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	02/05/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on visitor interview, staff interview, clinical record review and facility document review the facility staff failed to report an allegation of neglect for 1 of 3 residents, Resident #1.The findings included:Resident #1's clinical record listed diagnoses which included but not limited to vascular dementia and diabetes mellitus.Resident #1's most recent minimum data set with an assessment reference date of 01/29/26 assigned the resident a brief interview for mental status score of 3 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Section B, Hearing, Speech, and Vision, coded the resident as having clear speech. Section P, alarms and restraints, coded the resident as using a wander/elopement alarm daily. Resident #1's comprehensive care plan was reviewed and contained a plan for . wanders aimlessly from place to place and is an elopement risk. Interventions for this care plan include notify staff of wandering and elopement risk and wanderguard in place to right ankle.Resident #1's physician's order summary was reviewed and contained an order which read in part, Place wanderguard bracelet on the RIGHT wrist if appropriate .Check wanderguard placement every shift, Check wanderguard function daily every night shift for Wanderguard function, Check wanderguard function daily one time a day for Wanderguard function and Check Wanderguard function every shift every day shift for elopement.Resident #1's electronic treatment administration records for the month of January 2026 were reviewed and contained entries as above. All entries were documented as completed per the physician's orders. Surveyor observed Resident #1 on 02/04/26 at 6:45 pm. Resident was seated in the dining room alone. Surveyor asked resident his name and resident stated, . (Resident #1 first name only). Surveyor observed a wanderguard in place on resident's right wrist. Surveyor spoke with a facility visitor on 02/05/26 at 9:40 am. Visitor stated they had come to the facility on [DATE] at 6:00 pm to return laundry for a family member. Visitor stated when they arrived at the facility, the front door was locked, and no one was at the reception desk. Visitor stated they rang the doorbell, but no one came to the door. Visitor stated they could hear an alarm going off inside the facility. Visitor stated they were at the front door for about 10 minutes, when they heard someone coming around the building, so they stepped back to look, and saw a facility resident walking around from the right side of the building, dressed in pants and short sleeved shirt, no coat and was visibly cold. Visitor stated this resident had a wanderguard to right wrist. Visitor stated they asked the resident his name and he stated . (Resident #1) Visitor stated they called the facility around four times but no one answered the phone. Visitor stated they then called 911 for assistance. Visitor stated that the 911 operator called the facility twice before anyone answered. Visitor stated a female staff person came to the door, stated to the resident, how did you get out?, and took the resident back inside toward Unit 1 of the facility. Visitor stated they did not know this staff person. Visitor stated they called the facility the following day and spoke with the director of nursing (DON) to make sure someone reported the resident being outside. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. Building B. Wing	02/05/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Visitor stated the DON said they would investigate.Surveyor spoke with the local police department's communications manager on 02/05/26 at 8:30 am regarding the 911 call. Communications manager stated they have no documentation related to a 911 call, and stated, I guess because they answered the phone and we didn't send anybody out, we didn't log the call. Surveyor asked communications manager if they have a transcript of 911 calls received, and communications manager stated that information would have the be requested via Freedom of Information Act. Surveyor spoke with the executive director (ED) and DON regarding the allegation of Resident #1 having been found outside on 02/05/26 at 10:15 am. ED stated that no one called them or the DON regarding Resident #1 having been found outside of the facility. When surveyor informed ED that a visitor had found the resident outside and asked his name, ED stated that Resident #1 is non-verbal. Surveyor informed ED they had asked Resident #1 his name, and he stated his name. Surveyor informed ED and DON that they had spoken with the visitor that allegedly found the resident outside, and that visitor stated they had talked with the DON, DON stated, that was the call I got on 01/30/26. The person that called said the resident's name was . (similar sounding name as Resident #1), and I told them we don't have a resident by that name. DON stated they did an investigation related to the call they had received but could not determine whether any resident had been found outside. Surveyor requested and was provided with a facility policy titled Abuse, Neglect, and Exploitation which read in part, Neglect is the intentional carelessness, negligence, or disregard of policy, or care, that causes or could reasonably be expected to cause pain, injury, or death.Examples of neglect include, but are not limited to: Failure to take precautionary measures to protect the health and safety of the resident. Failure to report observed or suspected abuse, neglect or misappropriation of resident property or property. Failure to adequately supervise a resident known to wander from the facility without staff knowledge.V. Reporting of Incident and Facility Response. 1. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause this allegation involve or result in serious bodily injury a. If the events that cause the allegations do not result in serious bodily injury, reporting to the administrator (Executive Director) and to other reporting regulatory bodies must occur within twenty-four (24) hours.VII. Reporting and Response. VIRGINIA i. Within 24 hours of learning of an incident the facility must report it to the OLC (Office of Licensure and Certification) unless the incident is an allegation of abuse or involves serious bodily injury and then the facility must report to the OLC within 2 hours.The concern of not reporting an allegation of neglect was discussed with the ED and DON on 02/05/26 at 1:00 pm.No further information was provided prior to exit.

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	02/05/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on visitor interview, staff interview, clinical record review and facility document review the facility staff failed to complete a thorough investigation of allegation of neglect for 1 of 3 residents, Resident #1.The findings included:Resident #1's clinical record listed diagnoses which included but not limited to vascular dementia and diabetes mellitus.Resident #1's most recent minimum data set with an assessment reference date of 01/29/26 assigned the resident a brief interview for mental status score of 3 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Section B, Hearing, Speech, and Vision, coded the resident as having clear speech. Section P, alarms and restraints, coded the resident as using a wander/elopement alarm daily. Resident #1's comprehensive care plan was reviewed and contained a plan for . wanders aimlessly from place to place and is an elopement risk. Interventions for this care plan include notify staff of wandering and elopement risk and wanderguard in place to right ankle.Resident #1's physician's order summary was reviewed and contained an order which read in part, Place wanderguard bracelet on the RIGHT wrist if appropriate .Check wanderguard placement every shift, Check wanderguard function daily every night shift for Wanderguard function, Check wanderguard function daily one time a day for Wanderguard function and Check Wanderguard function every shift every day shift for elopement.Resident #1's electronic treatment administration records for the month of January 2026 were reviewed and contained entries as above. All entries were documented as completed per the physician's orders. Surveyor observed Resident #1 on 02/04/26 at 6:45 pm. Resident was seated in the dining room alone. Surveyor asked resident his name and resident stated, . (Resident #1 first name only). Surveyor observed a wanderguard in place on resident's right wrist. Surveyor spoke with a facility visitor on 02/05/26 at 9:40 am. Visitor stated they had come to the facility on [DATE] at 6:00 pm to return laundry for a family member. Visitor stated when they arrived at the facility, the front door was locked, and no one was at the reception desk. Visitor stated they rang the doorbell, but no one came to the door. Visitor stated they could hear an alarm going off inside the facility. Visitor stated they were at the front door for about 10 minutes, when they heard someone coming around the building, so they stepped back to look, and saw a facility resident walking around from the right side of the building, dressed in pants and short sleeved shirt, no coat and was visibly cold. Visitor stated this resident had a wanderguard to right wrist. Visitor stated they asked the resident his name and he stated . (Resident #1) Visitor stated they called the facility around four times but no one answered the phone. Visitor stated they then called 911 for assistance. Visitor stated that the 911 operator called the facility twice before anyone answered. Visitor stated a female staff person came to the door, stated to the resident, how did you get out?, and took the resident back inside toward Unit 1 of the facility. Visitor stated they did not know this staff person. Visitor stated they called the facility the following day and spoke with the director of nursing (DON) to make sure someone reported the resident being outside. Visitor stated the DON said they would investigate.Surveyor spoke with the local police department's communications manager on 02/05/26 at 8:30 am regarding the 911 call. Communications manager stated they have no documentation related to a 911 call, and stated, I guess because they answered the phone and we didn't send anybody out, we didn't log the call. Surveyor asked communications manager if they have a transcript of 911 calls received, and communications manager stated that information would have the be requested via Freedom of Information Act. Surveyor spoke with certified nurse's aide (CNA) #1 on 02/05/26 at 9:30 am regarding Resident #1. Surveyor asked CNA #1 if they recalled the resident being outside on 01/29/26, and CNA #1 stated they did not.Surveyor spoke with CNA #2 on 02/05/26 at 10:00 am regarding Resident #1. (continued on next page)

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	02/05/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked CNA #2 if they recalled the resident being outside on 01/29/26 and CNS #2 stated they did not. Surveyor spoke with registered nurse (RN #1) on 02/05/26 at 10:05 am regarding Resident #1. RN #1 stated they do not recall Resident #1 having been outside on 01/29/26. Surveyor spoke with the executive director (ED) and DON regarding allegation of Resident #1 having been outside on 01/29/26. ED stated that no one called them or the DON regarding Resident #1 having been found outside of the facility. When surveyor informed ED that a visitor had found the resident outside and asked his name, ED stated that Resident #1 is non-verbal. Surveyor informed ED they had asked Resident #1 his name, and he stated his name. Surveyor informed ED and DON that they had spoken with the visitor that allegedly found the resident outside, and that visitor stated they had talked with the DON, DON stated, that was the call I got on 01/30/26. The person that called said the resident's name was . (similar sounding name as Resident #1), and I told them we don't have a resident by that name. DON stated they did an investigation related to the call they had received. DON provided surveyor with witness statements from herself, RN #1, Licensed practical nurse (LPN) #2, CNA #2, CNA #3, and CNA #4. DON's witness statement was dated 01/30/26. All other witness statements were dated 01/29/26. DON also provided a Body/Skin Inspection Form for Resident #1 dated 01/30/26. Surveyor asked DON who took the statements, and DON stated the unit manager.Surveyor spoke with LPN #1, who is the unit manager, on 02/05/26 at 11:05 am regarding witness statements. Surveyor asked LPN #1 when they took the witness statements, and LPN #1 stated they took them on 01/30/26. Surveyor pointed out to LPN #1 that all statements except the DON's were dated 01/29/26. LPN #1 stated they told each witness to date the statements for the day of the incident.Surveyor spoke with CNA #3 on 02/05/26 at 11:10 am regarding Resident #1. CNA stated they do not recall resident getting out of building. Surveyor asked CNA #3 if they were asked to provide a witness statement, and CNA #3 stated, Yes, I gave a statement yesterday (02/04/26).Surveyor spoke with CNA #2 on 02/05/26 at 11:12 am regarding giving a witness statement. CNA #2 stated they were never asked to provide a witness statement.Surveyor spoke with RN #1 on 02/05/26 at 11:15 am. Surveyor asked RN #1 if they were asked to give a witness statement and when. RN #1 stated that they were asked to provide a witness statement yesterday evening (02/04/26).Surveyor unable to speak with LPN #2, CNA #1 and CNA #2 regarding witness statements.Surveyor requested and was provided with a facility policy entitled Abuse, Neglect, and Exploitation which read in part, Neglect is the intentional carelessness, negligence, or disregard of policy, or care, that causes or could reasonably be expected to cause pain, injury, or death.Examples of neglect include, but are not limited to: Failure to take precautionary measures to protect the health and safety of the resident. Failure to report observed or suspected abuse, neglect or misappropriation of resident property or property. Failure to adequately supervise a resident known to wander from the facility without staff knowledge. Investigation of Incidents. 1. In the event a situation is identified as abuse, neglect or misappropriation, an investigation by the executive leadership will immediately follow. i. Documentation of the facts and findings will be completed in each resident medical record.2. Suspected abuse. A. Neglect or Misappropriation Investigation reports will be initiated by the Director of Nursing or designee.d. Statements will be obtained from staff related to the incident, including victim, person reporting incident, accused perpetrator and witnesses. This statement should be in writing, signed, and dated at the time it is written. f. Findings/conclusion of the investigation are then reported to the physician (with the exception of misappropriation of funds/property) and resident representative and documented on the investigation form. g. by the fifth day, the alleged abuse investigation form is completed and reviewed for completeness and accuracy by the Executive Director or designee and submitted to the state.The concern of not conducting a thorough investigation was (continued on next page)

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	02/05/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discussed with the ED and DON on 02/05/26 at 1:00 pm.No further information was provided prior to exit.