party. The Resident spoke only Spanish. The Resident required extensive assistance from one staff member for hygiene and bathing. On 10-1-24, the first day of survey, Resident #521 went out to a medical appointment and lost consciousness while there. She was sent directly to the hospital, and did not return during the remainder of the survey. While on continued tour of the facility on 10-4-24, Resident #68 was interviewed and asked if any person in the facility had abused her or if she had ever witnessed abuse. She stated yes that her former room mate (Resident #521) had kicked her, thrown fruit at her, hit her, and had spit on her. She stated that Resident #521 had also cursed and yelled at her, gotten in her bed, held her wheel chair so she could not leave the room for help, and had stood over her while she was laying in bed menacing her. She stated that she had been bruised by the kick and punch, but luckily suffered no other injuries. She further stated that she had complained to staff repeatedly but they did nothing until 9-20-24 when Resident #521 punched her in the arm and the Assistant Director of Nursing saw it. She went on to say that they moved her that day. The Resident was asked if she was still afraid and she stated no, she's gone now. On 10-7-24 the clinical records of Resident's #68, and #521 were reviewed. Those reviews contained the following information in chronological order; On 9-20-24 at 3:42 PM the records indicated that Resident #521 had been moved to another room for Safety. No other descriptions about the allegations of abuse on Resident #68 were documented. On 9-20-24 Resident #521's progress notes documented she was moved to the room containing Resident #20. On 9-21-24 at 12:47 AM (7.5 hours later) after the move, progress note review indicated that Resident #521 was observed to throw a cup of water across the room and spit on her new room mates charger for her electric wheel chair. On 9-21-24 at 8:41 PM, Later the same day, documents record Resident #521 hit Resident #20 and it was witnessed by staff. There was no mention of the scratches to Resident #20 inflicted by Resident #521. On 9-22-24 at 1:34 AM (5 hours later) progress notes go on to describe that Resident #521 was moved to a private room. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Virginia Beach Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 Camelot Drive Virginia Beach, VA 23454	
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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Victim #3 unknown name) On 9-22-24 at 2:54 AM, (1.5 hours after move) another note describes Resident #521 as standing next to her neighbors bed (unknown which neighboring room to the private room or which Resident this involved) staring at her (the neighbor of Resident #521) while sleeping and threatened anger aggressive behavior. On 9-23-24 a psychiatric consultation was ordered. It was never obtained. On 9-25-24 the Physician's Assistant (PA) described in a note that (Resident #521) Patient assault on room mate multiple times, resident denied, on alternate location at this time. On 10-7-24 Resident #20 was interviewed and stated that Resident #521 was placed in her room and almost immediately began to yell at her, spit at her, and throw things at her. She went on to state that Resident #521 finally came over to her side of the room after dinner sometime and lashed out at her hitting her, causing several small scratches on her hand. She stated she was fending off the blows with her arm raised. and Resident #521's fingernails scratched her. She went on to state that the staff saw it and moved her out of the room until they could find a place for Resident #521. She stated that Resident #521 was moved Sometime late that night around midnight. Resident #20 was asked if she was afraid of Resident #521, and she stated no, she went to the hospital and I don't think she's ever coming back. Nursing staff on the units where Resident #521 was housed were interviewed and stated they remembered Resident #521, and her aggressive behaviors, however, those working during survey interviews were not present during the abuses. They stated they were aware of the incidents, however, most of the staff were from a staffing agency and did not work there every day. During interview and review of the clinical record, it was found that the Social Worker/Discharge Planner (SWDP) was only involved with Resident #521 on 3 occasions. Those instances follow below: 1. Nine days after admission on 9-13-24 for a Trauma Informed Care assessment which was negative for trauma experienced by the Resident. 2. After the first abuse on 9-20-24 to Resident #68, to notify Resident #521's son of the first room change. 3. Finally, at the first Interdisciplinary care plan meeting on 9-26-24 with only the SWDP and the Activity Assistant present. The facility staff provided a copy of their Abuse policy, and the policy review revealed that all allegations of abuse will be investigated, Residents will be protected and prevented from further abuse, reports will be sent initially to the State agency VDH/OLC (and other agencies) within 24 hours or within 2 hours if serious injury occurs, and a follow up report will be sent in 5 days to include findings and corrections. Resident #68 reported abuse for days before staff observed the abuse and moved Resident #521. Resident #521 was then placed with Resident #20 who was not protected and was abused. Resident #521 was moved again and went to a third unknown Resident's room to abuse. (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The allegations of abuse were never reported to the state agency. Residents were not protected from a known abuser. Abuse was not investigated fully, and the facility policy was not implemented for the protections of Residents from abuse. Further, there was never any added staff supervision for Resident #521 to prevent the abuse from continuing. No staff ever noted the suspicion of a crime, so no police report was ever filed. The first alleged report by the Administrator was never signed and had errors in information giving the appearance of a severely demented alleged abuser to APS in a single occurrence resulting in no investigation opened by them. Resident #521's nursing and physician progress notes were reviewed and revealed the following: 9-8-24 nurses documented Resident with language barrier (speaks only Spanish) states frustration with interpreter. 9-11-24 the physician documented Plan: - The patient has had a diagnosis of depression or has had a diagnosis of Bipolar Disorder. 9-12-24 nurses documented refused, wants to be left alone to therapy, refused weight yelling in Spanish 9-19-24 nurses documented Google translator only means of translation in the facility. 9-20-24 nurses documented room change for safety. 9-21-24 12:47 AM nurses documented woke from nap anxious, stating dead bodies everywhere, resident extremely restless and gestures for sleep but will not stay in bed more than 15-20 minutes at a time. 9-21-24 10:41 PM nurses documented Aggression and hitting roommate, removed from room. 9-22-24 1:34 AM nursing notes documented another room change to a private room. 9-22-24 2:54 AM nursing notes Aggressive behavior standing over sleeping neighbor threatening neighbor room. 9-23-24 2:45 PM nursing note Psyche consult placed in psyche referral book. 9-23-24 11:12 PM nursing note difficulty communicating with Resident. 9-25-24 physician documented resident's roommate spoke up about Resident #521 laying hands on her multiple times. Staff made aware, management involved, room changed. That reveals that the physician was only aware of one abuse victim, and not the other two. Resident #521's frustration was identified on day 1, and no plan was implemented to improve communication between staff and residents for this Resident. (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The psychiatric evaluation was put in a book at the nursing station awaiting the next visit from psyche professionals to see other residents before they knew Resident #521 needed services. This was revealed during interview at the nursing station when the consult book was requested, on 10-7-24 they stated that's our procedure. From 9-4-24 through 10-1-24 (28 days), no psychosocial nor behavioral services were ever afforded a disturbed Resident #521 even after 3 abuses of other Residents and aggression toward staff. Resident #521's care plan was reviewed and revealed no focus nor interventions for dementia, language barrier, nor behaviors was ever derived nor implemented before or after the abuses occurred. Resident #521's physician's orders and progress notes were reviewed and revealed On 9-8-24 Geriatric psyche consult (as needed) PRN. No other assessments nor orders for behavioral health support were ever obtained. On 10-9-24 at approximately 5:30 p.m., the facility Administrator, Corporate Registered Nurse, and Corporate Administrator were notified of the findings. They stated they had no further information or documentation to offer.		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interview, facility record review, and clinical record review, the facility staff failed to provide specific and adequate treatment services for mental health and psychosocial concerns for one Resident with depression, and anxiety (Resident #126) in a survey sample of 30 Residents. Resident #126 did not receive adequate psychosocial, psychiatric, nor psychoactive medication care and services while in the facility after multiple falls, a hospitalization with fracture and head injury, and after return to the facility with behavioral issues complicated by new onset confusion. Further the facility failed to reinstitute long standing medication therapy for depression and anxiety after the hospitalization return. The findings included: Resident #126 was admitted to the facility on [DATE] and discharged back to the hospital on 11-26-24 for a fall with refracture of right hip, and head injury with acute subdural hematoma. He was readmitted on [DATE] after the 2-day hospital stay, and was transferred back to the hospital 11-28-24 for intractable pain and did not return until 11-29-24. Resident #126's Diagnoses included but were not limited to; Cardiovascular disease, congestive heart failure, coronary heart disease, Atrial fibrillation, high cholesterol, chronic kidney disease, right hip & sacrum Fractures, major long standing depressive disorder, anxiety, long standing family history of psychiatric illness, heart disease, history of prostate cancer with resection, and chronic obstructive pulmonary disease with nicotine dependency. Resident #126's most recent Minimum Data Set (an assessment protocol) was a 5-day admission assessment with an Assessment Reference Date of 11-5-24 which coded Resident #126 with a BIMS (brief interview of mental status) score of 14, of a possible 15 points indicating no cognitive impairment. The Resident was documented as able to be understood and to understand others, and able to see and hear. Resident #126 required limited assistance of 1 staff member according to the Kardex care plan for the baseline care staff including Certified Nursing Assistant's (CNA's) dated 11-29-24. According to the ADL (activities of daily living) documentation, however, the Resident was totally dependant on staff for toileting. The resident was documented as always incontinent of bowel & bladder, and the Resident falls were linked to the Resident attempting to go unassisted to the bathroom. On 12-4-24 at 12:30 p.m., Resident #126 was observed in bed lying flat on his back. The Resident was resting and refused interview stating he was tired. The surveyor asked him if he needed help and he replied no. Staff stated that the Resident was oriented to person, place, time, and could answer questions if he wanted to, but he would at times have behaviors and yell at staff. When asked what type of behaviors they stated he would yell, throw things, urinate on the floor if they didn't answer his call light immediately. The entire clinical record was reviewed and revealed the following; (continued on next page)		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of behavior notes revealed that from 10-30-24 through 11-17-24 six notes were documented in the clinical record by nursing which revealed the following; On 11-1-24 (3 notes) the Resident complained about going nuts and had no one to control him, yelling out, threw crackers at wife, shaking physically and stating he was going crazy and something needed to be done. The Resident requested that the thermostat be set automatically to alternate from hot to cold, and stated if he didn't get some type of sedative he would be a Bitch all night. On 11-2-24 (2 notes) the behavior notes continued documenting that he was in bed naked stating he needed help and was locked in his room. The nurse documented that she placed an adult brief on the Resident and he calmed down. Later that day another note describes the Resident had removed his clothes and was continuously yelling for help, and complaining that nothing in the room worked. The note documented that nursing staff attempted to show him that things did work, however, no documentation was included on what those things were. The note goes on to describe that her intervention did not help and he continued yelling out for help. On 11-17-24 (1 note) the document described that the Resident urinated on the floor, and when the nurse asked him why he had done that, he stated because he could not get out of bed. The note goes on to say that the Resident still had on an adult brief but refused to use it, indicating staff inconvenience, in that they wanted the Resident to use the incontinent brief rather than go to the bathroom. It is notable to mention that if the resident refused to use the incontinence brief, and removed it to urinate on the floor then reapplied it, the Resident did so as a choice, with full knowledge of how to accomplish it, and not as an aberrant behavior. The behavior notes do indicate that the Resident willingly verbalized distress to staff, asked for help, and retaliated when help was not given. This is a reasonable person concept of reaction when needs are expected to be met in a facility, and necessary in the Resident's point of view, which went unfulfilled. The Resident was told not to go to the bathroom alone because of falls, yet could not get help in his point of view, and he found no alternatives. The Resident was seen by psychiatric service providers only twice from admission on 10-30-24 until the time of survey on 12-5-24. No other psychiatric evaluations, nursing behavior notes, nor psychosocial treatments and or therapy were conducted and documented in the clinical record for review. The 2 Psychiatric provider notes indicated that the Resident was initially evaluated on 11-6-24, and seen a second time on 11-20-24. Those follow below; On 11-6-24 - The Psychiatric Registered (NP) Nurse Practitioner documented that the Resident had a long standing family and personal psychiatric history, and described the individuals diagnoses and histories to included medications being used prior to hospitalization and admission to the facility with the Resident's spouse of [AGE] years at the bedside to corroborate. A PHQ-9 assessment was completed at the bedside which is an assessment of screening for and monitoring to include measurement of severity of depression, anxiety, sleep disorders and other psychological illness. The assessment tool indicated that a score of 5 or above is positive for requiring a follow up plan to include behavioral health consult, psychotherapy, and pharmacotherapy as indicated. The Resident scored a 10. The document goes on to describe the Residents current medications which were Trazadone, Ativan, Buspar, and Welbutrin. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Virginia Beach Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 Camelot Drive Virginia Beach, VA 23454	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11-26-24 the Resident was sent out to the hospital after having fallen multiple times with serious injuries. Those injuries included a Subdural hematoma from striking his head, and he had refractured the hip which had been recently surgically repaired. The Resident had exhibited and expressed psychological distress, and according to Psychiatric NP documentation had experienced falls and hallucinations as reported by facility staff. The rapidly changing cocktail of concomittant administration of numerous psychoactive medications to include; rapid introductions of new medications, withdrawals of long standing medications, and increases of medications over a 3 week period could have contributed to Resident #126's distress and statements of going crazy. These medication changes coupled with 3 hospitalization s and entrance into a skilled nursing facility, with the known transfer trauma effect which is a medically recognized syndrome and typically care planned by healthcare providers was not assessed for nor care planned by the facility staff. On 11-28-24 the Resident returned to the facility and on the same day was returned to the hospital for unrelieved pain due to unavailable pain medication at the facility according to hospital records. The Resident was then readmitted to the facility on [DATE]. The Resident was not seen by the Psychiatric NP's from 11-20-24 to the time of survey exit on 12-5-24, however the facility Administrator assured surveyors that the Resident would be seen that day. It was stated that outside of the orders previously issued by the Psychiatric NP on 11-6-24, and 11-20-24, the facility Medical Director would have been responsible for issuing any of the other orders that were made for Resident #126. On 12-4-24 Olanzipine/Zyprexa 5 mg at bedtime for Bipolar disorder was ordered. It is notable to mention that the Resident did not have a diagnosis of Bipolar Disorder. Zyprexa also has a black box warning of increased risk of death in older adults. On 12-4-24 after surveyor concerns were made known to the facility, the medications Wellbutrin, and Buspar were discontinued and Zyprexa was ordered, however, had not yet been administered at the time of survey exit on 12-5-24. All discipline progress notes from 11-4-24 through 12-4-24 were reviewed. The prog notes revealed the following; The Medical doctor saw the Resident only one time on 11-9-24 through the time of survey. That note described the Resident as Sedated and normal participated in conversation, coherent. The Psychiatric NP's saw him, on 11-6-24, and nursing documented that the Resident's room was changed to be closer to the nursing station for observation due to falls, and was seen on 11-20-24 as stated above. On 11-15-24 a computerized auto generated pharmacy system identified and alerted staff to medication concerns for use of Trazadone and buspar being combined with a potential severe reaction of increased possibility of Serotonin syndrome which can be life threatening, and Trazadone could increase the effects of Ativan if used together causing confusion and sedation. (continued on next page)		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12-19-24 Nurses notes indicated that the Resident's spouse complained that the Ativan was causing the Resident's confusion and requested it be stopped. It was held on 11-19-24, and on 11-20-24 the Ativan was discontinued The Family practice NP also saw him on 11-20-24. Nursing notes indicated that on 11-26-24 the Resident was sent to the hospital after a fall as requested by the Resident and his spouse with no indication that he was seen by facility physician staff. On 11-28-24 the NP and Third Eye a computer generated telehealth company, sent the Resident back to the hospital. On all nursing skilled notes the area for Non-pharmacy interventions was blank, with none were used, nor specified for use. Review of the current care plan derived 10-30-24 upon discharge from the hospital, revealed only 3 care planned problem areas that could be related to psychiatric needs. The first focus was repeated in the document so not mentioned twice. Those follow below; 1. FOCUS. Antipsychotics (medications): The Resident is at risk for adverse reactions related to the use of antipsychotics secondary to a diagnosis of : (no diagnosis given, left blank.) GOAL. The resident will be free from adverse effects related to antipsychotic use through review period. INTERVENTIONS. Administer medications as ordered. Aims assessment as indicated (abnormal involuntary movement scale) (never completed). Labs as ordered, Monitor for behaviors related to medication use (none specified). Pharmacy review as indicated (none in clinical record), PHQ-9 mood screening as indicated, psyche services as needed/indicated, observe for signs and syptoms of adverse side effects related to medication use and notify MD (doctor) as indicated (no signs or symptoms specified), nonpharmacological interventions: (SPECIFY), (none were specified). 2. FOCUS. The resident has a level 2 PASARR. GOAL. The resident will communicate feelings related to emotional state by review date. INTERVENTIONS. Administer medications as ordered, monitor document for side effects, psychological/psychiatric interventions/consultation as ordered, If reasonable, discuss the resident's behavior, explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. (no behaviors specified). 3. FOCUS. The resident will continuously get out of bed and put himself on floor related to depressive disorder, yells and screams, throws items, removes clothing. GOAL. The resident's behaviors will not cause them or other residents distress through the review period. (continued on next page)		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	INTERVENTIONS. Administer medications as ordered, assure the resident they are safe if they become distressed, listen to the resident and try to calm, physician review of medications as needed, psyche services referral as needed, take the resident to a quiet place if they become overstimulated. In the first careplan focus no diagnosis was listed, no AIM's assessment was conducted, and appeared unnecessary as the Resident was never documented as having abnormal involuntary movements, no pharmacy evaluation was conducted, no adverse behaviors, signs, nor symptoms were listed for medication side effects, and no non-pharmacologic interventions for distress were listed. In the second focus no inappropriate or unacceptable behaviors were specified. In the third focus of putting self on floor, yelling, screaming, throwing things, and removing clothes are not causes of distress, they are expressions of distress. The Resident did not put himself on the floor, he fell , which is well documented in the clinical record as he was trying to go to the bathroom. He also complained of being uncomfortable and asked for the thermostat in the room to be reset, and the Resident was obese. It is notable to mention that during the most recent fall and hospitalization the Resident experienced a head injury with resultant subdural hematoma. The Resident did not receive a CT (computed tomography) scan of his head after hospitalization , and so it was unclear if the medication changes or a worsening head injury was at fault for causing the Resident's psychological distress, as it was not exhibited upon initial admission. On 12-5-24 The Corporate RN (Registered Nurse) consultant stated she had obtained an order for the follow up CT for the Resident and that it would be completed on 12-6-24 at 9:00 AM. On 12-5-24 at 1:15 PM multiple staff members to include CNA's and Licensed Practical Nurses (LPN's) were interviewed in the conference room by surveyors. All agreed that psychiatric and behavioral health training had not been received by them. On 12-4-24 an interview with the Discharge planner was conducted in the conference room with surveyors. That interview revealed that only she and the Activities Director had been attending care plan meetings for Residents. The care planning was not interdisciplinary, and neither of the attendees were trained in healthcare. When asked what should be in a Care Plan for patients with psychiatric concerns, she stated she would have to find out, and there should be non-pharmacological interventions for specific behaviors and activities specific to Resident's needs. When asked what those would be, she replied I'll have to find out. On 12-4-24 at a morning meeting, and on 12-5-24 at an end of day debriefing, the Corporate RN, Administrator and Director of Nursing (DON) were made aware of the findings. At the time of exit they stated there was no further information available to submit to surveyors.		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on resident interviews, staff interview, clinical record review, and facility document review, it was determined that the facility social worker failed to provide services for one resident (Resident #521) in the survey sample of 55 Residents The findings included; For Resident #521, the facility Social worker failed to provide medically related social services to meet the Resident's needs for a strictly Spanish speaking Resident who had signs of frustration, and aggression. Resident #521 abused 3 Residents in the facility and exhibited aggressive behaviors and signs of distress which were never assessed and care planned, and not evaluated by medical social work. For Resident #521 the facility staff failed to obtain a physician ordered psychiatric consult timely, failed to conduct behavior monitoring, failed to provide a comprehensive care plan for emotion regulation, failed to identify stressors and responses such as language barrier and supervision, to those stressors, which resulted in aggressive behaviors aimed at and impacting other residents. The facility failures described above resulted in the willful abuse of Residents #68, #20, and a third unknown Resident victim as perpetrated by Resident #521. Resident #521 was not receiving any psychotropic medications, to include antidepressants. Resident #68 (victim 1) was admitted to the facility on [DATE]. Diagnoses included but were not limited to: heart failure, hypertension, high cholesterol, malnutrition, peripheral venous insufficiency, hypothyroidism, rheumatoid arthritis, scoliosis, rhabdomyolysis, and foot pain. Resident #68's most recent Minimum Data Set with an Assessment Reference Date of 8-2-24 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and her own responsible party. The Resident required extensive assistance from one staff member for hygiene and bathing. The Resident had no aberrant behaviors documented, and had no complaints against any other staff or situations since her admission on 11-14-19. Resident #20 (victim 2) was admitted to the facility on [DATE]. Diagnoses included but were not limited to chronic ischemic heart disease, stroke with hemiplegia right side, anemia, diabetes, chronic hepatic failure, neck fracture, chronic kidney disease, depression, and femur fracture. (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #20's most recent Minimum Data Set was a quarterly assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and her own responsible party. The Resident was independent for transferring and used a motorized wheel chair to leave the building for shopping trips to walmart using a van. The Resident had no aberrant behaviors documented, and had no complaints against any other staff or situations since her admission on 7-18-23. Resident #521 (perpetrator of 1 and 2) was admitted to the facility on [DATE], went back out to the hospital for syncope on 9-5-24, and returned on 9-8-24. Hospital discharge records indicated that the Resident was alert and oriented to person, place and time, and was ambulatory at the time of discharge. Diagnoses included but were not limited to: Heart failure, hypertension, Gastro Esophageal reflux disease, renal insufficiency, diabetes, thyroid disorder, dementia, malnutrition, and asthma. Resident #521's most recent Minimum Data Set with an Assessment Reference Date of 9-5-24 after one day in the facility was coded as an admission assessment. The Brief Interview for Mental Status was coded as 12 out of a possible 15 points which indicated mild cognitive impairment, however, the language barrier may have contributed to a false lower score. The Resident was her own responsible party. The Resident spoke only Spanish. The Resident required extensive assistance from one staff member for hygiene and bathing. On 10-1-24, the first day of survey, Resident #521 went out to a medical appointment and lost consciousness while there. She was sent directly to the hospital, and did not return during the remainder of the survey. While on continued tour of the facility on 10-4-24, Resident #68 was interviewed and asked if any person in the facility had abused her or if she had ever witnessed abuse. She stated yes that her former room mate (Resident #521) had kicked her, thrown fruit at her, hit her, and had spit on her. She stated that Resident #521 had also cursed and yelled at her, gotten in her bed, held her wheel chair so she could not leave the room for help, and had stood over her while she was laying in bed menacing her. She stated that she had been bruised by the kick and punch, but luckily suffered no other injuries. She further stated that she had complained to staff repeatedly but they did nothing until 9-20-24 when Resident #521 punched her in the arm and the Assistant Director of Nursing saw it. She went on to say that they moved her that day. The Resident was asked if she was still afraid and she stated no, she's gone now. On 10-7-24 the clinical records of Resident's #68, and #521 were reviewed. Those reviews contained the following information in chronological order; On 9-20-24 at 3:42 PM the records indicated that Resident #521 had been moved to another room for Safety. No other descriptions about the allegations of abuse on Resident #68 were documented. On 9-20-24 Resident #521's progress notes documented she was moved to the room containing Resident #20. On 9-21-24 at 12:47 AM (7.5 hours later) after the move, progress note review indicated that Resident #521 was observed to throw a cup of water across the room and spit on her new room mates charger for her electric wheel chair. (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9-21-24 at 8:41 PM, Later the same day, documents record Resident #521 hit Resident #20 and it was witnessed by staff. There was no mention of the scratches to Resident #20 inflicted by Resident #521. On 9-22-24 at 1:34 AM (5 hours later) progress notes go on to describe that Resident #521 was moved to a private room. (Victim #3 unknown name) On 9-22-24 at 2:54 AM, (1.5 hours after move) another note describes Resident #521 as standing next to her neighbors bed (unknown which neighboring room to the private room or which Resident this involved) staring at her (the neighbor of Resident #521) while sleeping and threatened anger aggressive behavior. On 9-23-24 a psychiatric consultation was ordered. It was never obtained. On 9-25-24 the Physician's Assistant (PA) described in a note that (Resident #521) Patient assault on room mate multiple times, resident denied, on alternate location at this time. On 10-7-24 Resident #20 was interviewed and stated that Resident #521 was placed in her room and almost immediately began to yell at her, spit at her, and throw things at her. She went on to state that Resident #521 finally came over to her side of the room after dinner sometime and lashed out at her hitting her, causing several small scratches on her hand. She stated she was fending off the blows with her arm raised. and Resident #521's fingernails scratched her. She went on to state that the staff saw it and moved her out of the room until they could find a place for Resident #521. She stated that Resident #521 was moved Sometime late that night around midnight. Resident #20 was asked if she was afraid of Resident #521, and she stated no, she went to the hospital and I don't think she's ever coming back. Nursing staff on the units where Resident #521 was housed were interviewed and stated they remembered Resident #521, and her aggressive behaviors, however, those working during survey interviews were not present during the abuses. They stated they were aware of the incidents, however, most of the staff were from a staffing agency and did not work there every day. During interview and review of the clinical record, it was found that the Social Worker/Discharge Planner (SWDP) was only involved with Resident #521 on 3 occasions. Those instances follow below: 1. Nine days after admission on 9-13-24 for a Trauma Informed Care assessment which was negative for trauma experienced by the Resident. 2. After the first abuse on 9-20-24 to Resident #68, to notify Resident #521's son of the first room change. 3. Finally, at the first Interdisciplinary care plan meeting on 9-26-24 with only the SWDP and the Activity Assistant present. (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility staff provided a copy of their Abuse policy, and the policy review revealed that all allegations of abuse will be investigated, Residents will be protected and prevented from further abuse, reports will be sent initially to the State agency VDH/OLC (and other agencies) within 24 hours or within 2 hours if serious injury occurs, and a follow up report will be sent in 5 days to include findings and corrections. Resident #68 reported abuse for days before staff observed the abuse and moved Resident #521. Resident #521 was then placed with Resident #20 who was not protected and was abused. Resident #521 was moved again and went to a third unknown Resident's room to abuse. The allegations of abuse were never reported to the state agency. Residents were not protected from a known abuser. Abuse was not investigated fully, and the facility policy was not implemented for the protections of Residents from abuse. Further, there was never any added staff supervision for Resident #521 to prevent the abuse from continuing. No staff ever noted the suspicion of a crime, so no police report was ever filed. The first alleged report by the Administrator was never signed and had errors in information giving the appearance of a severely demented alleged abuser to APS in a single occurrence resulting in no investigation opened by them. Resident #521's nursing and physician progress notes were reviewed and revealed the following: 9-8-24 nurses documented Resident with language barrier (speaks only Spanish) states frustration with interpreter. 9-11-24 the physician documented Plan: - The patient has had a diagnosis of depression or has had a diagnosis of Bipolar Disorder. 9-12-24 nurses documented refused, wants to be left alone to therapy, refused weight yelling in Spanish 9-19-24 nurses documented Google translator only means of translation in the facility. 9-20-24 nurses documented room change for safety. 9-21-24 12:47 AM nurses documented woke from nap anxious, stating dead bodies everywhere, resident extremely restless and gestures for sleep but will not stay in bed more than 15-20 minutes at a time. 9-21-24 10:41 PM nurses documented Aggression and hitting roommate, removed from room. 9-22-24 1:34 AM nursing notes documented another room change to a private room. 9-22-24 2:54 AM nursing notes Aggressive behavior standing over sleeping neighbor threatening neighbor room. (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9-23-24 2:45 PM nursing note Psyche consult placed in psyche referral book. 9-23-24 11:12 PM nursing note difficulty communicating with Resident. 9-25-24 physician documented resident's roommate spoke up about Resident #521 laying hands on her multiple times. Staff made aware, management involved, room changed. That reveals that the physician was only aware of one abuse victim, and not the other two. Resident #521's frustration was identified on day 1, and no plan was implemented to improve communication between staff and residents for this Resident. The psychiatric evaluation was put in a book at the nursing station awaiting the next visit from psyche professionals to see other residents before they knew Resident #521 needed services. This was revealed during interview at the nursing station when the consult book was requested, on 10-7-24 they stated that's our procedure. From 9-4-24 through 10-1-24 (28 days), no psychosocial nor behavioral services were ever afforded a disturbed Resident #521 even after 3 abuses of other Residents and aggression toward staff. Resident #521's care plan was reviewed and revealed no focus nor interventions for dementia, language barrier, nor behaviors was ever derived nor implemented before or after the abuses occurred. Resident #521's physician's orders and progress notes were reviewed and revealed On 9-8-24 Geriatric psyche consult (as needed) PRN. No other assessments nor orders for behavioral health support were ever obtained. Resident #521's Social Work/Discharge Planning (SW/DP) notes were reviewed and only 4 existed in the clinical record. They are as follows: 9-13-24 Trauma informed screening completed . Resident has experienced none at this time. Resident has no reported trauma indicators. 9-13-24 Psychosocial, medical and behavioral health related needs explained. None, Patient is alert and oriented times 2. Patient is long term care, and has no advanced directive. 9-20-24 (name) Resident notified of room change. Family/responsible party notified of room change. Reason for room change: Safety. 9-26-24 IDT (interdisciplinary team) met for the patients care plan meeting. Members in attendance were the Activities assistant and Discharge planner (DCP), aka (SW/DP), DCP called the patients son and left a voicemail regarding the care planning meeting. The patient declined to participate in the meeting. The SW/DP was interviewed on 10-8-24 and was asked why no social work notes existed for this Resident's distressed behavior, and she stated she had not known as none of the staff alerted her to the issues. She stated she was aware of the single first altercation with her roommate, and that she had been moved, but she was not further updated after that or she would have documented those moves as well. (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10-9-24 at approximately 5:30 p.m., the facility Administrator, Corporate Registered Nurse, and Corporate Administrator were notified of the findings. They stated they had no further information or documentation to offer.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review, the facility staff failed to procure routine medications as ordered by the physician for 2 Residents (#142, #161) in the survey sample of 55 residents and establish a system of records of receipt and disposition of all controlled drugs. The findings included: 1. For Resident #142 the facility staff failed to sign off administration of all 9 a.m. medications on 9/1/24 as well as failing to document why the medications were not given. On 10/10/24 during clinical record review it was discovered that Resident #142 did not receive any of his 9 a. m. medications on 9/1/24. Those medications included vitamins, iron, aspirin (given for dx. of Atrial Fibrillation, a cardiac arrhythmia) and Namenda (a medication given to slow the progression of dementia). The record contained no skilled charting for 9/1/24 and none of the ordered vital signs for that shift. On 10/10/24 at approximately 2 p.m. an interview with the DON and the Clinical Nurse Consultant was conducted, and the DON stated, If it wasn't documented it wasn't done. She indicated that the nurse should have done the vital signs and documented if the medication was refused or held and the reason why and notification of the physician. She stated that as it stands it gives the appearance that nothing was done. A review of the document entitled Medication Administration Policy revealed the following excerpt: Page 4 II Administration 2. Medications are administered in accordance with written orders of the prescriber. Page 5 16. For residents not in their rooms or otherwise unavailable to receive medications on the pass, the MAR is 'flagged.' After completing the medication pass, the nurse returns to the missed resident to administer the medication. On 10/10/24 during the end of day meeting the Administrator was made aware of the findings and don further information was provided. 2. For the Facility, the facility staff failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DHP presented concrete evidence that too many count narcotics were observed in an unlocked file cabinet. On 10/10/24 at approximately 9:00 a.m. the following nurses on each unit were interviewed about the facility process for destroying narcotics. Unit 1 - LPN (Licensed Practical Nurse) # 3 was asked the process for disposal of narcotic medications no longer in use and she stated that the card of meds and the narc sheet were kept locked in the narc box on the cart until the DON came to collect them for disposal. When asked how many nurses were required to waste narcotics, she stated 2 and both must sign the narc sheet after verifying the count and witnessing the disposal. Unit 2- LPN #6 was asked the process for disposal of narcotic medications no longer in use and she stated that the meds and the narc sheet were kept locked in the narc box on the cart until the DON came to collect them for disposal. When asked how many nurses were required to waste narcotics, she stated 2 and both must sign the narc sheet after verifying the count and witnessing the disposal. She added that the narcotics must continue to be counted every shift change until they were destroyed. Unit 3- LPN #5 was asked the process for disposal of narcotic medications no longer in use and she stated that the meds and the narc sheet were to be counted every shift and left locked in the narc drawer until the DON came to collect them for disposal. When asked how many nurses were required to waste narcotics, she stated 2 and both must sign the narc sheet after verifying the count and witnessing the disposal. Unit 4 - RN #1 was asked the process for disposal of narcotic medications no longer in use and she stated that the DON and another nurse will come and get the unused narcotics and take them for disposal. She stated until then they are kept locked in the cart and counted as usual shift to shift. When asked how many nurses are required to waste narcotics, she stated always 2 nurses. On 10/10/24 at approximately 11 a.m. the current DON and the Corporate Nurse Consultant were shown the evidence submitted by the DHP (Dept. of Health Professions). The DON stated that, though that might have been the process in the past the current process for narcotic destruction is that the medications and the count sheets stay locked on the cart until the DON picks them up then if she has no one to witness destruction she will lock them in the safe in her office until another Nurse is available to witness and countersign the form. The DON demonstrated use of the safe. On 10/10/24 during the end of day meeting the Administrator was made aware of the findings and don further information was provided. 34894 3. For Resident # 161, the facility staff failed to ensure that oral antibiotics were available for administration as per physician's orders. Resident # 161 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, Primary Osteoarthritis of the Knee, Septic Arthritis of the Knee, Heart Failure, and edema. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Virginia Beach Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 Camelot Drive Virginia Beach, VA 23454	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent Minimum Data Set (MDS) was an Admission Assessment with an Assessment Reference Date (ARD) of 9/10/2024. Resident # 161's BIMS (Brief Interview for Mental Status) Score was a 14 out of 15, indicating no cognitive impairment. Review of the clinical record was conducted on 10/9/2024-10/11/2024. Review of the clinical record revealed the following order: Amoxicillin Oral Capsule 500 mg (milligrams) Give 2 capsules by mouth three times a day related to Arthritis due to other bacteria, left knee, for 14 Days. Give with food. Order Date-09/18/2024 0833 The medication was scheduled for administration at 9:00 a.m., 2:00 p.m., and 9:00 p.m. and to stop on 10/1/2024 at 9:00 p.m. Review of the September 2024 Medication Administration Record revealed documentation that the antibiotic (Amoxicillin) was started on 9/18/2024 at 9:00 a.m. and was not available for administration 6 times during the two week course of treatment, including four consecutive missed doses on 9/28/2024-9/29/2024. The dates of missed doses were: Amoxicillin was not administered on: 9/21/2024 at 9:00 p.m. 9/28/2024 at 9:00 p.m. 9/29/2024 at 9:00 a.m. 9/29/2024 at 2:00 p.m. 9/29/2024 at 9:00 p.m. 10/1/2024 at 9:00 a.m. Review of the Progress Notes revealed documentation that the Amoxicillin was not administered because it was on order. On 10/9/2024 at 2:05 p.m., inspection of the B cart on Unit 4 was conducted with LPN (Licensed Practical Nurse)- 4. LPN-4 stated the medications come on a blister pack for each resident. The blister pack should have the medications for each scheduled dose. LPN-4 stated if medication was not available, the nurse was expected to check the Omnicell for an available supply of the medication and to notify the Pharmacy that the medication was not available. The nurse would order the medication from the Pharmacy so it would be available for the next scheduled dose. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/2024 at 11 a.m., an interview was conducted with the Regional Nurse Consultant (Corporate-2) who stated medications should be available for administration as ordered by the physician. Corporate-2 stated the Pharmacy should have ensured the medication was available for administration. She also stated the nurses should have checked the Omnicell (in house Stat box) for an available supply of the medication. Corporate-2 stated she did not understand why a blister pack of medications from the Pharmacy would not have been available for the nurses to have administered the medications. Corporate-2 explained that on the first day the order was written, the Pharmacy would have sent a blister pack with the entire 14 day course of medication. The nurses would have had access to the medications for each time of scheduled administration. During the end of day debriefing on 10/11/2024, the Facility's Acting Administrator, Administrator in Training, Regional Nurse Consultant (Corporate-2) and Director of Nursing were informed of the findings. No further information was provided.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49917 Based on observations, resident interview, staff interview, clinical record review, and review of facility documents, the facility staff failed to ensure significant medication was administered for 5 of 55 residents (Resident #47, Resident #57, Resident #424, Resident #372 and #161), in the survey sample. The findings included: 1. Resident #47 was originally admitted to the facility 3/11/20. The resident's diagnoses included chronic obstructive pulmonary disease, essential hypertension, anemia, and constipation. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/22/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #47's cognitive abilities for daily decision making were intact. On 10/1/24 at 7:00 PM an interview was conducted with Resident #47. Resident #47 stated that there was no nurse on unit 3 from 3pm to 11pm and 11pm to 7am on 8/17/24. Resident #47 also stated that due to this, she did not receive the scheduled dose of Lisinopril on 8/18/24. Resident #47 voiced that due to not taking this medication, she experienced severe pain in her neck, head, and shaking of her hands. The Physician's Order Summary (POS) for August 2024 read: Lisinopril Tablet 5 MG Give 1 tablet by mouth two times a day for hypertension Hold for SBP<110mmHg. A review of the Medication Administration Record (MAR) revealed that Resident #47 missed 1 dose of Lisinopril Tablet 5 MG Give 1 tablet by mouth two times a day on the following date: 8/18/24. Lisinopril is in a class of medications called angiotensin-converting enzyme (ACE) inhibitors. It works by decreasing certain chemicals that tighten the blood vessels, so blood flows more smoothly and the heart can pump blood more efficiently. https://medlineplus.gov/druginfo/meds/a692051.html On 10/7/24 at 12:50 PM an interview was conducted with the two Regional Nurse Consultants. The Regional Nurse Consultants stated that the medication was available for Resident #47, and they could not explain why the resident was not administered the medication on 8/18/24. On 10/9/24 at approximately 5:30 PM, a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing, and the two Regional Nursing Consultants. They had no further comments and voiced no concerns regarding the above allegation. 40026 2. For Resident #57 the facility staff failed to administer Flomax, Gabapentin, and Eliquis and amlodipine as ordered by physician. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #57 was admitted to the facility on [DATE] with diagnoses that include but were not limited to hemiplegia and hemiparesis following cerebral infarction, benign prostatic hyperplasia, acute embolism and thrombosis, and personal history of transient ischemic attack. Resident #57 most recent MDS (Minimum Data Set with an ARD (Assessment Reference Date) of 10/3/24 coded Resident #57 as having a BIMS (Brief Interview of Mental Status) score of 15/15 indicating no cognitive impairment. On the morning of 10/8/24 an interview was conducted with Resident #57 who stated that sometimes he didn't get his medicine on time. He stated that sometimes they even missed his meds if he went to an activity. On 10/10/24 a review of the clinical record revealed that Resident #57 had the following orders: Eliquis Oral Tablet 2.5 MG (Apixaban) Give 1 tablet by mouth two times a day for anticoagulation -Order Date-09/13/2023 Not given on 9/13. 9/14/24 at 5 p.m. Baclofen Tablet 10 MG Give 2.5 tablet by mouth in the afternoon for Muscle relaxer -Order Date- 03/27/2023 9/13-14 4p.m. Baclofen Tablet 10 MG Give 2 tablet by mouth at bedtime for Muscle relaxer -Order Date 9p.m. 9/13/14/18 Not given 9/13, 9/14/24 at 4.p.m. Not given 9/13, 9/14, & 9/18/24 at 9 p.m. Flomax Capsule 0.4 MG (Tamsulosin HCl) Give 1 capsule by mouth one time a day for benign prostatic hyperplasia -Order Date- 08/01/2022 Not given on 9/13, 9/14/24 at Not signed off as administered on 9/13/24 and 9/14/24 at 5 p.m. Gabapentin Capsule 300 MG Give 1 capsule by mouth two times a day for pain -Order Date- 08/02/2022. Not signed off as being administered on 9/13/24 and 9/14/24 at 5 p.m. Eliquis Oral Tablet 2.5 MG (Apixaban) Give 1 tablet by mouth two times a day for anticoagulation -Order Date- 09/13/2023 9/13/24, 9/14/24, 10/4/24 at 5 p.m. and 10/3/24 at 9 a.m. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Amlodipine besylate Tablet 5 MG Give 1.5 tablet by mouth one time a day for HTN Hold for SBP<120 -Order Date- 10/04/2022 Amlodipine - Signed off as given on 9/7/24, with b/p of 106/63, on 9/8/24 with b/p of 106/63, 9/9/24 given with bp 104/65, on 9/21/24 with a b/p of 116/81, and on 9/28/24 with a b/p of 115/80. A review of the clinical record revealed that there was no nursing notes entered to explain why medications were not given for the dates in September however the 10/3/24 and 10/4/24 progress notes read: Orders -Administration Note - Note Text: Pt. not in room, when med due. On 10/10/24 at approximately 2 p.m. an interview with the DON and the Clinical Nurse Consultant was conducted, and the DON stated, If it wasn't documented it wasn't done. She indicated that the nurse should have done the vital signs and held the medications per parameters for the amlodipine. When asked if it is the expectation of the facility that nurses administer medications per physician order, and she stated that it was. When asked what should be done if the Resident was not in the room when she was passing medications, she stated that the nurse should have come back at a later time or went to find the Resident. When asked what should be done when a medication is not given, she stated that the physician should be notified, and it should be documented in the chart. A review of the medication administration policy revealed the following excerpts. Page 4 II Administration 2. Medications are administered in accordance with written orders of the prescriber. Page 5 16. For residents not in their rooms or otherwise unavailable to receive medications on the pass, the MAR is flagged. After completing the medication pass, the nurse returns to the missed resident to administer the medication. On 10/10/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 3. For Resident #424 the facility staff failed to notify physician / seek clarification on giving medications the pharmacy has identified as having a possible serious drug interaction. Resident #424 was admitted to the facility on [DATE] with diagnoses of but not limited to extended Spectrum Beta Lactamase (ESBL) Resistance, vascular dementia, without behavioral disturbance, psychotic disturbance, mood disturbance anxiety, COPD (Chronic Obstructive Pulmonary Disease, CHF (Congestive Heart Failure) diabetes and A-Fib. On 10/10/24 a review of the clinical record revealed that on 10/5/24 Resident #424 was prescribed Levofloxacin (an antibiotic) for respiratory symptoms associated with COPD. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	After entering the order for Levofloxacin into the system the pharmacy responded by entering the following alert into the progress notes: Effective Date: 10/05/2024 4:16 p.m. Type: Order Note: The order you have entered Levofloxacin Tablet [an antibiotic] 500 MG Give 1 tablet by mouth one time a day for infection for 5 Days Has triggered the following drug protocol alerts/warning(s): Drug to Drug Interaction: The system has identified a possible drug interaction with the following orders: Citalopram Hydrobromide Tablet 20 MG [an anti-depressant] Give 1 tablet by mouth one time a day for depression Severity: Severe Interaction: Additive QT interval prolongation may occur during coadministration of moderate-risk QT-prolonging agents, Citalopram Hydrobromide Oral Tablet 20 MG and levofloxacin Oral Tablet 500 MG. This warning was repeated 2 more times in the progress notes on the following dates/times: Effective Date: 10/06/2024 12:19 p.m. Effective Date: 10/06/2024 8:32 p.m. [QT Prolongation can be caused by electrolyte abnormalities or certain medications, such as antibiotics, antifungals, diuretics, antidepressants, antipsychotics, and antiarrhythmics. A prolonged QT interval can lead to torsade's de pointes, a potentially life-threatening type of irregular heart rhythm. A corrected QT interval (QTC) of more than 500 milliseconds (MS) or an increase in the QTC of more than 60 MS is generally considered to indicate a high risk of torsade's de pointes.] On the afternoon of 10/9/24 an interview was conducted with LPN (Licensed Practical Nurse) #6 who was asked what the nurses do when the pharmacy flags a new order with a drug-to-drug interaction. LPN #6 stated that she thought that alert was for the prescriber to deal with since they have access to Resident charts. On 10/10/24 at approximately 2 p.m. an interview with the DON and the Clinical Nurse Consultant was conducted, when asked if it is the expectation of the facility that nurses administer medications per physician order and the DON stated that it was. When asked what should be done if the physician order is questioned by the pharmacy, is flagged by the pharmacy or is unclear and she stated the physician should be notified and clarification should be given and documented in the nurse notes. When asked if this was done in this case and she stated that it was not. On 10/10/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	40711 4. Resident #372 was originally admitted to the facility on [DATE] from an acute hospital stay and discharged on [DATE]. The facility's staff failed to procure and administer Resident #372's Anti-Seizure medication, Insulin and Analgesic, narcotic medications for numerous days. Diagnosis for Resident #372 included but not limited to Diabetes Mellitus and Stage 3 Chronic Kidney Disease. The discharge Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 08/16/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #372 cognitive abilities for daily decision making were intact. The Physicians Order Summary (POS) for July read: clonazepam Oral Tablet Disintegrating 0.125 MG (Clonazepam) Give 1 tablet by mouth two times a day for psychosomatic disorder. Dated: 7/28/2024. Clonazepam Oral Tablet Disintegrating 0.125 MG (Clonazepam) Give 2 tablet by mouth two times a day for psychosomatic disorder. Dated: 7/30/24. Divalproex Sodium ER Oral Tablet Extended Release 24 Hour 500 MG (Divalproex Sodium) Give 1 tablet by mouth at bedtime for seizure disorder. Dated: 7/28/24. Insulin Glargine Subcutaneous Solution Pen injector 100 UNIT/ML Inject 10 unit subcutaneously at bedtime for Diabetes Mellitus 2. Dated: 7/30/2024. Insulin Glargine Subcutaneous Solution Peninjector 100 UNIT/ML. Inject 10 unit subcutaneously one time a day. Dated: 7/28/24. Insulin Glargine subcutaneously one time a day for Diabetes 2 Dated: 7/30/24 Insulin Glargine, Subcutaneous Solution Peninjector 100 UNIT/ML (Insulin Glargine) Inject 20 unit subcutaneously at bedtime for Diabetes Mellitus. Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) Give 1 tablet by mouth every 8 hours as needed for Pain for 14 Days. Order date 7/29/2024. The POS for August Read: Divalproex Sodium ER Oral Tablet Extended Release 24 Hour 500 MG (Divalproex Sodium) Give 1 tablet by mouth at bedtime for seizure disorder. Order Date 7/28/2024. Missed dose on 7/31/24 at 9:00 PM, 8/03/24 at 9:00 PM. Insulin Glargine Subcutaneous Solution Peninjector 100 UNIT/ML (Insulin Glargine) Inject 20 unit subcutaneously at bedtime for Diabetes Mellitus. Order Date 7/30/2024. Missed dose on 7/31/24 at 9:00 PM, 8/03/24 at 9:00 PM. Clonazepam Oral Tablet Disintegrating 0.125 MG (Clonazepam) Give 2 tablet by mouth two times a day for psychosomatic disorder. Order Date 7/30/2024. Missed dose on 8/03/24 at 6:30 PM. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ketorolac Tromethamine Tablet 10 MG Give 1 tablet by mouth two times a day for inflammation for 5 Days. Order Date 8/01/2024. Missed doses on 8/03/24 at 4:00 PM. Lidocaine Pain Relief External Patch 4 % (Lidocaine) Apply to back topically two times a day for pain. Order Date 7/28/2024. Missed doses 8/03/24 at 7:30 AM., and on 8/07/24 at 4:00 PM. Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) Give 1 tablet by mouth three times a day for pain. Order Date 08/01/2024. Missed 8/03/24 at 8:00 PM. What is clonazepam used for? Clonazepam is commonly used to treat the following conditions. Certain types of seizure disorders, also called epilepsy. How does clonazepam work (mechanism of action)? Clonazepam produces a calming effect on the brain and nerves, which helps to reduce anxiety, prevent seizures, and promote relaxation. How is clonazepam supplied (dosage forms)? Clonazepam is available as Klonopin, Klonopin ODT, and generic clonazepam in the following dosage forms that are taken by mouth.https://www.webmd.com/drugs/2/drug-920-6006/klonopin-oral/clonazepam-oral/details. Divalproex sodium is used to treat certain types of seizures (epilepsy). This medicine is an anticonvulsant that works in the brain tissue to stop seizures (https://www.mayoclinic.org/drugs-supplements/divalproex-sodium-oral-route/description/drg-20072886). Insulin glargine is a long-acting type of insulin that works slowly, over about 24 hours. Insulin is one of many hormones that help the body turn the food we eat into energy. This is done by using the glucose (sugar) in the blood as quick energy. Also, insulin helps us store energy that we can use later. When you have diabetes mellitus, your body cannot make enough insulin or does not use insulin properly. This causes you to have too much sugar in your blood. Like other types of insulin, insulin glargine is used to keep your blood sugar level close to normal. You may have to use insulin glargine in combination with another type of insulin or with a type of oral diabetes medicine to keep your blood sugar under control.https://www.mayoclinic.org/drugs-supplements/insulin-glargine-recombinant-subcutaneous-route/description/drg-20067770. Oxycodone hydrochloride: A drug used to treat moderate to severe pain. It is made from morphine and binds to opioid receptors in the central nervous system. Oxycodone hydrochloride is a type of analgesic agent and a type of opiate.https://www.cancer.gov/publications/dictionaries/cancer-terms/def/oxycodone-hydrochloride. Prescription lidocaine transdermal (Dermalid, Lidoderm, Ztildo) is used to relieve the pain of post-herpetic neuralgia (PHN; burning, stabbing pains, or aches that may last for months or years after a shingles infection). Nonprescription (over-the-counter) lidocaine (Absorbine Jr, Aspercreme, Lidocare, Salonpas, others) is also available to relieve minor pain in shoulders, arms, neck and legs in adults and children [AGE] years of age and older. Lidocaine is in a class of medications called local anesthetics. It works by stopping nerves from sending pain signals.https://medlineplus.gov/druginfo/meds/a603026.html (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/2024 at approximately 6:00 p.m., the above findings were shared with the Acting Administrator in Training, Director of Nursing and the Regional Nurse Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. 34894 5. For Resident # 161, the facility staff failed to ensure that antibiotics were administered as per physician's orders. There were six missed doses during the course of treatment including 4 consecutive doses. Resident # 161 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, Primary Osteoarthritis of the Knee, Septic Arthritis of the Knee, Heart Failure, and edema. The most recent Minimum Data Set (MDS) was an Admission Assessment with an Assessment Reference Date (ARD) of 9/10/2024. Resident # 161's BIMS (Brief Interview for Mental Status) Score was a 14 out of 15, indicating no cognitive impairment. Review of the clinical record was conducted on 10/9/2024-10/11/2024. Review of the clinical record revealed the following order: Amoxicillin Oral Capsule 500 mg (milligrams) Give 2 capsules by mouth three times a day related to Arthritis due to other bacteria, left knee, for 14 Days. Give with food. Order Date-09/18/2024 0833. Review of the September 2024 MAR (Medication Administration Record) revealed that the order was started on 9/18/2024 at 9:00 a.m. and continued through 10/01/2024 at 9:00 p.m. The scheduled times of administration were 9:00 a.m., 2:00 p.m., and 9:00 p.m. Review revealed there were six doses not administered during the course of treatment. Amoxicillin was not administered on: 9/21/2024 at 9:00 p.m. 9/28/2024 at 9:00 p.m. 9/29/2024 at 9:00 a.m. 9/29/2024 at 2:00 p.m. 9/29/2024 at 9:00 p.m. 10/1/2024 at 9:00 a.m. Review of the Progress Notes revealed documentation that the Amoxicillin was not administered because it was on order. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/2024 during clinical record review, it was noted that Resident # 161's order for Amoxicillin was supposed to be administered for 14 days. The Medication Administration Record revealed there had been 6 doses missed during the prescribed course of treatment. Four consecutive doses were missed from 9/28/2024 at 9:00 p.m. to 9/29/2024 at 9:00 p.m. The six missed doses equated to a total of two full days of missed doses. There was no indication that the antibiotic was extended to additional days to cover the missed doses. On 10/11/2024, the Regional Nurse Consultant (Corporate-2) was asked if antibiotics should be continued as ordered. She stated it was very important. When asked why it was important to continue the antibiotics as prescribed, Corporate-2 stated that it was important because the antibiotics were prescribed to kill the bacteria. She also stated that taking all of the antibiotic as prescribed would prevent the bacteria from growing and becoming antibiotic resistant. According to the Mayo Clinic, antibiotics are important drugs that can successfully treat infections caused by bacteria. Antibiotics can prevent the spread of disease. The way drugs are used affects how quickly and to what degree resistance occurs. It also stated: You need to to take the full treatment to kill the disease-causing bacteria. If you do not take an antibiotic as prescribed, you may need to start treatment again later. If you stop taking it, it can also promote the spread of antibiotic-resistant properties among harmful bacteria. The article also stated that Drug resistant infections can cause many problems including: More-serious illness, longer recovery, more-frequent or longer hospital stays, more health care provider visits and more-expensive treatments. Complete the entire treatment. During the end of day debriefing on 10/11/2024, the Facility's Acting Administrator, Administrator in Training, Regional Nurse Consultant (Corporate-2) and Director of Nursing were informed of the findings. No further information was provided.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49917 Based on observation and staff interview, the facility staff failed to remove expired medications and provide the date medications were opened on 2 of 4 facility units. The findings included: 1. On 10/9/24 at 12:55 PM an observation of the medication administration cart on Unit 3 with Licensed Practical Nurse (LPN) #1 revealed 1 opened multi-dose Humalog (insulin lispro) 100 units/ml KwikPen with an open date of 9/6/24. A review of the manufacturer's literature indicated to discard the insulin lispro Kwikpen 28 days after opening. An interview with LPN #1 was conducted on 10/9/24 at 12:57 PM. LPN #1 stated that the Humalog (insulin lispro) 100 units/ml KwikPen should not be on the medication cart due to the opening date being more than 28 days. 2. On 10/9/24 at 1:05 PM an observation of the medication administration cart on Unit 3 with Licensed Practical Nurse (LPN) #1 revealed 1 opened multi-dose Fiasp (insulin aspart) 100 units/ml injection pen with an open date of 7/31/24. A review of the manufacturer's literature indicated to discard the Fiasp (insulin aspart) 100 units/ml injection pen 28 days after opening. An interview with LPN #1 was conducted on 10/9/24 at 1:07 PM. LPN #1 stated that the Fiasp (insulin aspart) 100 units/ml injection pen should not be on the medication cart due to the opening date being more than 28 days. 3. On 10/9/24 at 1:10 PM an observation of the medication administration cart on Unit 3 with Licensed Practical Nurse (LPN) #1 revealed two (2) Toujeo (insulin glargine) 300 units/ml injection pens opened and undated. An interview with LPN #1 was conducted on 10/9/24 at 1:10 PM. LPN #1 stated that per training/competency, every nurse should put the date of opening on medications. On 10/9/24 at approximately 5:30 PM, a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing, and the two Regional Nursing Consultants. They had no further comments and voiced no concerns regarding the above allegation. 34894 4. For Unit 4-Skilled unit on the B cart, the facility staff failed to ensure the over-the- counter medications were labeled when opened. There were two carts (Cart A and Cart B) on each of the four units at the facility. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/9/2024 at 2:05 p.m., inspection of the B cart on Unit 4 was conducted with LPN (Licensed Practical Nurse)- 4. There were four bottles of over the counter medications that were open and available for use but not dated with a date of when opened. The medications not dated were: Senna 8.6 milligrams bottle of 100 tablets- bottle not dated, seal was open- approximately half empty. Ferrous Sulfate 325 milligrams - not dated and approximately a quarter was missing. Naproxen 220 milligrams, not dated, seal broken, approximately a quarter of the bottle was missing. Chewable aspirin 81 milligrams not dated, seal was broken, approximately a quarter of the bottle was missing. While inspecting the medication cart, an interview was conducted with LPN (Licensed Practical Nurse)-4 who stated the expectation was for all medications to be dated when opened. LPN-4 stated nurses should check to see the date the bottle was opened prior to administering the medications. During the end of day debriefing on 10/9/2024, the facility Administrator, [NAME] President of Operations-Acting Administrator (Administration-2), Director of Nursing and two Regional Nurse Consultants (Corporate-1 and Corporate-2) were informed of the findings. The Director of Nursing stated the expectation was for the bottles of medications to be dated upon opening. No further information was provided prior to survey exit		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40026 Based on observation, interview, clinical record review and facility documentation, the facility staff failed to serve food that is palatable, attractive, and an appetizing temperature for Residents on 4/4 units. The findings included: The facility staff was utilizing Styrofoam take out containers to serve food due to an inoperable dishwasher from August 9, 2024 - October 10, 2024. The Residents of all units complained about food being cold due to it sitting on the carts in the hall before being served. On 10/7/24 during the kitchen inspection it was noted that all food temps were within safe and acceptable ranges. food was plated in the Styrofoam containers and placed on the cart to send to the various units. Once arriving on the units the food was distributed by the CNA's. The time the carts sat on the floor before trays were delivered ranged from 10-20 minutes. Residents on 4/4 units complained of Lukewarm or Cold food. Many Residents stated that since they are using Styrofoam the food is cold. A review of the work orders and emails from maintenance to corporate revealed the dishwasher has been down since 8/9/24. Residents complained the portions were small and the food was not good. The following are excerpts from the Resident council indicating that the repeated food concerns have gone unaddressed by the Administration. 4/24/24 - Oatmeal watery, some residents getting trays not enough food not getting coffee o every meal not getting food that is on the ticket, not getting alternative requested. 5/29/24 Bring back dinner in dining room, would like hot tea instead of coffee, who do you tell you want alternative meal? 6/26/24 - Diets not being followed, tickets not matching trays, want more vegetables and fruits, condiments and decaf coffee, Chicken is hard over cooked difficult to eat, French fries/potatoes are not cooked all the way, food is cold. 7/23/24 - residents' would like bigger breakfast portions, more fresh fruit, diets not being followed / trays not matching ticket, decaf coffee, English muffin/bread not being toasted. 8/28/24 - portions small for all meals food cold no flavor more seasoning more variety. 9/24/24 - Small potions during breakfast / dinner meals, want more fruit, only getting a half a sandwich for snack, more variety of meals. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/11/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40026 Based on observation, interview, and facility documentation the facility staff failed to ensure food was prepared, in accordance with professional standards for food service safety for 1 of 4 kitchen staff. The findings included: The preparing the evening meal on 10/7/24 failed to ensure the beard guard was sufficient to cover his large amount of facial hair. On 10/7/24 at approximately 5:00 PM a staff member who identified himself as the cook (Other Employee #9) was observed preparing food with a beard guard that only halfway covered his facial hair. When asked about it he stated, It's the only one the facility provides, and it doesn't fit right. A review of the facility policy entitled Staff Attire read: Policy Statement: It the center policy that all Dining Services employees wear approved attire for the performance of their duties. Action Steps: 1. The Dining Services Director ensures that all staff members have their hair off their shoulders confined in a hair net or cap and facial hair properly restrained. On 10/7/24 at approximately 5:30 p.m. Corporate employee #1 went to kitchen with surveyor and observed employee #9 and she stated that it was the expectation of the facility and the facility policy that facial hair is fully covered. On 10/11/24 during the end of day meeting the Administrator was made aware and no further information was provided		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 34894 Based on observation, staff interview, facility documentation review, the facility staff failed to ensure the facility was administered effectively to maintain the highest practicable well being of each resident. The findings included: The facility had a multi-system failure to include deficient practices including environmental services, sanitary and a safe building and dining, infection control practices, medication storage and administration, and resident abuse. These issues affected the quality of life of the residents in the facility. During the survey, investigations revealed the facility had issues involving multiple systems. There were issues involving environmental services to include inadequate laundry services with only one working washing machine for several months. Residents were complaining of not having adequate linens for their beds, not being able to get clean gowns , not getting their personal clothing washed and returned in timely manner. Staff members were observed while performing duties and providing care. Some staff members were overheard apologizing to other staff members for using the last gowns during incontinence care rounds. Staff members were interviewed by surveyors who stated there had been issues with the laundry for months. Inspection of the kitchen revealed unsanitary conditions including rodent activity, roaches and an unsanitary ice machine. Resident expressed concerns about the food from the Dietary department. There were issues with resident to resident abuse where the facility staff did not protect other residents from the perpetrator. Substandard quality of care was identified at the facility during the survey resulting in an extended survey from 10/8/2024-10/11/2024. The Maintenance logs, Pest control logs were reviewed by the survey team. Review of the Resident Council minutes and Grievance logs revealed the facility's administration was aware of issues/concerns voiced by residents and families. The issues continued for several months without resolution. On 10/9/2024 at approximately 4:20 p.m., an interview was conducted with the Administrator who stated he was aware that the washing machines were not working. He stated he had been employed at the facility for 4 weeks and recognized there were issues with the washing machines. The Administrator stated he had ordered parts but received the wrong parts for one washing machine. He stated he was aware of the impact on the amount of linen for the residents. (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the end of day debriefing on 10/9/2024, the Facility Administrator, the Regional [NAME] President of Operations, Administrator in Training, two Regional Nurse Consultants (Corporate-1 and Corporate-2) and Director of Nursing were informed of the findings of the multi-system failures that were identified by the survey team. On 10/10/2024 upon arrival at the facility, the survey team was informed that the Administrator was no longer working at the facility as of the evening of 10/9/2024. The Regional [NAME] President of Operations was serving as the Acting Administrator. During the end of day debriefing on 10/11/2024, the Facility's Acting Administrator, Administrator in Training, Regional Nurse Consultant (Corporate-2) and Director of Nursing were informed of the findings. The Acting Administrator stated he would address the issues identified by the survey team. No further information was provided.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 34894 Based on staff interview and facility documentation review, the facility staff failed to devise a facility-specific facility assessment The Findings included: On 10/9/2024 at 4:00 p.m., the facility Administrator was informed of the plan to review the Facility Assessment with the Administrator on 10/10/2024. A copy of the Facility Assessment was given to the surveyor. On 10/10/2024 upon arrival at the facility, the survey team was informed that the Administrator was no longer working at the facility as of the evening of 10/9/2024. The Regional [NAME] President of Operations was serving as the Acting Administrator. On 10/10/2024 at 11:15 a.m., review of the facility assessment was conducted with the Regional Director of Operations (Acting Administrator). Review revealed the assessment was not tailored to the facility. The facility assessment was 22 pages in length. The assessment utilized a template but did not answer the questions as they related to the facility. Examples of non-compliance included: The facility assessment was dated 9/3/2024. There was no documentation that the assessment was reviewed by the Quality Assurance Process Improvement (QAPI) Committee. The date for review by the QAA/QAPI committee was blank. On page 18/22, 3.10, the answer was written about monthly meetings, daily rounds and an open door policy for staff, residents and families to speak with the Administrator. There was no mention of a compliance hot line, grievance process, Resident Council, Family Council or QAPI. Under # 3.11 List of contracts was written All contracts are kept in the Administrator's office and/or Medical Records office. There was no description of the facility's process for overseeing the services and how the services would meet the needs of the residents. Per the Regional consultant, Medical Records actually keeps them in the Medical Records office. The Regional Consultant stated the facility assessment did not list the contracts, memoranda of understanding or agreements with third parties. On page 19/22 -3.12-List health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. The only answer written was :The facility EHR (electronic health record) is PointClickCare. (continued on next page)		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The assessment did not address how the facility would securely transfer health information to a hospital, home health agency, or other providers for any resident transferred or discharged from the facility. There were concerns identified during the survey regarding residents not receiving access to their medical records upon request and copies were not obtained within required time frames. The Acting Administrator stated, We have a back up of the EHR (Electronic Health Record.) We have systems in place but they are not in this assessment. The facility assessment did not include an evaluation of the physical environment necessary to meet the needs of the residents. It did not address how the facility needed to be equipped and maintained to protect and promote the health and safety of residents. There was only one working washing machine in the facility at the time of survey. According to interviews conducted with the Housekeeping staff, the other washing machines had been inoperable for at least two months prior to survey. During the end of day debriefing on 10/11/2024, the Facility's Acting Administrator, Administrator in Training, Regional Nurse Consultant (Corporate-2) and Director of Nursing were informed of the findings that throughout the facility assessment, there were only generalizations but no tailoring of the assessment to the facility. The Acting Administrator stated the facility assessment needed more details added to it to make sure it reflected the facility. No further information was provided prior to survey exit.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 31199 Based on observation, Resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure the facility maintained a safe, sanitary, and comfortable environment to prevent the transmission of communicable diseases, infections, Legionnaires', and other potentially transmissible waterborne pathogens, on 4 of 4 Resident living units and communal spaces. The findings included; The facility staff failed to ensure that the facility was free from dampness, and mold. Surveyors observed wet mold on floors, walls, ceiling tiles, ceiling insulation and pipes, shower grout, base boards, and shower curtains, and Resident rooms. Unsanitary areas also included shower rooms, laundry facilities, the main kitchen, insects on 4 of 4 units, ice machines were not kept clean and sanitary, and staff further failed to complete, and document preventative maintenance, water/water damage testing, and cleaning schedules. On 10-9-24 observation of the Resident hydration ice machine in the closet across from the dining room revealed standing water on the floor, a 1/2 inch thick, 3 foot by 3 foot rubber hole punched mat, with live cock roaches (5-6 of them) crawling around it, and under it. The ice machine drainage pipe was dripping directly onto the floor, and not into a drain. Under the ice machine was an approximately 4 inches wide, by 4 inches long, by 1/2 inch high, irregularly shaped circular, black slimy mold growing substance. The mold had a gelatinous, semi solid, humped shape, with encircled stringy, anemone like tentacle out growths. The out growths had the appearance of a fringe with a yellow colored cast around the outer edges. The mold was partially on the wet floor and partially on the 5-7 pieces of wet paper trash under the ice machine, and behind it. The entire area smelled of dampness, dirt, and mold. The Administrator was coming down the hall at that time and was asked to view the area. When asked if he thought it was safe and sanitary for Residents to consume ice made in that environment, he stated that it was not. The date on the ice machine filter was illegible. There was no documentation of a cleaning schedule, nor inspection of the area. On 10-9-24 the Maintenance Director was asked about the cleaning schedule for the ice machines and he stated we wipe them down once a month, then quarterly we empty it and sanitize it, then every 6 months we change the filters. He was then asked to provide the policy for ice room and machine cleaning. The ice machine in the kitchen area had a filter change date of 6-7-24, however, the ice machine cleaning log had not been filled in (all sheets were blank). The following excerpt from the ice machine policy read: Policy: All ice machines will be inspected regularly as scheduled and preventative maintenance will be performed to verify proper and safe operation. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procedure: Monthly 1. Shut ice machines down for preventive maintenance service. 2. Check water valves and connectors. 3. Check for slime, sediment, build up, rust or corrosion clean/repair as needed. 4. Clean according to manufacturer instructions using nickel safe cleaner. The Centers for (CDC) Disease Control was stated as the facility standard for infection control practices and procedures for the facility. The CDC states in teaching that mold growing in buildings, regardless of type indicates there is a problem with water or moisture that should be immediately addressed. The CDC standards on mold review revealed the following: Exposure to damp and moldy environments may cause a variety of health effects. For some people, mold can cause a stuffy nose, sore throat, coughing or wheezing, burning eyes, or skin rash. People with asthma or who are allergic to mold may have severe reactions. Immune-compromised people and people with chronic lung disease may get infections in their lungs from mold. For people who are sensitive to molds, exposure to molds can lead to symptoms such as stuffy nose, wheezing, and red or itchy eyes, or skin. Severe reactions, such as fever or shortness of breath, may occur among workers (or those living in an environment) exposed to large amounts of molds in a setting. In 2004 the Institute of Medicine (IOM) found there was sufficient evidence to link indoor exposure to mold with upper respiratory tract symptoms, cough, and wheeze in otherwise healthy people; with asthma symptoms in people with asthma; and with hypersensitivity pneumonitis in individuals susceptible to that immune-mediated condition. In 2009, the World Health Organization issued additional guidance, the WHO Guidelines for Indoor Air Quality: Dampness and Mold. Other recent studies have suggested a potential link of early mold exposure to development of asthma in some children, particularly among children who may be genetically susceptible to asthma development, and that selected interventions that improve housing conditions can reduce morbidity from asthma and respiratory allergies. The National Institute of Occupational Safety and Health (NIOSH) recommendations follow: The health of those who live, attend school, or work in damp buildings has been a growing concern through the years due to a broad range of reported building-related symptoms and illnesses. Research has found that people who spend time in damp buildings are more likely to report health problems such as these: - o Respiratory symptoms (such as in nose, throat, lungs) - o Development or worsening of asthma (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	o Hypersensitivity pneumonitis (a rare lung disease caused by an immune system response to repeated inhalation of sensitizing substances such as bacteria, fungi, and organic dusts.) o Respiratory infections o Allergic rhinitis (often called hay fever) o Bronchitis o Eczema Exposures in damp buildings are complex. They vary from building to building, and in different places within a building. Mildew versus mold identification is not typically difficult. Mildew will appear as a white/gray, or tan powdery appearance which is superficial to the surface it is on, making cleaning and eradication easier than mold . Mold is imbedded in a surface and is much more difficult to eradicate, and in some instances impossible, thus the surface must be replaced entirely. Moisture allows indoor mold to multiply more easily on building materials or other surfaces, and people inside buildings may be exposed to microbes and their structural components, such as spores, biologically released chemicals, and fungal fragments. Mold may also produce substances that can cause or worsen health problems, and these substances vary depending on the mold species and on conditions related to the indoor environment. Moisture can also attract cockroaches, rodents, and dust mites. Moisture-damaged building materials can release volatile organic compounds that can cause health problems. Researchers have not found exactly how much exposure to dampness-related substances it takes to cause health problems. Research studies report that finding and correcting sources of dampness is a more effective way to prevent health problems. Therefore, NIOSH developed a tool to help assess areas of dampness in buildings and to help prioritize remediation of problems areas. Legionnaires' and other potentially transmissible waterborne pathogens. Resident symptoms were noted and complained of by 8 Residents on all 4 Resident living units. The complaints ranged from intractable headaches, to sore throats, asthma, shortness of breath, nausea, diarrhea, body aches, and head pressure with nasal congestion. Residents #424, 38, 151, 68, 20, and #127 all complained of these symptoms to 4 different surveyors independently of one another, and without knowing others had complained as well. On 10-7-24 at approximately 3:00 p.m. an interview was conducted with Resident #153 who stated that he had Mold and Mildew in his ceiling, and they keep just painting over it. He pointed out a spot on the ceiling that appeared freshly painted, however there were black spots bleeding through the painted area. Resident #153 stated that the ceiling leaks and then it dries and then when he complains of the black spots They just paint over it, that is not fixing the problem. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10-7-24 at approximately 3:30 PM an interview was conducted with Resident #424. The surveyor was talking to two nurses at the nursing station and Resident #424 came up the hall yelling someone has got to do something about my room! I am trying to get over pneumonia and I can not get better with that mold in my room. It's keeping me sick. A second surveyor joined and the three went to the Resident's room to inspect it. The ceiling tiles had been recently replaced and the room still smelled of fresh paint, however, black mold dots appeared through the paint behind the door all the way from the ceiling to the floor in varying stages of emergence. Some still under the new paint and some clearly visible on top of it. There were also 2 ceiling tiles which showed the mold coming through them as well. The surveyors continued back to the nursing station to find the Maintenance Director standing in the hallway under an open area in the ceiling where ceiling tiles had been removed. The area above was clearly wet and leaking, and he stated it was from condensation caused by the air conditioning lines, and the insulation around the pipes were soaking wet and slimy. The entire building was experiencing this water leakage with buckets and trash cans in the hallways noted to be under the continuously dripping leaks. Staff members stated this had been an ongoing issue for many months, and it's worse when it rains. Staff complained that they had symptoms too, and it was true what the Residents were saying. During the interview he explained he had just found 22 Blowers in the ceiling which would have kept air circulation above the ceiling moving, so that this would not happen. He went on to say he had been unaware of the blowers existence until he saw one today while changing out a ceiling tile. He stated they had not been operating and he was working on getting them operating. He was asked why the wet insulation was left in the ceiling which would continue to leak until it was removed. He stated that it needed to be removed, and he was working on it, however, if he could get the blowers working that would solved the problem. During the above interview at 4:30 PM the Maintenance Director came to the conference room and stated that he had the one blower working and it was an easy fix, so he was going to get them all working. He was asked if testing had been done in the ceiling and insulation to determine what was growing up there, as mold was already apparent throughout the building, and those blowers would then spread (aerosolize) it into the air. He stated no testing had been done and they were not required to test unless Residents had symptoms. He was informed that he was now aware that residents did have symptoms, and conditions were present for multiple pathogenic organisms to grow. He was asked for the Legionnaires' policy at that time. A review of the Legionnaires' policy revealed that the Infection Preventionist and the Maintenance Director would work together to identify those areas where there was a potential risk for contaminates associated with the development of Legionella. Those areas include Standing/non-circulating water, scale and sediment build-up, and the presence of biofilm, also known as slime. The policy goes on to say Conduct daily, weekly, monthly, and as needed rounds to inspect and monitor the environment .in order to identify whether conditions are present that could lead to the spread of Legionella. If conditions are present they need to contact a professional water treatment service in order to obtain samples and send to the lab for analysis. The policy goes on to describe areas in the facility where Legionella could grow which included the cooling system. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility staff was aware of the standing water in the leaking ceiling, and the slime on the insulation and should have known that this was an identified area of risk. Further, the policy did not state testing must only be completed after symptoms in the population. That would be counterproductive. Infection control policies are required by regulation to be implemented in order to guide the prevention of the spread of infection and communicable disease. Communal Resident shower room observations on all 4 units were made on 10-9-24 at 2:40 p.m. and were as follows: Unit 1 - Women's shower room- A wet washcloth left in bathroom on floor, floor needed mopping, stains were visible on the floor, black substances in shower area in grout lines and near the floor of shower. Unit 1 Men's shower room - The trash had not been emptied, the shower room smelled of urine, the floor was dirty, shower stalls had black substance in corners and at base of the shower. Unit 2 - Women's shower room - Bariatric shower seat in the stall which had a soaking wet sheet on it stained with brownish yellow stains, the toilet paper holder was broken, shower curtains had black substance on the bottom edge, opened toothpaste and deodorant sitting on the shelf with no name on it, the floor needed to be cleaned. Unit 2 Men's shower room - Rust stains behind a toilet, dirty pajama bottoms and socks were on the floor, strong urine odor was present in the shower room, shower curtains had black stains, and the shower stall floors had black in the grout and the corners. Unit 3 Women's shower room -Rust on a shower chair, chipped broken tiles at the corner of a wall, toilet paper holder was broken. Unit 3 Men's shower room - Oxygen concentrator was in the shower room with no name or room number on it, the light in toilet area was not working, the toilet paper holder was broken, and black and rust colored stains were in the shower area. Unit 4 Women's shower room - A dirty wash cloth was on a chair, the shower area was dirty, especially at the base where wall and floor meet encrusted in a black/brown substance, and the floor needed to be swept and mopped. Unit 4 Men's shower room - A used incontinence brief was in the trash, the floor needed to be swept and mopped, paper trash was on the floor, the shower area was dirty, with a black substance in the corners and in the grout. Pest Control Review: During the entire survey there were fruit flies as well as large flies, and cock roaches noted on all 4 living units, in the kitchen, and in the common areas. A review of the pest control logs revealed that the facility is having pest control services come to the building monthly, however, the pests continue to be in the facility. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Laundry and linen review: Residents on 4 of 4 units complained of lack of linens and personal clothing taking too long to come back from laundry, and wearing clothing for 2-3 days straight. On 10-10-24 at 2:00 PM, an interview was conducted with the director of housekeeping who was asked why there was a shortage of linens, and the laundry was not getting done in a timely manner. She stated that they are doing the best they could with 1 washing machine. When asked if that is all the facility has for 180 beds, she stated that the other 2 washers were broken. She stated that the laundry staff are working 7 days a week with the one washer, and they must try and keep up with all the linens and facility laundry as well as Resident personal clothing. Facility maintenance records indicated that on 9-30-24 Washer 1 & 2 down and waiting on replacement for #1. As of the close of survey on 10-11-24 the washing machines had still not been repaired nor replaced. Kitchen Review: On 10-4-24 at 12:45 PM during the active lunch service, the dining room and kitchen inspection was continued. 14 hospital beds were stacked haphazardly on the right side of the dining room close to the kitchen door. 3 of those beds were new, and 11 were old, used, and dirty, commingled with the new beds. The old used dirty beds were encrusted with hair, dust, brown greasy substances, what looked like food debris and cracker crumbs, rust, mold, chipped wood particles, and the head boards and foot boards were separating and broken. Residents were in the dining room eating lunch and being fed at tables in close proximity to the beds. Two CNAs were in the dining room assisting Residents at the time and both stated those beds have been in here for months. They are using this as a storage room and it's dangerous, they are nasty, and someone could fall. Two dead cock roaches were noted in the kitchen's dry food storage area and one in the kitchen near the 3-compartment sink. The floor in the dry storage area had paper trash and food debris on the floor. The floor was visibly stained, and the dishwasher was found to be inoperable. On 10-8-24 an interview was conducted with Other Employed #5 who stated that he wasn't exactly sure how long the dishwasher had been down. He was asked to research and provide a timeline. The kitchen staff were noted to be using Styrofoam take out containers for food service during the lunch and dinner meals. When questioned Other Employee #9 stated the dishwasher has been broken for weeks maybe months now. He stated, we have a new one it's just not hooked up yet. Food temps on 4 of 4 Resident living units was investigated, temperatures were taken, and found to be between 80 - 100 degrees Fahrenheit. On all 4 units the Residents complained of continued lukewarm, or cold food. Many Residents stated that since they started using Styrofoam boxes the food is cold. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the work orders and emails from the Maintenance Director to the facility corporate office revealed the dishwasher had been inoperable since 8-9-24. Review of those emails and communications follow below: 8-6-24 - dishwasher was purchased (evidenced by email from corporate purchasing office to maintenance). 9-24-24 - dishwasher arrived at facility (as evidenced by email between maintenance and supplier). 10-10-24 -during the survey, the dishwasher installed and running as of breakfast meal. On 10-11-24 at the end of day debriefing the facility Administrator, Director of Nursing and other corporate staff were made aware of the concerns. They stated they had no further information to provide prior to survey exit.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to Maintain all mechanical, electrical, and patient care equipment in safe operating condition The findings included: For the facility, the facility staff failed to ensure the dishwasher, and 2 washing machines were functional and available for use by staff. On 10/7/24 during the kitchen inspection the kitchen staff were noted to be using Styrofoam take out containers for food service during the lunch and dinner meals. When questioned Other Employee #9 stated the dishwasher has been broke for weeks now. He stated we have a new one it's just not hooked up yet. On 10/8/24 an interview was conducted with Other Employee #5 who stated that he wasn't exactly sure how long the dishwasher had been down. He was asked to research and provide a timeline. 8/6/24 - dishwasher was purchased (evidenced by email from corporate purchasing office to maintenance). 9/24/24 - dishwasher arrived at facility (as evidenced by email between maintenance and supplier). 10/10/24 - during the current survey, the dishwasher was installed and running as of breakfast meal. On 10/11/24 at 3:00 pm, an interview was conducted with the director of housekeeping who was asked why there was a shortage of linens, and the laundry was not getting done in a timely manner. She stated that they are doing the best they can with 1 washing machine. When asked if that is all the facility has for 180 beds, she stated that the other 2 washers are broken. She stated that they are working 7 days a week with the one washer they have to try and keep up with all the linens and facility laundry as well as Resident personal clothing. 9/30/24 - Washer 1&2 down and waiting on replacement for #1. As of close of survey, 10/11/24, the washers had still not been repaired or replaced. On 10/11/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 40026 Based on observation, interview, and facility documentation the facility staff failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The findings included: For the facility staff failed to ensure that the facility was free from damp mildew smell, wet ceiling tiles, unsanitary shower rooms, and ice machines were kept clean and sanitary and document preventative maintenance and cleaning schedules. On 10/11/24 observation of the ice machine in closet across from the dining room revealed standing water on the floor, a rubber mat with live roaches (5-6 of them) crawling around and under it, the ice machine drainage pipe was dripping on the floor not in the drain. Under the ice machine was black slimy substance and wet paper trash as well. The entire area smelled of dampness and mildew. The Administrator was coming down the hall and asked to view the area when asked if he thought it was safe and sanitary for Residents to consume ice made in that environment, he stated that it was not. The date on the ice machine filter was illegible. There was no documentation of cleaning schedule or inspection. On 10/11/24 the maintenance person was asked about the cleaning schedule for the ice machines and he stated we wipe them down once a month, then quarterly we empty it and sanitize it and every 6 months we change the filters. He was then asked to provide the policy for ice machine cleaning. The ice machine in the kitchen area had a filter change date of 6/7/24 however the ice machine cleaning log had not been filled in (all sheets were blank). The following excerpt from the ice machine policy read: Policy: All ice machines will be inspected regularly as scheduled and preventative maintenance will be performed to verify proper operation and safe operation. Procedure: Monthly 1. Shut ice machines down for preventive maintenance service 2. Check water valves and connectors 3. Check for slime, sediment, build up, rust or corrosion clean/repair as needed 4. Clean according to manufacturer instructions using nickel safe cleaner. Observations made on 10/11/24 at 2:40 p.m. (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Unit 1 - Women's shower room-wet washcloth left in bathroom on floor, floor needs mopping, stains visible on floor, black substance in shower area in grout lines and near floor of shower. Unit 1 Men's shower room - trash had not been emptied, shower room smelled of urine, floor dirty, shower stall has black substance in corners and at base of the shower. Unit 2 - Women's shower room - bariatric shower seat in the stall had a soaking wet sheet on it stained with brownish yellow stains, the toilet paper holder is broken, shower curtains have black substance on the bottom edge, opened toothpaste and deodorant sitting on the shelf no name on it. Floor needs to be cleaned. Unit 2 Men's shower room - rust stains behind toilet, dirty pajama bottoms and socks on the floor, strong urine odor in shower room, shower curtains have black stain, and the shower stall floors have black in the grout and the corners. Unit 3 Women shower room -Rust on shower chair, chipped broken tiles at corner of wall, toilet paper holder is broken. Unit 3 Men's shower - Oxygen concentrator in shower room no name or room number on it, light in toilet area is not working, toilet paper holder was broken, and black and rust colored stains in the shower area. Unit 4 Women's shower room - Dirty wash cloth on chair, shower area dirty especially at base where wall and floor meet, black/brown substance, and floor needs swept and mopped. Unit 4 Men's shower room - used incontinence brief in trash, floor needs swept and mopped, paper trash on floor, shower area dirty black substance in corners and in grout, On 10/11/24 during the end of day meeting the administrator was made aware of the concerns and no further information was provided,		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to maintain an effective pest control program so that the facility is free of pests for the facility. The findings included: For the facility, the facility staff failed to ensure the environment was kept pest free, roaches both alive and dead were observed at the facility. On 10/7/24 during the kitchen inspection there were 2 dead roaches noted in the dry storage area and one in the kitchen near the 3-compartment sink. On 10/11/24 observation of the ice machine in closet across from the dining room revealed standing water on the floor, a rubber mat with live roaches (5-6 of them) crawling around and under it, the ice machine drainage pipe was dripping on the floor not in the drain. Under the ice machine was black slimy substance and wet paper trash as well. The entire area smelled of dampness and mildew. During the entire survey there were fruit flies as well as large flies noted on all units and in the common areas as well. A review of the pest control logs revealed that the facility is having pest control services come to the building on a monthly basis however this is not an effective pest control program as the pests continue to be visible. On 10/11/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 34306 Based on staff interview the facility failed to maintain a training program for all new and existing staff based on the facility's assessment. The findings included: The facility failed to maintain a training program for all new and existing staff. Review of the Staff Education and Relias training transcripts revealed that not all facility staff had completed all the required training. On 10/11/24 at approximately 8:15 PM, a final interview was conducted with the Administrator, Interim Administrator, Director of Nursing and two regional Nurse Consultants. They had no comments and voiced no concerns regarding the above information.		

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 34306 Based on review of facility documents and staff interview the facility staff failed to ensure that all staff members were educated on Resident's rights and facility responsibilities. The findings included: Review of the Staff Education and Relias training transcripts revealed that not all facility staff had completed all the required training for the rights of the resident and the responsibilities of a facility to properly care for its residents. On 10/11/24 at approximately 8:15 PM, a final interview was conducted with the Administrator, Interim Administrator, Director of Nursing and two regional Nurse Consultants. They had no comments and voiced no concerns regarding the above information.		

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 34306 Based on review of facility documents and staff interview the facility staff failed to ensure that all staff members were educated regarding the Quality Assurance and Performance Improvement The findings included: Review of the Staff Education and Relias training transcripts revealed that not all facility staff had completed all the required training for Quality Assurance and Performance Improvement. On 10/11/24 at approximately 8:15 PM, a final interview was conducted with the Administrator, Interim Administrator, Director of Nursing and two regional Nurse Consultants. They had no comments and voiced no concerns regarding the above information.		

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. 34306 Based on review of facility documents and staff interview the facility staff failed to ensure that all staff members were educated on Compliance and Ethics. The findings included: Review of the Staff Education and Relias training transcripts revealed that not all facility staff had completed all the required training for Compliance and Ethics. On 10/11/24 at approximately 8:15 PM, a final interview was conducted with the Administrator, Interim Administrator, Director of Nursing and two regional Nurse Consultants. They had no comments and voiced no concerns regarding the above information.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 34306 Based on review of facility documents and staff interview the facility staff failed to ensure that all Certified Nurses Aides (CNA) completed the mandatory twelve (12) hours of education each year. The findings included: Review of the Staff Education and Relias training transcripts revealed that not all CNAs had completed the mandatory twelve (12) hours of education each year which addressed each CNA's areas of weakness as determined in nurse aides' performance reviews the facility assessment and the special needs of residents as determined by the facility staff. On 10/11/24 at approximately 8:15 PM, a final interview was conducted with the Administrator, Interim Administrator, Director of Nursing and two regional Nurse Consultants. They had no comments and voiced no concerns regarding the above information.		

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 34306 Based on review of facility documents and staff interview the facility staff failed to ensure that all staff members were educated on Behavioral health. The findings included: Review of the Staff Education and Relias training transcripts revealed that not all facility staff had completed all the required training for Behavioral health care and services. On 10/11/24 at approximately 8:15 PM, a final interview was conducted with the Administrator, Interim Administrator, Director of Nursing and two regional Nurse Consultants. They had no comments and voiced no concerns regarding the above information.		