

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Atlantic View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 540 Aberthaw Avenue Newport News, VA 23601	
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 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. Based on observation, resident interviews, staff interviews, and policy review, the facility failed to maintain an environment free of insects. This deficient practice was evidenced by the observation of insects in resident hallways on two separate occasions and interviews with five of 42 sampled residents (R7, R86, R144, R6, and R14), who stated they observed insects in the facility. This deficient practice had the potential to expose residents to insects in resident care areas, creating an unsanitary environment for all residents residing in the facility. Findings include: An observation on 07/07/26 at 10:20 AM revealed an approximately one-inch-long, dark brown insect with an oval-shaped body, long antennae, and six legs resembling a cockroach crawling in the resident hallway outside Rooms M5 and M6. During an interview on 07/07/26 at 10:21 AM, the Regional Director of Housekeeping (RDH) witnessed and killed the insect. The RDH stated he was unsure of the type of insect but believed it may have been a water bug. An observation on 07/08/26 at 7:27 AM revealed an approximately one half inch, brown insect crawling in the resident hallway outside Room H02. During an interview on 07/08/26 at 7:28 AM, the Staffing Coordinator (SC) witnessed the insect, stated it was a roach, and killed it. 1. A review of R 7's quarterly Minimum Data Set (MDS) located under the MDS tab of the electronic medical record (EMR) assessment with an Assessment Reference Date (ARD) of 06/23/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R7 was cognitively intact. During an interview on 07/08/26 at 11:00 AM, R7 stated he saw what he thought to be roaches in his room at least several times each week. 2. A review of R86's annual MDS assessment located under the MDS tab of the EMR with an ARD of 03/28/26 revealed a BIMS score of 15 out of 15, which indicated R86 was cognitively intact. During an interview on 07/08/26 at 11:15 AM, R86 stated she saw roaches and flies in the facility hallways and her room at least every other day. 3. On 07/06/26 at approximately 11:30 AM, during the initial tour of the facility, R174, he stated that (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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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he had seen live roaches in his room. Upon observations of his room at the time, no live roaches were seen. Review of R174's admission MDS located under the MDS tab of the EMR with an ARD of 07/07/26 indicated the resident had a BIMS of 15 of 15 indicating he was cognitively intact. 4. During initial rounds on 07/06/26 at 11:30AM, R14's representative reported seeing roaches in the room and bathroom, revealing that she reported to staff seeing the bugs. 5. During initial rounds on 07/06/26 at 12:30 PM R6 reported seeing roaches in the room, and R6's spouse stated she had killed several roaches. During an interview on 07/09/26 at 9:30 AM, the Maintenance Director stated he had been employed at the facility for approximately one month. The Maintenance Director stated he will see bugs from time to time due to the size of the facility and stated the pest control company visited the facility every two weeks since he started. During an interview on 07/09/26 at 10:00 AM, the Administrator stated roaches had been a problem in the facility for some time. The Administrator stated the facility previously had weekly pest control services and in the past month had them increased to biweekly due to increased insect reports by the staff and residents. Review of the facility's policy titled, Pest Control, dated May 2008, revealed the facility maintained an ongoing pest control program to ensure the building was kept free of insects and rodents.		

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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** Based on record review, interviews, and facility policy review, the facility failed to provide pharmaceutical services to ensure medications were available to be administered as ordered and failed to maintain accurate records of controlled substances for one of three residents (Resident (R) 161) reviewed for pharmacy services out of a sample of 42 residents. Specifically, the facility failed to have prescribed pain medication available for a resident admitted with cancer who was experiencing severe pain, did not obtain the medication from the pharmacy until two days after admission, failed to notify the physician that the medication was unavailable to obtain alternative orders, and failed to accurately reconcile medications brought into the facility by family members. This failure had the potential to result in unmanaged pain, delayed treatment, worsening clinical condition, medication errors, and diversion or loss of controlled substances. Findings include: Review of R161's admission Record located under the Profile tab of the electronic medical record (EMR) indicated an admission date of 04/13/26 with diagnoses of encephalopathy (brain disfunction), hypotension, kidney disease, kidney failure, anemia, hypo-osmolality and hyponatremia hypertension, osteoarthritis, spondylolisthesis, malignant neoplasm of prostate, hypercalcemia, hyperkalemia, gastroesophageal reflux disease, and intervertebral disc degeneration. R161 was discharged to the hospital on [DATE]. Review of R161's Physician Orders located under the Orders tab of the EMR indicated orders for morphine sulfate (narcotic pain medication) ER (extended release) 15 milligrams (mg) one tablet by mouth every six hours as needed for pain for one day starting 04/13/26, mirtazapine oral tablet disintegrating (anti-depressant) 15 mg give one tablet by mouth at bedtime for depression starting 04/13/26, rosuvastatin calcium (treats high cholesterol, prevents heart attacks and strokes) 5 mg give one tablet by mouth at bedtime for HLD (high-density lipoprotein), melatonin (natural hormone) 5mg give one table by mouth every 24 hours as needed for at bedtime for sleep starting 04/13/26 and acetaminophen Oral Tablet 500 mg - give 2 tables by mouth every 6 hour as needed for pain starting 04/13/26. Review of R161's April 2026 Medication Administration Report (MAR) located under the Physician's Orders Administration Report in the EMR indicated that on 04/13/26 morphine sulfate 15mg, mirtazapine 15mg, acetaminophen Oral Tablet 500 mg and rosuvastatin calcium 5mg were not documented as given. Review of R161's Progress Note located under the Progress Notes tab of the EMR dated 04/13/26 indicated that R161 arrived at the facility at 5:00 PM and was in an extreme amount of pain. There was no documentation in the EMR that the physician, pharmacist or Director of Nursing (DON) was notified. Review of Registered Nurse (RN)1's handwritten statement, dated 04/17/26, provided by the facility indicated that R161 was admitted to the facility in a great deal of pain, RN1 stated that the family was (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at bedside, that R161 had a pain pill prior to coming and the next would be due after dinner. RN1 explained the concern with obtaining the medications and that all R161's meds would come in the morning. RN1 asked the family to bring R161's morphine sulfate (pain medication) to ensure R161 had a good night. R161's family brought in 79 pills and the family gave one at 7:00PM on 04/13/26. RN1 stated that the pills were added to the controlled box on the med cart. RN1 stated after the scheduled morphine sulfate was given R161 did not have any pain concerns and rested during the rest of RN1's shift. Review of RN1's statement did not include information about other medications ordered for 04/13/26 in the evening or physician notification. Review of R161's Controlled Drug Record dated 04/13/26 provided by the facility, indicated that 79 morphine sulfate 15mg tablets were received from home signed by RN1. During an interview on 07/08/26 at 1:43 PM, RN1 stated that 19 morphine 15 mg tablets were received. When asked to clarify from previously saying in his statement that 79 morphine sulfate tablets 15 mg were received, RN1 stated he would go with the information in the statement. When asked if he created a flow sheet for the controlled drug book, RN1 stated, How would I know to create a flow sheet, I counted the pills with the family and put the medication in the narcotic medication section of the medication cart. When asked if he had called doctor, RN1 stated he would go with the statement When asked if any additional medications, were given to R161 during the shift, RN1 stated he would go with the statement. During an interview on 07/08/26 at 3:19 PM the DON confirmed that she was not notified about unavailability of R161's medications. The DON stated with physician notification and a prescription the facility could have obtained the morphine sulfate or another pain medication from the pyxis (automated medication dispensing cabinet) in the facility. Review of R161's April 2026 Medication Administration Report (MAR) located under the Physician's Orders Administration Report in the EMR indicated that on 04/14/26 morphine sulfate 15mg was administered. Review of R161's Controlled Durg Record dated 04/13/26 provided by the facility, indicated that 79 morphine sulfate 15mg tablets were received from home signed by RN1. There was no notation that one morphine sulfate 15mg tablet had been signed out on 04/14/26. There were no additional nurse signatures for shift change count on the morning or evening of 04/14/26. During an interview on 07/08/26 at 2:00PM Licensed Practical Nurse (LPN)7 stated she could not recall where she obtained the morphine medication from prior to administering on 04/14/26. That she could not recall if the morphine sulfate was provided by the family, the pyxis, or pharmacy delivery. During an interview on 07/08/26 at 1:52PM the facility pharmacy Pharmacist (PHR) stated that the pharmacy received a fax order for morphine sulfate 15 mg and processed it on 04/14/26 and delivered to the facility on [DATE]. During an interview on 07/09/26 at 1:21PM the Pharmacy Consultant (PHRC) stated that she became aware of the incident on 07/08/26. The PHRC stated that if medicine is given back to the family there (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed to be a chain of documentation and that if she had known about the non-availability of the meds, the facility could have found a way to address R161's pain. During an interview on 07/08/26 at 3:19PM the DON confirmed that she was aware that LPN7 did not sign out the morphine sulfate 15 mg po dose that was administered on 04/14/26. The DON confirmed that there was no documentation, reconciliation, or family signature that the family received the morphine tablets after R161 was discharged to the hospital on [DATE]. Review of facility policy titled Administering Medications dated 2001, provided by the facility indicated: .4. Medications are administered in accordance with prescriber orders, including any required time frame. Review of facility policy titled Med Whiz Pharmacy dated November 2021, provided by the facility: Regular and reliable pharmaceutical service is available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies. Review of the facility policy titled, Controlled Substances, Dispensing and Reconciling Controlled Substances, dated 2001, provided by the facility indicated: 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; and d. Destruction, waste and return to pharmacy records.		