STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Battlefield Park Healthcare Center	250 Flank Road Petersburg, VA 23805

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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, staff interviews, and a review of clinical records, the facility staff failed to develop a care plan that addressed the preference for a plant-based diet for one of four residents (Resident #1) in the survey sample. The findings included: Resident #1 was initially admitted to the facility on [DATE], as a transfer from another long-term care facility under hospice care. The current diagnoses included malignant ovarian and endometrial cancer, use of a right nephrostomy tube secondary to hydronephrosis with a ureteral stricture, and bilateral lymphedema of the lower extremities. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of July 10, 2025, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated that Resident #1's cognitive abilities for daily decision-making were intact. In section GG0130. (Self-Care), Resident #1 was coded as dependent in the following areas: oral care, toileting, upper and lower body dressing, personal hygiene, rolling in bed, and transitioning from lying to sitting in bed; she required setup assistance with eating. During an interview with Resident #1 on July 24, 2025, at approximately 10:35 AM, the resident stated that she was often nauseated and had vomited for five days straight because she was not consuming her preferred plant-based diet, as the facility would not provide the mostly beans, fresh vegetables, and fresh fruit diet that they had agreed upon. Resident #1 further stated that she had purchased bean burritos from a local restaurant and had them stored in her refrigerator. However, the staff threw them out because they were not permitted to store them beyond a specific date. The resident also stated that the facility's staff informed her that she was not allowed to have a personal refrigerator in her room because of the care required to maintain one.The resident's current nutritional care plan, with a revision date of April 28, 2025, had a problem which stated the resident was at risk for malnutrition secondary to a malignant neoplasm of her ovaries and endometrium, morbid obesity, and a-fib. The goal stated to provide comfort care through October 10, 2025. The interventions included identifying the resident's food and beverage preferences, monitoring her meal intake, and offering substitutions if the provided meal was declined.An interview was conducted with the Assistant Director of Nursing (ADON) on July 24, 2025, at approximately 4:10 PM. The ADON stated that the Interdisciplinary Team (IDT) was aware that the resident's preferred meal was plant-based and that her friends brought items in for her, and she purchased items to obtain the foods she desired. The ADON stated they would revisit the policy on personal refrigerators and have the Registered Dietitian revisit food preferences with the resident again.An interview was conducted with the Director of Nursing (DON) on July 25, 2025, at approximately 12:05 PM. The DON stated that the resident's person-centered care plan failed to reflect the plant-based food preferences. The DON also said that, after further review of the refrigerator policy, they learned that the resident could have a personal refrigerator. The DON further stated that the dietary department had updated the resident's plant-based diet preference and would make a greater effort to accommodate the resident's nutritional preferences. On July 25, 2025, at approximately 2:15 PM, the above information was reviewed with the Administrator, DON, ADON, two Unit Managers, and a Corporate Consultant. They acknowledged understanding of the findings and voiced no concerns.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, staff interviews, and a review of clinical records, the facility staff failed to administer medications as ordered for one of four residents (Resident #1) in the survey sample. The findings included: Resident #1 was initially admitted to the facility on [DATE], as a transfer from another long-term care facility under hospice care. The current diagnoses included malignant ovarian and endometrial cancer, use of a right nephrostomy tube secondary to hydronephrosis with a ureteral stricture, and bilateral lymphedema of the lower extremities. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of July 10, 2025, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated that Resident #1's cognitive abilities for daily decision-making were intact. In section GG0130. (Self-Care), Resident #1 was coded as dependent in the following areas: oral care, toileting, upper and lower body dressing, personal hygiene, rolling in bed, and transitioning from lying to sitting in bed; she required setup assistance with eating. On July 24, 2025, at approximately 10:35 AM, an observation was made of two white pills and one orange pill in a medication cup on the resident's over-the-bed table. At 1:50 PM, another observation was made of the medication cup containing two white pills and one orange pill still on the resident's over-the-bed table. At 1:50 PM on July 24, 2025, an interview was conducted with Resident #1 regarding the two white and one orange pill in the cup on the over-the-bed table. Resident #1 stated she was not aware that they were there, and she did not know what pills were in the cup or what time they were left there. Resident #1 stated she was not going to take the pills because she had vomited for five days straight, and she remained nauseated but was now experiencing some relief. An interview was conducted with Registered Nurse (RN) #1 on July 24, 2025, at approximately 1:57 PM. RN #1 stated she had not seen pills on the resident's over-the-bed table, and she had not left any pills on the resident's over-the-bed table. RN #1 entered the resident's room, viewed the items on the over-the-bed table, and observed the cup of three pills. RN #1 stated after a review of the medication administration record (MAR) that the pills were two Reglan tablets, five milligrams (mg) each, and one Benadryl, which were poured at 6:00 AM.The Physician's order summary revealed the following medication orders: Diphenhydramine HCl Capsule 25 mg - Administer one capsule orally every six hours for itching until July 26, 2025, as needed (PRN), for seven days for nausea and itching, with a start date of July 19, 2025. Reglan Oral Tablet ten mg - Give one tablet by mouth every six hours as needed for nausea for 14 days - Start Date: July 21, 2025.An interview was also conducted with the Unit One Manager (U1M) on July 26, 2025, at approximately 2:15 PM. The U1M stated she had rounded on Resident #1's room several times that day, and she did not see the cup of pills on the over-the-bed table. The U1M also stated that the medications should not have been left at the resident's bedside and that all medicines should be ingested in the presence of the nurse.On July 25, 2025, at approximately 2:15 PM, the above information was reviewed with the Administrator, DON, ADON, two Unit Managers, and a Corporate Consultant. They acknowledged understanding of the findings and voiced no concerns.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** Based on observations, staff interviews, and review of clinical records, the facility staff failed to ensure that a resident who is unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for one of four residents (Resident #3) in the survey sample. The findings included:Resident #3 was initially admitted to the facility on [DATE], as a transfer from another long-term care facility. The current diagnoses included a history of a stroke, diabetes, high blood pressure, and a contracted right hand with in-hand curled fingers. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of April 25, 2025, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated that Resident 3's cognitive abilities for daily decision-making were intact.In section GG0130. (Self-Care), Resident #1 was coded as independent with eating, toileting, rolling in bed, and transitioning from lying to sitting in bed, requiring assistance with oral care and chair to bed transfers, dependent in the following areas: upper and lower body dressing, putting on/taking off footwear, and personal hygiene. During an interview with Resident #3 on July 24, 2025, at approximately 12:17 PM, the resident stated that his right hand was hurting because of his long fingernails. An observation was made of a right-hand splint on the over-the-bed table. The resident said he removed the splint because it was hurting. An observation of the resident's right hand revealed healed scars, dry skin, and long, rammed fingernails. The resident stated he could not remember the last time that the staff cut his fingernails. The person-centered care plan revision date was May 3, 2023, with a problem, which stated (name of the resident) has a potential for pain related to limited mobility, a contracture of the right hand requiring use of a palm guard, and deep vein thrombosis. The goal stated that the resident will not exhibit nonverbal signs and symptoms of pain (grimacing, groaning, agitation, yelling, moaning, resisting care, crying, refusal to eat), through the target date of July 24, 2025. The interventions included pain management consult, provide medication as ordered, monitor for signs and symptoms of side effects, and evaluate effectiveness of medication, Physical Therapist / Occupational Therapist to assess and treat as ordered, and a palm guard as ordered (the resident refuses to wear the palm guard at times). An interview was conducted with the Unit 2 Manager (U2M) on July 24, 2025, at approximately 4:10 PM. The U2M stated that it was care planned for the resident to be non-compliant with fingernail care, resulting in his fingernails being extremely long. The U2M could not provide documentation of instances where the resident resisted fingernail care or of education provided. On July 25, 2025, at approximately 12:15 PM, the U2M stated that Resident #3 allowed her to assess his fingernails on the evening of July 24, 2025, and they were indeed rammed. The U2M stated Resident #3 agreed to have his fingernails soaked, clipped, and filed, and to use a rolled washcloth to assist with contracture management if the splint was not tolerated. The U2M stated the resident tolerated the care well.On July 25, 2025, at approximately 2:15 PM, the above information was reviewed with the Administrator, DON, ADON, two Unit Managers, and a Corporate Consultant. They acknowledged understanding of the findings and voiced no concerns.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, staff interviews, and a review of clinical records, the facility staff failed to make reasonable efforts to honor and meet the meal choices and preferences of one of four residents (Resident #1) in the survey sample. The findings included: Resident #1 was initially admitted to the facility on [DATE], as a transfer from another long-term care facility under hospice care. The current diagnoses included malignant ovarian and endometrial cancer, use of a right nephrostomy tube secondary to hydronephrosis with a ureteral stricture, and bilateral lymphedema of the lower extremities. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of July 10, 2025, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated that Resident #1's cognitive abilities for daily decision-making were intact. In section GG0130. (Self-Care), Resident #1 was coded as dependent in the following areas: oral care, toileting, upper and lower body dressing, personal hygiene, rolling in bed, and transitioning from lying to sitting in bed; she required setup assistance with eating. During an interview with Resident #1 on July 24, 2025, at approximately 10:35 AM, the resident stated that she was often nauseated and had vomited for five days straight because she was not consuming her preferred plant-based diet, as the facility would not provide the mostly beans, fresh vegetables, and fresh fruit diet that they had agreed upon. Resident #1 further stated that she had purchased bean burritos from a local restaurant and had them stored in her refrigerator. However, the staff threw them out because they were not permitted to store them beyond a specific date. The resident also stated that the facility's staff informed her that she was not allowed to have a personal refrigerator in her room because of the care required to maintain one. The resident's current nutritional care plan, with a revision date of April 28, 2025, had a problem which stated the resident was at risk for malnutrition secondary to a malignant neoplasm of her ovaries and endometrium, morbid obesity, and a-fib. The goal stated to provide comfort care through October 10, 2025. The interventions included identifying the resident's food and beverage preferences, monitoring her meal intake, and offering substitutions if the provided meal was declined. An interview was conducted with the Assistant Director of Nursing (ADON) on July 24, 2025, at approximately 4:10 PM. The ADON stated that the Interdisciplinary Team (IDT) was aware that the resident's preferred meal was plant-based and that her friends brought items in for her, and she purchased items to obtain the foods she desired. The ADON stated they would revisit the policy on personal refrigerators and have the Registered Dietitian revisit food preferences with the resident again. An interview was conducted with the Director of Nursing (DON) on July 25, 2025, at approximately 12:05 PM. The DON stated that the resident's person-centered care plan failed to reflect the plant-based food preferences. The DON also said that, after further review of the refrigerator policy, they learned that the resident could have a personal refrigerator. The DON further stated that the dietary department had updated the resident's plant-based diet preference and would make a greater effort to accommodate the resident's nutritional preferences. The DON stated the Registered Dietitian met with the resident on July 24, 2025, and they reviewed her dietary preferences and, in the future, will make greater efforts to meet the resident's preferences, much like providing the peanut butter and jelly sandwiches. On July 25, 2025, at approximately 2:15 PM, the above information was reviewed with the Administrator, DON, ADON, two Unit Managers, and a Corporate Consultant. They acknowledged understanding of the findings and voiced no concerns.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and review of clinical records, the facility staff failed to ensure that the written plan of care included both the most recent hospice plan of care and a description of the services for one of four residents (Resident #1) in the survey sample. The findings included: Resident #1 was initially admitted to the facility on [DATE], as a transfer from another long-term care facility under hospice care. The current diagnoses included malignant ovarian and endometrial cancer, use of a right nephrostomy tube secondary to hydronephrosis with a ureteral stricture, and bilateral lymphedema of the lower extremities. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of July 10, 2025, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated that Resident #1's cognitive abilities for daily decision-making were intact. In section GG0130. (Self-Care), Resident #1 was coded as dependent in the following areas: oral care, toileting, upper and lower body dressing, personal hygiene, rolling in bed, and transitioning from lying to sitting in bed; she required setup assistance with eating.During an interview with Resident #1 on July 24, 2025, at approximately 10:35 AM, the resident stated that she was receiving hospice services before admission to the facility. A review of the Physician's Order Summary revealed an order dated April 14, 2025, that stated to admit to (name of the hospice agency) malignant neoplasm of the ovaries and a-fib. A review of the clinical record failed to reveal the hospice agency's plan of care; therefore, an interview was conducted with the Assistant Director of Nursing and the Unit 1 Manager on July 25, 2025, at approximately 4:10 PM. The ADON stated that if the hospice care plan was not in the clinical record, it was likely not uploaded by Medical Records, and she would ask to have it uploaded. On July 25, 2025, at approximately 1:00 PM, a hospice document dated July 25, 2025, at 12:25 PM, titled Hospice IDG Comprehensive Assessment and Care Plan Update Report, was added to the clinical record. The report revealed the benefit period was May 17, 2025, to July 15, 2025, which does not cover the current period.On July 25, 2025, at approximately 2:15 PM, the above information was reviewed with the Administrator, DON, ADON, two Unit Managers, and a Corporate Consultant. They acknowledged understanding of the findings, and the Corporate Consultant stated the requirement was that the hospice care plan be included with the facility's care. Since it wasn't, they would work on ensuring the requirement was met going forward.