STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 28567 Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to honor the residents preference of eating meals in the dining room for 1 of 22 current residents, Resident #3. The findings include: The facility staff failed to ensure the dining room was available for all three meals 7 days a week. Resident #3's diagnoses included, but were not limited to, mild protein calorie nutrition and diabetes. Section C (cognitive patterns) of Resident #3's significant change in status minimum data set (MDS) assessment with an assessment reference date (ARD) of 08/03/24 included a brief interview for mental status (BIMS) score of 15 out of a possible 15 points. Per the MDS manual a score of 15=cognitively intact. Section GG (functional abilities and goals) was coded to indicate this resident used a wheelchair for mobility and was partial/moderate assist with eating. On 09/04/24 at 11:35 a.m., during an interview with Resident #3, this resident stated they liked to get out of their room and needed to move around. Resident #3 stated they went to the dining room for meals but was unable to go on weekends as the dining room was not open. On 09/04/24 at 11:40 a.m., during an interview with Licensed Practical Nurse (LPN) #1, this staff stated the dining room was not open on weekends due to staffing issues. On 09/04/24 at 12:30 p.m., during an interview with Certified Nursing Assistant (C.N.A.) #1 this staff stated the dining room was not open in the evenings and weekends. It was open if they have a special event. On 09/04/24 at 2:30 p.m., during a meeting with the Administrator, Director of Nursing (DON), and Regional Nurse Consultant (RNC) these staff were asked if the dining room was being utilized on weekends and nights. The Administrator stated they were not aware if it wasn't being utilized and the DON stated they had a big turn out at lunch and for breakfast on Fridays. (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
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/05/24 at 8:29 a.m., the surveyor observed the housekeeping staff cleaning the floors in the dining room. No residents were observed to be in the dining area. Housekeeper #1 stated the dining room was not being used this morning and stated COVID was on the rise. This facility did not have any COVID positive cases during the time of the survey. On 09/05/24, the Dietary Manager stated the dining room was always open at mealtimes for the residents and some choose not to come. On 09/05/24 at 10:30 a.m., the Administrator, DON, and RNC, were made aware of Resident #3's concern that the dining room was not opened for all meals and that the dining room was observed by the surveyor not being utilized for breakfast this morning. The Administrator stated they did not know why it was not being used. No further information regarding this issue was provided to the survey team prior to the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28567 Based on staff interview, clinical record review, and facility document review the facility staff failed to ensure that residents and/or resident representatives had the opportunity to develop an Advanced Directive for 12 of 22 residents, Residents #3, 5, 29, 47, 4, 16, 62, 2, 38, 42, 50, and 75 and failed to honor an Advance Directive for 1 of 22 Residents, Resident #23. The findings include: On [DATE], the facility administrative staff provided the survey team with a copy of a policy titled, ADVANCE DIRECTIVES PROTOCOL. This policy read in part, .Upon Admission during Your Path Meetings, advance directives will be discussed with resident and/or resident representative to determine if any advance directives have be [sic] chosen .Advance directives will be reviewed at minimum annually according to MDS [minimum data set] schedule . 1. For Resident #3, the facility staff failed to provide the resident and/or the resident representative with information concerning the right to accept or refuse medical or surgical treatment and the option to formulate an advance directive. Resident #3's diagnoses included, but were not limited to, mild protein calorie nutrition and diabetes. Section C (cognitive patterns) of Resident #3's significant change in status MDS assessment with an assessment reference date (ARD) of [DATE] included a brief interview for mental status (BIMS) score of 15 out of a possible 15 points. Per the MDS manual a score of 15=cognitively intact. During the clinical record review, the surveyor was unable to locate any evidence to indicate the facility staff had provided the resident and/or their representative the option to formulate an advance directive. On [DATE] at 2:30 p.m., during a meeting with the Administrator, Director of Nursing, and Regional Nurse Consultant the concern with the missing information regarding advance directives was reviewed. On [DATE] at 12:04 p.m., the Administrator stated they were unable to find any information on advance directives. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #5, the facility staff failed to provide the resident and/or the resident representative with information concerning the right to accept or refuse medical or surgical treatment and the option to formulate an advance directive. Resident #5's diagnoses included acute ischemic heart disease and congestive heart failure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section C (cognitive patterns) of Resident #5's quarterly MDS assessment with an assessment reference date (ARD) of [DATE] had been coded [DATE] to indicate this resident had problems with long- and short-term memory and was severely impaired in cognitive skills for daily decision making. During the clinical record review, the surveyor was unable to locate any evidence to indicate the facility staff had provided the resident and/or their representative the option to formulate an advance directive. On [DATE] at 2:30 p.m., during a meeting with the Administrator, Director of Nursing, and Regional Nurse Consultant the concern with the missing information regarding advance directives was reviewed. On [DATE] at 12:04 p.m., the Administrator stated they were unable to find any information on advance directives. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. For Resident #29, the facility staff failed to provide the resident and/or the resident representative with information concerning the right to accept or refuse medical or surgical treatment and the option to formulate an advance directive. Resident #29's diagnoses included, but were not limited to, Schizoaffective disorder. Section C (cognitive patterns) of Resident #29's quarterly MDS assessment with an assessment reference date (ARD) of [DATE] included a brief interview for mental status (BIMS) score of 1 out of a possible 15 points. Per the MDS manual a score of 1=severe impairment. During the clinical record review, the surveyor was unable to locate any evidence to indicate the facility staff had provided the resident and/or their representative the option to formulate an advance directive. On [DATE] at 2:30 p.m., during a meeting with the Administrator, Director of Nursing, and Regional Nurse Consultant the concern with the missing information regarding advance directive was reviewed. On [DATE] at 12:04 p.m., the Administrator stated they were unable to find any information on advance directives. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #47, the facility staff failed to provide the resident and/or the resident representative with information concerning the right to accept or refuse medical or surgical treatment and the option to formulate an advance directive. Resident #47's diagnoses included, but were not limited to, cerebral infarction and chronic obstructive pulmonary disease. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section C (cognitive patterns) of Resident #47's quarterly MDS assessment with an assessment reference date (ARD) of [DATE] included a brief interview for mental status (BIMS) score of 14 out of a possible 15 points. Per the MDS manual a score of 14=cognitively intact. During the clinical record review, the surveyor was unable to locate any evidence to indicate the facility staff had provided the resident and/or their representative the option to formulate an advance directive. On [DATE] at 2:30 p.m., during a meeting with the Administrator, Director of Nursing, and Regional Nurse Consultant the concern with the missing information regarding advance directives was reviewed. On [DATE] at 12:04 p.m., the Administrator stated they were unable to find any information on advance directives. No further information regarding this issue was provided to the survey team prior to the exit conference. 5. For Resident #23, the facility staff failed to honor the residents advance directive wishes. Resident #23's diagnoses included, but were not limited to, diabetes and neuropathy. Section C (cognitive patterns) of Resident #23's quarterly MDS assessment with an assessment reference date (ARD) of [DATE] included a brief interview for mental status (BIMS) score of 5 out of a possible 15 points. Per the MDS manual a score of 5=severe impairment. Resident #23's clinical record included a Virginia Advance Directive for Health Care form signed and notarized on [DATE]. Resident #23 had been admitted to this facility on [DATE]. Under the section MY HEALTH CARE INSTRUCTIONS the box that read in part, I do not want any treatments to prolong my life. This includes .cardiopulmonary (CPR) . had been marked with an X. All the other boxes were left blank. Resident #23's clinical record included the following information: Face sheet that indicated this resident was a full code. Provider order dated [DATE] that read full code. Comprehensive Care Plan (CCP) revised on [DATE] indicating this resident was a full code. On [DATE] at 9:35 a.m., the concern with the residents code status not being honored was shared with the Social Worker. This staff person never provided the surveyor with any updated information. On [DATE] at 2:30 p.m., during a meeting with the Administrator, Director of Nursing, and Regional Nurse Consultant the concern regarding Resident #23's code status was reviewed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE], the administrative staff provided the surveyor with the following, updated face sheet indicating the resident was a do not resuscitate (DNR), provider order dated [DATE] that read Code Status DNR, updated CCP indicating the Resident had chosen to be a DNR, and a progress note that read in part, .spoke with RP [responsible party] .in regards to a code status audit for [Resident #23] .We discussed her prior advanced directive and her RP wishes to respect her wishes of being a DNR. No further information regarding this issue was provided to the survey team prior to the exit conference. 34307 6. For Resident #4 the facility staff failed to ensure the resident had an opportunity to develop an advance directive. Resident #4's face sheet listed diagnoses which included but not limited to dementia, cerebral infarction, and type 2 diabetes mellitus. Resident #4's most recent minimum data set with an assessment reference date of [DATE] coded the resident has having both long- and short-term memory problems with severely impaired cognitive skills for daily decision making. Resident #4's comprehensive care plan was reviewed and contained a care plan for Resident is DNR (do not resuscitate). Approaches for this care plan included Review advanced directives with resident/family periodically, Involve physician/NP (nurse practitioner) in advanced directives conversations, and document resident's advanced directive. Resident #4's clinical record was reviewed, and surveyor could not locate any information related to an advance directive. Surveyor spoke with the facility administrator on [DATE] at 2 pm regarding Resident #4's advance directive. Administrator stated the facility changed electronic health record software in [DATE], and they haven't completed uploading documents to the new record system. Administrator stated they still have access to the previous electronic health record system. Surveyor could not locate advance directive information in either system. The concern on not offering an opportunity to develop an advance directive was discussed with the administrator, director of nursing, and regional director of clinical services on [DATE] at 10:40 am. The administrator informed the surveyor on [DATE] at 12:05 that they did not have any information related to advance directives for Resident #4. No further information was provided prior to exit. 7. For Resident #16 the facility staff failed to ensure the resident had an opportunity to develop an advance directive. Resident #16's face sheet listed diagnoses which included but not limited to chronic obstructive pulmonary disease, end stage renal disease, and congestive heart failure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #16's most recent minimum data set with an assessment reference date of [DATE] coded the resident as 9 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #16's clinical record was reviewed and contained an Advance Care Planning Tracking Form dated [DATE] which read in part, Resident guardian . (name omitted) stated Resident has a living will. Surveyor reviewed the clinical record and could not locate a living will. Surveyor spoke with the facility administrator on [DATE] at 2 pm regarding Resident #16's living will. Administrator stated the facility changed electronic health record software in [DATE], and they haven't completed uploading documents to the new record system. Administrator stated they still have access to the previous electronic health record system. Surveyor could not locate advance directive information in either system. The concern on not offering an opportunity to develop an advance directive was discussed with the administrator, director of nursing, and regional director of clinical services on [DATE] at 10:40 am. The administrator informed the surveyor on [DATE] at 12:05 that they did not have any information related to advance directives for Resident #16. No further information was provided prior to exit. 8. For Resident #62 the facility staff failed to ensure the resident had an opportunity to develop an advance directive. Resident #62's face sheet listed diagnoses which included but not limited to congestive heart failure, type 2 diabetes mellitus, and peripheral vascular disease. Resident #62's most recent minimum data set with an assessment reference date of [DATE] assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #62 comprehensive care plan was reviewed and contained a care plan for Resident has chosen DNR (do not resuscitate) status. Approaches for this care plan included Review code status as needed, and at least annually with resident and/or responsible party. Resident #62's clinical record was reviewed, and surveyor could not locate any information regarding advance directive planning. Surveyor spoke with the facility administrator on [DATE] at 2 pm regarding Resident #62's advance directive planning. Administrator stated the facility changed electronic health record software in [DATE], and they haven't completed uploading documents to the new record system. Administrator stated they still have access to the previous electronic health record system. Surveyor could not locate advance directive information in either system. The concern on not offering an opportunity to develop an advance directive was discussed with the administrator, director of nursing, and regional director of clinical services on [DATE] at 10:40 am. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The administrator informed the surveyor on [DATE] at 12:05 that they did not have any information related to advance directives for Resident #16. No further information was provided prior to exit. 28169 9. For Resident #2, facility staff failed to ensure the resident had an opportunity to develop an advance directive. Resident #2's most recent minimum data set with an assessment reference date of [DATE] coded the resident as having long-term and short-term memory problems with severely impaired cognitive skills for daily decision making. The resident's clinical record contained a Durable Do Not Resuscitate document. The surveyor found no evidence of an advance directive or evidence facility staff provided the resident or representative written information regarding the formulation of an advance directive. The administrator reported the facility transitioned from one clinical record software system to their current software system in [DATE]. The administrator acknowledged facility staff have maintained access to the previous software system. On [DATE] at 2:32 p.m. during a meeting with the administrator, director of nursing, and regional nurse consultant, the concern regarding Resident #2's advance directive was discussed. On [DATE] at 12:05 p.m., the administrator informed the survey team that he was unable to find anything on Advanced Directives for any of the residents the survey team had discussed which included Resident #2. No further information was provided prior to the exit conference. 10. For Resident #38, facility staff failed to ensure the resident had an opportunity to develop an advance directive. Resident #38's most recent minimum data set with an assessment reference date of [DATE] coded the resident's brief interview for mental status score a 5 out of 15 in section C, cognitive patterns. This score indicated a severe cognitive impairment. The resident's clinical record contained a Durable Do Not Resuscitate document. The surveyor found no evidence of an advance directive or evidence facility staff provided the resident or representative written information regarding the formulation of an advance directive. The administrator reported the facility transitioned from one clinical record software system to their current software system in [DATE]. The administrator acknowledged facility staff have maintained access to the previous software system. On [DATE] at 2:32 p.m. during a meeting with the administrator, director of nursing, and regional nurse consultant, the concern regarding Resident #38's advance directive was discussed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:05 p.m., the administrator informed the survey team that he was unable to find anything on Advanced Directives for any of the residents the survey team had discussed with administration which included Resident #38. No further information was provided prior to the exit conference. 11. For Resident #42, facility staff failed to ensure the resident had an opportunity to develop an advance directive. Resident #42's most recent minimum data set with an assessment reference date of [DATE] coded the resident's brief interview for mental status score an 8 out of 15 in section C, cognitive patterns. This score indicated a moderate cognitive impairment. The resident's clinical record contained a Durable Do Not Resuscitate document. The surveyor found no evidence of an advance directive or evidence facility staff provided the resident or representative written information regarding the formulation of an advance directive. The administrator reported the facility transitioned from one clinical record software system to their current software system in [DATE]. The administrator acknowledged facility staff have maintained access to the previous software system. On [DATE] at 2:32 p.m. during a meeting with the administrator, director of nursing, and regional nurse consultant, the concern regarding Resident #42's advance directive was discussed. On [DATE] at 12:05 p.m., the administrator informed the survey team that he was unable to find anything on Advanced Directives for any of the residents the survey team had discussed which included Resident #42. No further information was provided prior to the exit conference. 12. For Resident #50, facility staff failed to ensure the resident had an opportunity to develop an advance directive. Resident #50's most recent minimum data set with an assessment reference date of [DATE] coded the resident as having long-term and short-term memory problems with severely impaired cognitive skills for daily decision making. The resident's clinical record contained a Durable Do Not Resuscitate document. The surveyor found no evidence of an advance directive or evidence facility staff provided the resident or representative written information regarding the formulation of an advance directive. The administrator reported the facility transitioned from one clinical record software system to their current software system in [DATE]. The administrator acknowledged facility staff have maintained access to the previous software system. On [DATE] at 2:32 p.m. during a meeting with the administrator, director of nursing, and regional nurse consultant, the concern regarding Resident #50's advance directive was discussed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:05 p.m., the administrator informed the survey team that he was unable to find anything on Advanced Directives for any of the residents the survey team had discussed which included Resident #50. No further information was provided prior to the exit conference. 49622 13. For Resident #75, the facility staff failed to ensure the resident and/or the resident's representative had the opportunity to develop an advanced directive. Resident #75's diagnosis list indicated diagnoses that included, but were not limited to, Unspecified Dementia, Adult Failure to Thrive, Chronic Kidney Disease, and Herpes Simplex Myelitis. The most recent minimum data set (MDS) with an assessment reference date (ARD) of [DATE], indicated the resident was severely impaired in cognitive skills for daily decision making with short and long-term memory deficits. No BIMS (brief interview for mental status) score was indicated in Section C for cognitive patterns of the MDS. Review of Resident #75's clinical record failed to provide evidence of the facility staff addressing whether the resident and/or the resident's representative desired to formulate an advanced directive. On [DATE] at 11:04 AM, Administrative Staff #4 stated there was no evidence for advance directives or advance directive education for Resident #75 and/or the resident's representative. This concern was discussed at the end of day meeting on [DATE] at 2:32 PM with administrator, director of nursing, and regional director of clinical services, and again at the pre-exit meeting on [DATE] at 5:03 PM with the above noted staff and the regional vice president of operations. No further information was provided to the survey team prior to the exit conference on [DATE].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47299 Based on staff interview, clinical record review and facility document review, the facility staff failed to notify the provider of a critical lab result for 1 of 9 closed records, Resident #129. The findings included: Resident # 129's diagnoses included but were not limited to history of cerebral infarction (stroke), chronic obstructive pulmonary disease, hypertension, moderate protein calorie malnutrition, depression, vitamin deficiency and depression. The minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/21/23 assigned the resident a brief interview for mental status (BIMS) score of 15 out of 15 indicating intact cognition. A review of resident # 129's medication administration record (MAR) revealed they were on aspirin 81 mg daily for CVA (stroke) prophylaxis and Eliquis (an anticoagulant medication used to treat and prevent blood clots and prevent stroke) 5 mg twice daily. Each of these medications are given to thin the blood and put the patient at risk of bleeding. There was an entry on the treatment administration record (TAR) that read, Monitor for signs and symptoms of bleeding while receiving Eliquis. Notify MD if resident has dark/discolored urine, black tarry stools, nosebleed, vomiting and/or coughing up blood. This nursing intervention is signed as done September 1, 2023, through September 10, 2023. A Nurse Practitioner (NP) progress note dated 9/10/23 read in part, She is being seen today for f/u labs. Pt is sitting up in her bed, appears comfortable and in no acute distress. A&O x3, pleasant and responsive. Resident had recent labs drawn for CBC, CMP & TSH, results were significant for H&H of 6.1/19.2 and elevated LFT's ALT 180, AST 189 & Alk Phos 757. She was sent to the ER for blood transfusion. There have been no reported fevers or hypoxia. Denies CP, abd pain, SOB or N/V. H & H is the abbreviation for hemoglobin and hematocrit. The hemoglobin of 6.1 was a critical low result and this was indicated in red lettering on the lab report. The lab results were reviewed by this surveyor and noted to have a resulted date of 9/9/23 at 5:03 PM. According to the progress notes, the critical results were not given to, or addressed by a practitioner until 9/10/23 at 2:54 PM. According to the National Center for Biotechnology, a hemoglobin of less than 6.5 is life threatening and should be considered a medical emergency. The resident was readmitted to the facility on [DATE], less than 2 weeks later. Hospital records indicate they required two units of blood for a diagnosis of a gastrointestinal bleed. A hospital progress note with a date of service of 9/11/23 read in part, .presented at (hospital name omitted) on September 10 with complaints of vomiting and anemia. She also complained of feeling lightheaded for the past month but denies blood in her stool that she was aware of. She was found to be anemic (not enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues) and tachycardic (fast heart rate which is a common symptom of blood loss). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/24 at 4:44 PM this surveyor interviewed the Director of Nursing (DON) and the Regional Nurse Consultant. Surveyor asked about the delay between the lab results being available in the electronic medical record and actually being seen and addressed by the practitioner. The DON stated, They didn't call us, so we didn't know. It was just a routine lab, so we weren't looking for the results, we didn't expect any problem. They are supposed to call us when they get a critical result and then they put on the actual results who they talked to, but they didn't do that. I just don't feel like that is our fault. The Regional Nurse Consultant stated the facility has been having concerns with the lab service for some time. This surveyor reviewed the policy entitled, Resident Change in Condition Policy with an effective date of 1/27/2011. The document read in part, A Significant Change in Condition is a decline or improvement in the resident's status and 6. In the event of an emergency situation, 911 will be called immediately and the physician or provider/family/responsible party will be notified as soon as practicably possible. The survey team met with the Administrator, DON, Regional Nurse Consultant and the Regional VP of Operations on 9/5/24, this concern was discussed. No further information was provided to the survey team prior to the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 42353 Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide Notice of Medicare Non-Coverage at least two days prior to the end of a Medicare covered Part A stay when benefit days were not exhausted for 1 of 3 sampled residents, Resident #45. The findings included: For Resident #45, the facility staff failed to provide Notice of Medicare Non-Coverage at least two days prior to the end of their Medicare covered Part A stay. Resident #45's diagnosis list indicated diagnoses, which included, but not limited to Sepsis, Generalized Muscle Weakness, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Chronic Kidney Disease, and Type 2 Diabetes Mellitus. The minimum data set (MDS) with an assessment reference date (ARD) of 3/14/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #45's last covered day of Medicare Part A services was 4/03/24. A Notice of Medicare Non-Coverage (NOMNC) was issued and signed by the resident on 4/02/24. An 4/02/24 2:37 PM social services progress note read in part Notice of Medicare Non Coverage [sic] given to resident on this date. Last covered day of skilled care will be 4/03/24. Appeals and denials process explained to resident. [Resident #45] states [he/she] does not want to appeal this denial and will discharge home . On 9/05/24 at 12:57 PM, surveyor spoke with the facility social worker (SW) and inquired reason why Resident #45 was not issued a NOMNC at least two days prior to their last cover day. SW stated the NOMNC should have been signed 48 hours prior and they were not sure why it was not. Surveyor requested and received the facility policy titled Medicare Cut Letter Policy with a last revision date of 8/24/23 which read in part The Facility will assure all residents receive timely and appropriate notification of Medicare non-coverage for services in accordance with State and Federal guidelines .Notice must be issued prior to, but no later than 2 days before the termination of such services .For Residents who have days remaining in their benefit period, and will be discharged the first calendar day following their last Medicare covered day, the Social Worker, or Designee, will notify the Resident/Authorized Representative when the resident is approaching the end of coverage, but no later than 2 days prior to the last covered Medicare Part A day, by issuing the Notice of Medicare Provider Non-Coverage CMS-10123 . No further information regarding this concern was presented to the survey team prior to the exit conference on 9/05/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 47299 Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure appropriate information is documented and/or communicated to the receiving healthcare institution for 1 of 31 sampled residents Resident #26. The findings included: For resident # 26 the facility staff failed to provide evidence that the receiving healthcare facility was provided adequate information to care for the resident on 3/31/24. Resident # 26's diagnoses included but were not limited to Type 2 diabetes, chronic obstructive pulmonary disease, protein calorie malnutrition, congestive heart failure, hypertension, depression and chronic kidney disease. The minimum data set (MDS) assessment with an assessment reference date of 8/16/24 assigned the resident a brief interview for mental status score of 15 out of 15 indicating intact cognition. During a review of the clinical record, a progress note dated 3/31/24 at 11:16 PM read, Patient present with confusion and hallucination. Patient daughter called requesting that the patient be sent out. ____ called and stated that another course of action needed to be taken and to not send the patient out. Writer went into patient room again and patient is still hallucinating. Patient states that kids are in her room and that things are crawling on the ceiling and the walls trying to get her. Writer is waiting on call back from ____ as to course of action to take. ____ called back and stated to send patient to the ER. No further information was documented in the notes. Surveyor was unable to locate a transfer form in the record. On 9/5/24 at 11:14 AM this surveyor interviewed corporate staff # 4. Surveyor asked for evidence that the staff communicated all pertinent information to the receiving hospital including contact information of the practitioner responsible for the care of the resident, resident representative contact information, advance directives, special instructions and/or precautions for ongoing care; special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions, the resident's comprehensive care plan goals, and all other information necessary to meet the resident's needs. They stated, They didn't even do the transfer form or anything. On 9/5/24 at 4:44 PM the survey team met with the Administrator, Director of Nursing, Regional Nurse Consultant, and Regional VP of Operations. This concern was discussed with them at that time. No further information was provided to the survey team prior to the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47299 Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure that written transfer notices were provided for 4 of 31 Residents, Residents #26, #129, #71, and #72. The findings included: 1. For resident # 26 the facility failed to notify the resident and/or the resident's representative(s) of the transfer and the reasons in writing, and in a language and manner they understand. The facility staff also failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman. Resident # 26's diagnoses included but were not limited to, history of cerebral infarction (stroke), chronic obstructive pulmonary disease, hypertension, moderate protein calorie malnutrition, depression, vitamin deficiency and depression. The minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/21/23 assigned the resident a brief interview for mental status (BIMS) score of 15 out of 15 indicating intact cognition. During a review of the clinical record, a progress note dated 3/31/24 at 11:16 PM read, Patient present with confusion and hallucination. Patient daughter called requesting that the patient be sent out. ____ called and stated that another course of action needed to be taken and to not send the patient out. Writer went into patient room again and patient is still hallucinating. Patient states that kids are in her room and that things are crawling on the ceiling and the walls trying to get her. Writer is waiting on call back from ____ as to course of action to take. ____ called back and stated to send patient to the ER. No further information was documented in the notes. Surveyor was unable to locate a transfer form in the record. On 9/5/24 at 9:25 AM a surveyor interviewed Licensed Practical Nurse (LPN) # 4. They stated the Social Worker is not notifying the Ombudsman of transfers to hospitals, only the transfers to homes. On 9/5/24 at 10:28 AM a surveyor interviewed the Regional Director of Clinical Services who stated the social worker is not notifying the Ombudsman of transfers to the hospital. On 9/5/24 at 11:14 AM this surveyor interviewed Corporate staff # 4. Surveyor asked for evidence that the staff notified the resident and/or the resident's representative(s) of the transfer and the reasons for the transfer in writing, and in a language and manner they understand. They stated, They didn't even do the transfer form or anything. On 9/5/24 at 4:44 PM the survey team met with the Administrator, Director of Nursing, Regional Nurse Consultant, and Regional VP of Operations. This concern was discussed with them at that time. No further information was provided to the survey team prior to the exit conference. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. For resident # 129, the facility failed to notify the resident and/or the resident's representative(s) of the transfer and the reasons in writing, and in a language and manner they understand. The facility staff also failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman. Resident # 129's diagnoses included but were not limited to history of cerebral infarction (stroke), chronic obstructive pulmonary disease, hypertension, moderate protein calorie malnutrition, depression, vitamin deficiency and depression. The minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/21/23 assigned the resident a brief interview for mental status (BIMS) score of 15 out of 15 indicating intact cognition. A nurse progress note dated 6/8/23 at 1:15 PM read, at 0830, CNA informed this nurse, that the resident was c/o tightness in her chest and chest pain on the left side. Nurse assessed pt and pt complain of chest pain 4/10. Vitals: 127/74-bp, 97-HR, 16-R, 94%RA. Pt emergency contact was called and informed and she requested that the pt be sent out to ER for further eval. Dr. [NAME] was informed and made aware of the family request to send pt out to ER. Pt was sent out to ER at 0930 and paperwork(care plan, bed hold, med list, face sheet) was given to EMT. On 9/5/24 at 9:25 AM a surveyor interviewed Licensed Practical Nurse (LPN) # 4. They stated the Social Worker is not notifying the Ombudsman of transfers to hospitals, only the transfers to homes. On 9/5/24 at 10:28 AM a surveyor interviewed the Regional Director of Clinical Services who stated the social worker is not notifying the Ombudsman of transfers to the hospital. On 9/5/24 at 11:14 AM this surveyor interviewed Corporate staff # 4. Surveyor asked for evidence that the staff notified the resident and/or the resident's representative(s) of the transfer and the reasons for the transfer in writing, and in a language and manner they understand. They stated, They didn't even do the transfer form or anything. On 9/5/24 at 4:44 PM the survey team met with the Administrator, Director of Nursing, Regional Nurse Consultant, and Regional VP of Operations. This concern was discussed with them at that time. No further information was provided to the survey team prior to the exit conference. 49622 3. For Resident #71, the facility staff failed to provide the resident and the resident's representative written notice of the reason(s) of transfer/discharge to the hospital on 5/8/24 and 7/5/24 and failed to notify the Office of the State Long-Term Care Ombudsman of the transfer/discharge on 5/8/24 and 7/5/24. Resident #71's diagnosis list indicated diagnoses that included, but were not limited to, Prostate Cancer, Chronic Obstructive Pulmonary Disease, Muscle Weakness, Congestive Heart Failure, Depression and Candidal Cystitis, and Urethritis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent minimum data set (MDS) with an assessment reference date (ARD) of 7/15/24, assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating Resident #71 was cognitively intact. A review of the clinical record indicated Resident #71 was transferred to the hospital on 5/8/24 and on 7/5/24. No evidence of written notice of the transfer being provided to the resident and the resident's representative could be located. On 9/5/24 at 10:15 AM, surveyor interviewed the social worker-other staff #1 (OS#1) and she informed surveyor she notifies the ombudsman once a month of transfers and discharges via fax and that she would look for notification of the transfer for Resident #71 for the 5/8/24 and 7/5/24 discharges to the hospital. On 9/5/24 at 11:05 AM, corporate staff #4 (CS#4) informed surveyor that no evidence of written notification for the reason of transfer could be located for Resident #71 and resident's representative for 5/8/24 or 7/5/24, and there was no evidence of notification of transfer or discharge for the ombudsman for the transfers for 5/8/24 and 7/5/24. This concern was discussed at the pre-exit meeting on 9/5/24 at 5:03 PM with the administrator, director of nursing, regional director of clinical services, and regional vice president of operations. Surveyor requested and received a facility document, titled, Resident Discharge/Transfer Letter Policy, that read in part, .The facility will complete discharge letters .according to all federal, state, and local regulations . C .3. Completed and signed letters will be uploaded back to the electronic chart .D. Discharge notices must have the following components: 1. The reason for discharge/transfer .E. Social Service or designee will assure the original discharge/transfer letter is given to the resident .1. Copies will be sent to .Ombudsman Office .and/or scanned into the electronic chart .F. Social service or designee will document in the chart all discharge/transfer reasons, any notices given .G. The resident .responsible party will receive . discharge/transfer letter . No further information regarding this concern was presented to the survey team prior to the exit conference on 9/5/24. 4. For Resident #72, the facility staff failed to provide the resident and the resident's representative written notice of the reason(s) of transfer to the hospital on 5/17/24 and 7/18/24 and failed to notify the Office of the State Long-Term Care Ombudsman of the transfer/discharge on 5/17/24 and 7/18/24. Resident #72's diagnosis list indicated diagnoses that included, but were not limited to, Encounter for surgical aftercare following surgery on the digestive system, Diabetes Mellitus Type 2, Difficulty Walking, Transient Ischemic Attack (TIA), Dementia, Atherosclerotic Heart Disease, Hyperlipidemia, Osteoarthritis of Knee, and Depression. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 8/13/24, assigned the resident a brief interview for mental status (BIMS) summary score of 10 out of 15 for cognitive abilities, indicating Resident #72 was moderately impaired in cognition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record indicated Resident #72 was transferred to the hospital on 5/17/24 and on 7/18/24. No evidence of written notice of the transfer being provided to the resident and the resident's representative could be located. On 9/5/24 at 9:25 AM, surveyor interviewed licensed practical nurse #4 (LPN#4) and she stated the social worker is not notifying the ombudsman of transfers to the hospital, she is only notifying the ombudsman of discharges home. LPN#4 stated she would look for evidence of written reason for transfer/discharge to the resident and resident representative. LPN#4 returned to surveyor at 9:53 AM and stated there was no evidence that written notice of the reason for transfer was given to Resident #72 or resident's representative. On 9/5/24 at 10:15 AM, surveyor interviewed the social worker-other staff #1 (OS#1) and she informed surveyor she notifies the ombudsman once a month of transfers and discharges via fax and that she would look for notification of the transfer for Resident #72 for the 5/17/24 and 7/18/24 discharges to the hospital. On 9/5/24 at 10:28 AM, regional director of clinical services informed surveyor that OS#1 is not sending transfer notifications to the ombudsman. This concern was discussed at the pre-exit meeting on 9/5/24 at 5:03 PM with the administrator, director of nursing, regional director of clinical services, and regional vice president of operations. Surveyor requested and received a facility document, titled, Resident Discharge/Transfer Letter Policy, that read in part, .The facility will complete discharge letters .according to all federal, state, and local regulations . C .3. Completed and signed letters will be uploaded back to the electronic chart .D. Discharge notices must have the following components: 1. The reason for discharge/transfer .E. Social Service or designee will assure the original discharge/transfer letter is given to the resident .1. Copies will be sent to .Ombudsman Office .and/or scanned into the electronic chart .F. Social service or designee will document in the chart all discharge/transfer reasons, any notices given .G. The resident .responsible party will receive . discharge/transfer letter . No further information regarding this concern was presented to the survey team prior to the exit conference on 9/5/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 47299 Based on Staff interview, clinical record review and facility document review, the facility staff failed to provide evidence of a bed hold being provided to 2 of 31 residents, Residents #26 and #71. The findings included: 1. Resident # 26's diagnoses included but were not limited to Type 2 diabetes, chronic obstructive pulmonary disease, protein calorie malnutrition, congestive heart failure, hypertension, depression and chronic kidney disease. The minimum data set (MDS) assessment with an assessment reference date of 8/16/24 assigned the resident a brief interview for mental status score of 15 out of 15 indicating intact cognition. During a review of the clinical record, a progress note dated 3/31/24 at 11:16 PM read, Patient present with confusion and hallucination. Patient daughter called requesting that the patient be sent out. ____ called and stated that another course of action needed to be taken and to not send the patient out. Writer went into patient room again and patient is still hallucinating. Patient states that kids are in her room and that things are crawling on the ceiling and the walls trying to get her. Writer is waiting on call back from ____ as to course of action to take. ____ called back and stated to send patient to the ER. No further information was documented in the notes. Surveyor was unable to locate a transfer form in the record. On 9/5/24 at 11:14 AM this surveyor interviewed Corporate staff # 4. Surveyor asked for evidence that the staff provided the resident or resident representative with the bed hold policy. They stated, They didn't even do the transfer form or anything. On 9/5/24 at 4:44 PM the survey team met with the Administrator, Director of Nursing, Regional Nurse Consultant, and Regional VP of Operations. This concern was discussed with them at that time. No further information was provided to the survey team prior to the exit conference. 49622 2. For Resident #71, the facility staff failed to provide the resident and/or the resident's representative with the facility bed-hold policy upon transfer on 5/8/24 and 7/5/24. Resident #71's diagnosis list indicated diagnoses that included, but were not limited to, Prostate Cancer, Chronic Obstructive Pulmonary Disease, Muscle Weakness, Congestive Heart Failure, Depression and Candidal Cystitis, and Urethritis. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 7/15/24, assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating Resident #71 was cognitively intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the clinical record indicated Resident #71 was transferred to the hospital on 5/8/24 and on 7/5/24. No evidence of the facility's bed-hold policy being provided to the resident and/or the resident's representative could be located. On 9/5/24 at 11:05 AM, corporate staff #4 (CS#4) informed surveyor that no evidence could be located of the bed hold being given to Resident #71 and/or resident's representative for the transfers to the hospital on 5/8/24 and 7/5/24. This concern was discussed at the pre-exit meeting on 9/5/24 at 5:03 PM with the administrator, director of nursing, regional director of clinical services, and regional vice president of operations. Surveyor requested and received a facility document, titled, Resident Discharge/Transfer Letter Policy, that read in part, .G. The resident or responsible party will receive a bed hold notice .3. A copy of the completed bed hold notice will be scanned into the electronic chart . Surveyor also received a facility document titled, BED HOLD NOTICE, that read in part, .This notice is to be provided to the resident and his/her representative at the time of transfer. In the case of an emergency, the paperwork should be provided within 24 (twenty-four) hours . No further information regarding this concern was presented to the survey team prior to the exit conference on 9/5/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 34307 Based on staff interview and clinical record review the facility staff failed to ensure an accurate minimum data set (MDS) assessment for 2 of 9 closed record reviews, Resident #76 and Resident #25. The findings included: 1. For Resident #76 the facility staff incorrectly coded the resident's discharge MDS assessment. Resident #76's face sheet listed diagnoses which included but not limited to cellulitis and diabetes mellitus. Resident #76's discharge MDS with an assessment reference date of 06/14/24 coded the resident as being discharged to short-term general hospital (acute hospital). Resident #76's clinical record contained a nurse's progress note dated 06/14/24 which read in part, Resident discharged home with home health services. His transportation via wheelchair took him to his residence. All medications and paperwork was taken by the resident. Resident signed for his narcotics and other medications. Vital signs are within normal limits. All personal belongings were taken by the resident. Nursing educated resident on fall precautions and resident verbalized understanding. NP (nurse practitioner) approved all orders. Surveyor spoke with registered nurse (RN) # 1 on 09/04/24 at 4:40 pm. Surveyor asked RN #1 where resident discharged to, and RN #1 stated, He discharged home on 06/14/24. Surveyor asked RN #1 where resident's MDS read that they were discharged to, and RN #1 looked at MDS and stated, It says he discharged to the hospital, that's not right. RN #1 stated they would do a correction to the MDS. The concern with the incorrectly coded MDS was discussed with the administrator, director of nursing, and regional director of clinical services on 09/05/24 at 10:30 am. No further information was provided prior to exit. 28567 2. For Resident #25, the facility staff failed to complete a discharge minimum data set (MDS) assessment. Resident #25's diagnoses included, but were not limited to, diabetes and dementia. During the Resident Assessment task Resident #25 had flagged for an MDS assessment over 120 days old. During the record review the surveyor was unable to find a discharge MDS assessment when the Resident had been discharged from the facility (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/04/24 at 4:36 p.m., during an interview with MDS coordinator #1 and #2 both staff were asked about a discharge MDS assessment for Resident #25. After reviewing the clinical record these staff confirmed that a discharge MDS assessment had not completed and stated they had switched software systems in March of 2024. Under the census tab in the clinical record, the facility staff had documented this resident had been discharged in April 2024 return not anticipated. On 09/04/24 at 2:30 p.m., during a meeting with the Administrator, Director of Nursing, and Regional Nurse Consultant the concern with the missing discharge MDS assessment was reviewed. Prior to the exit conference the MDS coordinators provided the surveyor with a copy of a form (no title) indicating they had completed Resident #25's discharge assessment and it had been accepted. No further information regarding this issue was provided to the survey team prior to the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 28567 Based on staff interview, clinical record review, and facility document review, the facility staff failed to follow provider orders for 2 of 9 closed record reviews, Residents #229 and #379. The findings include: 1. For Resident #229, the facility staff failed to complete provider ordered treatments to a surgical wound. Resident #229's diagnoses included, muscle weakness, need for assistance with personal care, diabetes, and non-pressure related chronic ulcer of other part of left foot. Section C (cognitive patterns) of Resident #229's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 04/04/23 included a brief interview for mental status (BIMS) score of 15. Per the MDS manual a score of 15=cognitively intact. Resident #229's comprehensive care plan included the focus area resident has risk of skin breakdown and actual impaired skin integrity. Interventions included administer medications/treatments as ordered. The clinical record included the following progress note documented on the residents admission to the facility .Wound type is skin graft .Wound Location left heel .Area is community acquired. Skin impairment was present on admission . On 03/08/23 the nursing staff documented a progress note indicating the surgical incision wound location was the left plantar foot and lateral foot. Treatment updated to pack with normal saline moist gauze. A review of the clinical record revealed that on March 9, 10, and 31 the treatment administration blocks where the nursing staff would have documented that they had completed the treatment were left blank. For the month of April, the nursing staff had failed to document they had completed the treatment on April 1 and 11. For the month of May the facility nursing staff failed to document they had completed the provider ordered treatment on May 8 and 19. On 09/04/24 at 4:10 p.m., during an interview with Licensed Practical Nurse #6 this staff stated they remembered this resident having dressings to their feet but did not recall them saying anything about the treatments not being completed. On 09/05/24 at 2:14 p.m., during an interview with the Regional Nurse Consultant this staff was asked what a blank spot (hole) on the treatment administration record (TAR) where nursing would document they had completed a treatment would mean. The Nurse Consultant stated it could mean it wasn't done or they just forgot to sign for the treatment. On 09/05/24 at 2:45 p.m., the Administrator, Director of Nursing (DON), and Regional Nurse Consultant were made aware that there was no evidence to indicate the facility nursing staff had completed the provider ordered treatments to Resident #229's surgical wound for the dates provided in March, April and May of 2023. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No evidence was provided to the survey team to indicate these treatments had been completed by the nursing staff prior to the exit conference on 09/05/24. 49622 2. For Resident #379, the facility staff failed to follow a provider's order for the resident to be NPO (nothing by mouth) for a scheduled medical procedure on 3/29/23. This was a closed record review. Resident #379's diagnosis list indicated diagnoses, which included, but not limited to End Stage Renal Disease, Edema, Depression, Dependence on Renal Dialysis, Type 2 (two) Diabetes Mellitus with Diabetic Neuropathy, Chronic Obstructive Pulmonary Disease, Weakness, and Retention of Urine. The minimum data set (MDS) with an assessment reference date (ARD) of 3/22/23 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of the clinical record revealed a nursing progress note dated, 3/28/2023, that read in part, .Follow up appointment made for 3/29/23 with an arrival time of 1130am [sic], surgery time scheduled for 130pm [sic]. Resident is NPO after midnight for the procedure . A provider's order dated 3/28/24, that read in part, .NPO diet NPO texture for Upcoming surgery for 1 (one) Day . Surveyor requested and received Resident #379's meal intake record that revealed a code of 3 (three) on 3/29/23, which indicated the resident had eaten 76%-100% of breakfast on the day of the scheduled surgical procedure. On 9/5/24 at 10:52 AM, administrative staff #4 agreed that resident received breakfast on 3/29/23, prior to the scheduled medical procedure. The medical procedure was performed, but the resident was not able to have anesthesia for the procedure. This concern was discussed with the administrator and administrative staff #4 on 9/5/24 at 9:45AM and again at the pre-exit meeting on 9/5/24 at 5:03 PM with the administrator, director of nursing, regional director of clinical services, and regional vice president of operations Surveyor requested and received a facility policy title, Physician/Provider Orders, that read in part, .The Charge Nurse shall .review all physician/provider orders . No further information regarding this concern was presented to the survey team prior to the exit conference on 9/5/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 28169 Based on staff interview and clinical record review, the facility staff failed to ensure residents were free of significant medication errors for 1 of 9 closed record reviews. (Resident #279). The findings were: For Resident #279, facility staff failed to administer Insulin Lispro (1 Unit dial) Solution Pen-Injector 100 UNIT/ML according to hospital discharge orders. Resident #279's stay at the facility was approximately two (2) days. The admission record listed diagnoses which included but not limited to sepsis, and osteomyelitis, left ankle and foot. The acute care hospital discharge summary listed the active problem of type 2 diabetes mellitus with complication, with long-term current use of insulin. Resident #279's minimum data set (MDS) Kardex Report listed the resident's cognition having ok short-term and long-term memory. The resident was able to recall the season, room location, staff names/faces, and that the resident was in a nursing home. The MDS Kardex read the resident was independent with daily decision making. The provider orders included but were not limited to, two (2) insulin orders. One order dated 01/07/2023 was for Insulin Lispro Kwikpen 100 unit/1 ml insulin pen. Inject as per sliding scale: If 100 - 120 = 10 units; 151 - 200 = 14 units; 201 - 250 = 18 units; 251+ = 22 units, subcutaneously three times a day for DMII (diabetes mellitus type 2). This provider order's sliding scale did not address blood sugar results between 121 and 150. The second insulin order read, Basaglar KwikPen Solution Pen-Injector 100 units/ml (Insulin Glargine). Inject 42 units subcutaneously two times a day for diabetes mellitus type 2. The medication administration record (MAR) for January 2023 was reviewed and noted three (3) times when the Insulin Lispro Kwikpen dose was not administered. Those doses were documented as a 3 which the chart code defined as no insulin required. 1. On 01/07/23 at 6:00 a.m., the blood sugar = 137 with no insulin administered. 2. On 01/07/23 at 2:00 p.m., the blood sugar = 143 with no insulin administered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 01/08/23 at 6:00 a.m., the blood sugar = 75 with no insulin administered. On 09/05/24 at 4:26 p.m., the staff development coordinator, (licensed practical nurse - LPN #4) was interviewed about the insulin and sliding scale provider order that did not include orders for blood sugars between 121 and 150. LPN #4 reported facility staff use hospital discharge orders to document facility admission orders for residents. The nurse stated the insulin sliding scale orders had been transcribed incorrectly which resulted in an insulin administration error. LPN #4 provided the acute care hospital discharge summary and pointed out the Insulin Lispro (1 Unit Dial) 100 unit/ml pen injector order read to inject subcutaneously three times a day before meals using a sliding scale: 100 - 150 = 10 units; 151 - 200 = 14 units; 201 - 250 = 18 units; greater than 250 = 22 units. LPN #4 acknowledged that if facility staff had transcribed the insulin sliding scale from the hospital discharge orders correctly, Resident #279 should have received insulin for two of the three doses when the resident did not receive any insulin: the blood sugar = 137 and the blood sugar = 143. The MAR noted the Basaglar KwikPen Solution (Insulin Glargine) doses were administered on 01/07/23 for both doses however, the 01/08/23 9:00 a.m. dose was not administered with a chart code listed as 19 which was defined as Other/See Nurses Notes. No nurses note for that date and time was found in the progress notes. The surveyor was unable to determine the exact time Resident #279 left the facility. The MAR did not contained documentation to indicate Resident #279 refused insulin. The concern regarding Resident #279's insulin sliding scale transcription error and subsequent missed insulin doses was discussed with the administrator, director of nursing, regional nurse consultant, and vice president of operations on 09/05/24 at 5:05 p.m. On 09/05/24 at 4:16 p.m., this surveyor unsuccessfully attempted to contact the nurse who admitted Resident #279. The nurse who provided care to the resident during day shift no longer worked at the facility. No further information was provided prior to the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42353 Based on observation, staff interview, and facility document review, the facility staff failed to ensure the safe and secure storage of medications and biologicals for 2 of 4 medication carts (Unit 1/Cart 1 and Unit 2/Cart 1) and 1 of 2 medication storage rooms (Unit 1). The findings included: 1. For Unit 1/Medication Cart 1, the facility staff left a Colestipol tablet (medication used to lower cholesterol) unattended on top of the medication cart. On [DATE] at 8:26 AM during a medication pass observation, surveyor observed Licensed Practical Nurse (LPN) #1 place a Colestipol tablet in a separate medication cup as it appeared damaged and obtained a replacement tablet for administration. LPN #1 left the cup containing the damaged tablet on top of the medication cart unattended and entered a resident's room. While in the resident's room, LPN #1 provided care and administered medications with the door closed leaving the Colestipol tablet unattended in the hall for approximately nine (9) minutes. When asked about the unattended medication, LPN #1 placed the cup containing the medication in the medication cart and stated they wanted to show other staff members the damaged tablet. Surveyor requested and received the facility policy titled General Dose Preparation and Medication Administration with a last revision date of [DATE] which read in part, .2.8 Facility staff should not leave medications or chemicals unattended . On [DATE] at 10:40 AM, the survey team met with the Administrator, Director of Nursing, and Clinical Services Manager and discussed the concern of the unattended medication. No further information regarding this concern was presented to the survey team prior to the exit conference on [DATE]. 2. For Unit 2/Medication Cart 1, the facility staff failed to label a multi-dose insulin pen with the date of opening and/or discard date. On [DATE] at 1:40 PM, surveyor observed an open, partially used Aspart ,d+[DATE] Insulin pen in the Unit 2/Medication Cart 1. The insulin pen was not labeled with an opened or discard date. Registered Nurse (RN) #4 stated there were two doses remaining and they were ordering a new insulin pen for the resident. Surveyor requested and received the facility policy titled General Dose Preparation and Medication Administration with a last revision date of [DATE] which read in part .2.10 Facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulins, irrigation solutions, etc.). 2. 10.1 Facility staff may enter the expiration date based on date opened on the label of medications with shortened expiration dates . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 5:00 PM, the survey team met with the Administrator, Director of Nursing, Clinical Services Manager, and the [NAME] President of Operations and discussed the concern of the undated insulin pen. No further information regarding this concern was presented to the survey team prior to the exit conference on [DATE]. 3. For the Unit 1 Medication Storage Room, the facility staff failed to discard expired COVID-19 testing cards. On [DATE] at 1:16 PM, surveyor observed an opened box containing 30 [NAME] BinaxNOW COVID-19 Ag tests (Lot #220976) with a printed expiration date of [DATE]. According to the [NAME] product website (https://www.globalpointofcare.[NAME]/us/en/product-details/binaxnow-covid-19.html), [NAME] BinaxNOW COVID-19 Ag testing cards Lot #220976 with an original expiry date of [DATE] had been extended to a 22 month expiry date of [DATE]. Surveyor spoke with Registered Nurse (RN) #3 on [DATE] at 2:34 PM and discussed the extended expiry date of [DATE]. RN #3 stated they were discarding the tests. Surveyor requested and received the facility policy titled Storage and Expiration Dating of Medications and Biologicals with a last revision date of [DATE] which read in part, .10. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines .are stored separate from other medications until destroyed or returned to the pharmacy or supplier . On [DATE] at 5:00 PM, the survey team met with the Administrator, Director of Nursing, Clinical Services Manager, and the [NAME] President of Operations and discussed the concern of the expired COVID-19 tests. No further information regarding this concern was presented to the survey team prior to the exit conference on [DATE].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 47299 Based on staff interview, clinical record review, and facility document review, the facility staff failed to obtain a provider ordered laboratory test for 1 of 22 residents, Resident #20. The findings included: For resident # 20, the facility staff failed to obtain a Depakote level on 11/22/23 per physician's order. Resident # 20's diagnoses included but were not limited to unspecified dementia, bipolar disorder and depression. Resident # 20's minimum data set (MDS) assessment with an assessment reference date of 6/8/24 indicated that resident is severely cognitively impaired, they are rarely/never understood, rarely never understands others and decision making is severely impaired as well. During a review of resident # 20's Medication Regimen Reviews for the last year, a pharmacist Consultation Report with a date of 12/19/23, read in part, .has orders for labs but at the time of this review they were not available in the medical record. The missing lab values include: Depakote level every Wed related to bipolar disorder .Unless otherwise indicated, please ensure that ordered labs are obtained. Please disregard recommendation if these labs have been recently obtained. The report was signed by the Director of Nursing (DON) on 1/16/24. This surveyor was unable to locate the lab results in the clinical record. The orders were reviewed and an order for the lab work was noted, it was dated 11/21/23. The treatment administration record (TAR) for November 2023 was reviewed. The order for the lab was on the TAR to be obtained on 11/22/23. The order had not been signed off as done on the TAR. On 9/5/24 at 2:19 PM this surveyor spoke with the DON and asked if they could provide the results of the Depakote level done on 11/22/23. At 2:26 PM Licensed Practical Nurse (LPN) # 3 brought in labs dated 1/3/24 and 1/10/24. They stated they were not able to locate any labs from 11/22/23 and that they had even checked with the contracted lab provider. When surveyor asked why the lab wasn't done, they stated, I'm not sure. It was missed. The survey team met with the DON, Administrator, Regional Nurse Consultant and Regional VP of Operations on 9/5/24 at 4:44 PM. This concern was discussed at that time. No further information was provided to the survey team prior to the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 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. 42353 Based on observation and staff interview, the facility staff failed to store food in accordance with professional standards for food service safety in the facility kitchen. The findings included: The facility staff failed to discard seven (7) containers of unsweetened coconut milk that had exceeded the best by date of 5/13/24. On 9/04/24 at 9:30 AM, in the presence of the Dietary Manager (DM), the surveyor observed seven (7) 32-ounce containers of unsweetened coconut milk each with a best if used by date of 5/13/24 present in the dry storage area of the facility kitchen. The DM removed the containers of unsweetened coconut milk from the dry storage area. On 9/05/24 at 10:40 AM, the survey team met with the Administrator, Director of Nursing, and the Clinical Services Manager and discussed the concern of out-of-date coconut milk present in the facility kitchen. No further information regarding this concern was presented to the survey team prior to the exit conference on 9/05/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49622 Based on staff interviews, clinical record reviews, and facility document review, the facility staff failed to ensure a complete and/or accurate clinical record for 3 of 31 sampled residents, Resident #379, Resident #9, and Resident #62. The findings include: 1. For Resident #379, the facility staff failed to document the resident's allergy to the medication Hydrocodone in the clinical record. This was a closed record review. Resident #379's diagnosis list indicated diagnoses, which included, but not limited to End Stage Renal Disease, Edema, Depression, Dependence on Renal Dialysis, Type 2 (two) Diabetes Mellitus with Diabetic Neuropathy, Chronic Obstructive Pulmonary Disease, Weakness, and Retention of Urine. The minimum data set (MDS) with an assessment reference date (ARD) of 3/22/23 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of the clinical record revealed Resident #379 had no known allergies on the face sheet, provider's orders, care plan, and on the March 2023 MAR (medication administration record). Further review of an H & P (history and physical exam) dated 3/5/23 from the transferring hospital, revealed Resident #379 had an allergy to Hydrocodone-Acetaminophen. A facility document titled, Nursing Admission Report, indicated resident had an allergy to Hydrocodone. This concern was discussed with the administrator and administrative staff #4 on 9/5/24 at 9:45 AM and again at the pre-exit meeting on 9/5/24 at 5:03 PM with the administrator, director of nursing, regional director of clinical services, and regional vice president of operations. Surveyor requested and received a facility policy titled Physician/Provider Orders, that read in part, . PROCEDURE .All information received from the referring facility or agency shall be reviewed. 1. Transcribe all orders from the transfer form to the facility admission physician order form. Orders should include the following .l. Allergies . No further information regarding this concern was presented to the survey team prior to the exit conference on 9/5/24. 47299 2. For resident # 9, the facility staff failed to ensure a complete and accurate Social Services Annual Evaluation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 9's diagnoses included but were not limited to chronic obstructive pulmonary disease, history of stroke, moderate protein calorie malnutrition, adult failure to thrive and major depressive disorder. During a review of the clinical record an order for DNR (do not resuscitate) status was observed. There were no advanced directives in the record. An annual Social Services Evaluation with an effective date of 5/23/23 was reviewed. The document stated that resident # 9 had a Living Will. On 9/5/24 at 9:29 AM this surveyor asked the Regional Nurse Consultant for a copy of resident # 9's Living Will. On 9/5/24 at 10:26 AM this surveyor asked Registered Nurse (RN) # 3 if they were aware of resident # 9 having a Living Will. They did not and stated it would be in the electronic record if there was one. When informed of the Social Services Annual Assessment they stated, It was marked incorrectly. On 9/5/24 at 4:44 PM the survey team met with the Administrator, Director of Nursing, Regional Nurse Consultant and Regional VP of Operations. This concern was discussed at that time. No other information was provided to the survey team prior to the exit conference. 34307 3. For Resident #62 the facility staff failed to accurately complete a Virginia Department of Health Durable Do Not Resuscitate (DDNR) form. Resident #62's face sheet listed diagnoses which included but not limited to congestive heart failure, diabetes mellitus, and peripheral vascular disease. Resident #62's most recent minimum data set with an assessment reference date of 08/03/24 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #62's comprehensive care plan was reviewed and contained a care plan for Resident has chosen DNR (do not resuscitate) status. Resident #62's clinical record was reviewed and contained a Virginia Department of Health DDNR for which read in part, I, the undersigned, state that I have a [NAME] fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest. I further certify (must check 1 or 2): No boxes were check under this section. The form went on the read, If you checked 2 above, check A, B, or C below: No boxes in this section were checked. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor spoke with the regional director of clinical services (RDCS) on 09/05/24 at 10:20 am regarding Resident #62's DDNR form. RDCS stated that form was incomplete. The concern of the incomplete DDNR form was discussed with the administrator, director or nursing, and RDCS on 09/05/24 at 10:30 am. 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
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42353 Based on observation and staff interview, the facility staff failed to maintain infection prevention and control practices during medication administration for 1 of 2 nursing units, Unit #1. The findings included: For Unit #1, the licensed practical nurse (LPN) placed a resident's inhaler in their uniform pocket to transport into the resident's room prior to administration. On 9/05/24 at 8:43 AM, surveyor observed LPN #5 place a resident's Breo inhaler in the pocket of their uniform top to transport to the resident's room. LPN #5 removed the inhaler from their pocket and handed it to the resident for administration. When asked about placing the Breo inhaler in their pocket, LPN #5 stated they did not know if the resident would have tissues available in their room for use with their eye drops so they took theirs from the medication cart causing them to have extra items in their hands and they did not want to make two trips. On 9/05/24 at 10:40 AM, the survey team met with the Administrator, Director of Nursing, and Clinical Services Manager and discussed the concern of LPN #5 placing a resident's inhaler in their uniform pocket. No further information regarding this concern was presented to the survey team prior to the exit conference on 9/05/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42353 Based on staff interview, clinical record review, and facility document review, the facility staff failed to offer a pneumococcal vaccine in accordance with nationally recognized standards for 3 of 5 sampled residents reviewed for immunizations (Resident #42, #49, and #72). The findings included: 1. For Resident #42, the facility staff failed to offer the resident a pneumococcal conjugate vaccine 15 (PCV15) or a pneumococcal conjugate vaccine 20 (PCV20) following admission to the facility. Resident #42's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus, Parkinson's Disease, and Generalized Muscle Weakness. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 7/02/24 assigned the resident a brief interview for mental status (BIMS) summary score of 8 out of 15 indicating the resident was moderately cognitively impaired. Resident #42 was over the age of [AGE] years when admitted to the facility. Surveyor reviewed Resident #42's clinical record and was unable to locate a pneumococcal vaccination history or evidence the resident was offered a PCV15 or PCV20 following admission to the facility. The Centers for Disease Control and Prevention (CDC) guideline titled, Recommended Adult Immunization Schedule for Ages [AGE] years or Older dated 12/28/23 read in part that adults age [AGE] years or older who have not previously received a dose of PCV13 (pneumococcal conjugate vaccine 13), PCV15, or PCV20 or whose previous vaccination history is unknown should receive one dose of PCV15 or PCV20. Surveyor met with the Infection Preventionist (IP) and Administrative Staff Member (ASM) #4 on 9/04/24 at 2:50 PM and discussed Resident #42's pneumococcal vaccination status. The IP and ASM #4 were unable to provide evidence of the facility offering the resident a PCV15 or PCV20 following admission. Surveyor requested and received the facility policy titled, Resident Vaccination Policy with a last revision date of 5/18/22 which read in part, Resident and/or their responsible party will be asked about prior vaccinations at admission. Prior doses of .pneumococcal .and other vaccines will be documented in the immunization portal in the electronic health record .The Infection Preventionist will track resident immunizations and holds the responsibility for ensuring resident's vaccination history is reviewed with/by their providers and that vaccines are administered timely when ordered . On 9/04/24 at 3:14 PM, the survey team met with the Administrator, Director of Nursing, and Regional Clinical Services Manager and discussed the concern of staff failing to offer Resident #42 a pneumococcal vaccine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this concern was presented to the survey team prior to the exit conference on 9/05/24. 2. For Resident #49, the facility staff failed to offer the resident a pneumococcal conjugate vaccine 20 (PCV20) or a pneumococcal polysaccharide vaccine 23 (PPSV23) following admission to the facility. Resident #49's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus, Aortic Valve Stenosis, and Essential Hypertension. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 6/13/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #49 was over the age of [AGE] years when admitted to the facility. Resident #49's clinical record revealed the resident had previously received a pneumococcal conjugate vaccine 13 (PCV13) in 2016 and a PPSV23 in 2018 prior to admission and before age 65. Surveyor was unable to locate evidence of Resident #49 being offered a PCV20 or PPSV23 following admission to the facility. The Centers for Disease Control and Prevention (CDC) guideline titled, Recommended Adult Immunization Schedule for Ages [AGE] years or Older dated 12/28/23 read in part that adults [AGE] years or older who have previously received both PCV13 and PPSV23 but no PPSV23 was received at age [AGE] years or older should receive 1 dose of PCV20 or 1 dose of PPSV23. Surveyor met with the Infection Preventionist (IP) and Administrative Staff Member (ASM) #4 on 9/04/24 at 2:50 PM and discussed Resident #49's pneumococcal vaccination status. The IP and ASM #4 were unable to provide evidence of the facility offering the resident a PCV20 or PPSV23. Surveyor requested and received the facility policy titled, Resident Vaccination Policy with a last revision date of 5/18/22 which read in part, Resident and/or their responsible party will be asked about prior vaccinations at admission. Prior doses of .pneumococcal .and other vaccines will be documented in the immunization portal in the electronic health record .The Infection Preventionist will track resident immunizations and holds the responsibility for ensuring resident's vaccination history is reviewed with/by their providers and that vaccines are administered timely when ordered . On 9/04/24 at 3:14 PM, the survey team met with the Administrator, Director of Nursing, and Regional Clinical Services Manager and discussed the concern of staff failing to offer Resident #49 a pneumococcal vaccine. No further information regarding this concern was presented to the survey team prior to the exit conference on 9/05/24. 3. For Resident #72, the facility staff failed to offer the resident a pneumococcal conjugate vaccine 15 (PCV15) or a pneumococcal conjugate vaccine 20 (PCV20) following admission to the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #72's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus, Atherosclerotic Heart Disease of Native Coronary Artery, Dementia, and Adult Failure to Thrive. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 8/13/24 assigned the resident a brief interview for mental status (BIMS) summary score of 10 out of 15 indicating the resident was moderately cognitively impaired. The MDS documented Resident #72's pneumococcal vaccination was not up to date with the reason being not offered. Resident #72 was over the age of [AGE] years when admitted to the facility. Surveyor reviewed Resident #72's clinical record and was unable to locate a pneumococcal vaccination history or evidence the resident was offered a PCV15 or PCV20 following admission to the facility. The Centers for Disease Control and Prevention (CDC) guideline titled, Recommended Adult Immunization Schedule for Ages [AGE] years or Older dated 12/28/23 read in part that adults age [AGE] years or older who have not previously received a dose of PCV13 (pneumococcal conjugate vaccine 13), PCV15, or PCV20 or whose previous vaccination history is unknown should receive one dose of PCV15 or PCV20. Surveyor met with the Infection Preventionist (IP) and Administrative Staff Member (ASM) #4 on 9/04/24 at 2:50 PM and discussed Resident #72's pneumococcal vaccination status. The IP and ASM #4 were unable to provide evidence of the facility offering the resident a PCV15 or PCV20 following admission. Surveyor requested and received the facility policy titled, Resident Vaccination Policy with a last revision date of 5/18/22 which read in part, Resident and/or their responsible party will be asked about prior vaccinations at admission. Prior doses of .pneumococcal .and other vaccines will be documented in the immunization portal in the electronic health record .The Infection Preventionist will track resident immunizations and holds the responsibility for ensuring resident's vaccination history is reviewed with/by their providers and that vaccines are administered timely when ordered . On 9/04/24 at 3:14 PM, the survey team met with the Administrator, Director of Nursing, and Regional Clinical Services Manager and discussed the concern of staff failing to offer Resident #72 a pneumococcal vaccine. No further information regarding this concern was presented to the survey team prior to the exit conference on 9/05/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 42353 Based on staff interview, clinical record review, and facility document review, the facility staff failed to offer an updated 2023-2024 COVID-19 vaccine for 1 of 5 sampled residents (Resident #49), failed to provide evidence of education regarding the risks, benefits and potential side effects of the COVID-19 vaccine prior to the administration for 2 of 5 sampled residents (Resident #2 and #42), and failed to provide evidence of consent prior to the administration of a COVID-19 vaccine for 1 of 5 sampled residents (Resident #42). The findings included: 1. For Resident #49, the facility staff failed to offer the resident an updated 2023-2024 formula COVID-19 vaccine. Resident #49's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus, Aortic Valve Stenosis with Insufficiency, and Essential Hypertension. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 6/13/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. A review of Resident #49's clinical record revealed their most recent COVID-19 vaccine was received on 2/02/23. Surveyor was unable to locate evidence of the resident being offered an updated 2023-2024 COVID-19 vaccine. Surveyor met with the Infection Preventionist (IP) and Administrative Staff Member (ASM) #4 on 9/04/24 at 2:50 PM and discussed Resident #49's COVID-19 vaccination status. The IP and ASM #4 were unable to provide evidence of the facility offering the resident an updated 2023-2024 COVID-19 vaccine. Surveyor requested and received the facility policy titled Resident Vaccination Policy with a last revision date of 5/18/22 which read in part .COVID vaccination will be offered to all residents and administered per provider orders .The Infection Preventionist will track resident immunizations and holds the responsibility for ensuring resident's vaccination history is reviewed with/by their providers and that vaccines are administered timely when ordered . On 9/04/24 at 3:14 PM, the survey team met with the Administrator, Director of Nursing, and the Regional Clinical Services Manager and discussed the concern of staff failing to offer Resident #49 an updated 2023-2024 formula COVID-19 vaccine. No further information regarding this concern was presented to the survey team prior to the exit conference on 9/05/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #42, the facility staff failed to provide evidence of the resident/resident representative (RR) receiving education regarding the risks, benefits, and potential side effects and obtaining consent prior to the administration of a COVID-19 vaccine. Resident #42's diagnosis list indicated diagnoses, which included, but not limited to Parkinson's Disease, Type 2 Diabetes Mellitus, and Generalized Muscle Weakness. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 7/02/24 assigned the resident a brief interview for mental status (BIMS) summary score of 8 out of 15 indicating the resident was moderately cognitively impaired. A review of Resident #42's clinical record revealed they received a COVID-19 vaccine on 6/27/24. Surveyor was unable to locate documentation indicating the resident and/or resident representative was provided education regarding the risks, benefits and potential side effects of the vaccine or consent was obtained prior to administration. On 9/04/24 at 2:50 PM, surveyor met with the Infection Preventionist (IP) and Administrative Staff Member (ASM) #4 who confirmed they were also unable to locate evidence of Resident #42's receiving education or providing consent prior to the administration of the COVID-19 vaccine. Surveyor requested and received the facility policy titled Resident Vaccination Policy with a last revision date of 5/18/22 which read in part .When a vaccination is ordered, a nurse or other licensed clinician/provider will review the CDC Vaccine Information Statement[s] (VIS) or Emergency Use Authorization (EUA) Statement[s] for any recommended vaccines with the resident/resident representative before obtaining consent. The resident/representative will have an opportunity to ask questions . On 9/04/24 at 3:14 PM, the survey team met with the Administrator, Director of Nursing, and the Regional Clinical Services Manager and discussed the concern of staff failing to provide education and obtain consent prior to the administration of a COVID-19 vaccine for Resident #42. No further information regarding this concern was presented to the survey team prior to the exit conference on 9/05/24. 3. For Resident #2, the facility staff failed to provide evidence of the resident/resident representative (RR) receiving education regarding the risks, benefits, and potential side effects prior to the administration of a COVID-19 vaccine. Resident #2's diagnosis list indicated diagnoses, which included, but not limited to Multiple Sclerosis, Schizophrenia, and Dementia. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 6/08/24 assessed the resident as rarely/never able to make self understood and rarely/never able to understand others. Resident #2 was assessed as being severely impaired in cognitive skills for daily decision making. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Health & Rehab Center, LLC	2230 Executive Drive Revised Hampton, VA 23666

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #2's clinical record revealed they received a Moderna Monovalent booster COVID-19 vaccine on 11/16/23. Surveyor was unable to locate documentation indicating the resident representative (RR) was provided education regarding the risks, benefits and potential side effects of the vaccine prior to administration. On 9/04/24 at 2:50 PM, surveyor met with the Infection Preventionist (IP) and Administrative Staff Member (ASM) #4 who confirmed they were also unable to locate evidence of Resident #2's RR receiving education prior to the administration of the COVID-19 vaccine. Surveyor requested and received the facility policy titled Resident Vaccination Policy with a last revision date of 5/18/22 which read in part .When a vaccination is ordered, a nurse or other licensed clinician/provider will review the CDC Vaccine Information Statement[s] (VIS) or Emergency Use Authorization (EUA) Statement[s] for any recommended vaccines with the resident/resident representative before obtaining consent. The resident/representative will have an opportunity to ask questions . On 9/04/24 at 3:14 PM, the survey team met with the Administrator, Director of Nursing, and the Regional Clinical Services Manager and discussed the concern of staff failing to provide education prior to the administration of a COVID-19 vaccine for Resident #2. No further information regarding this concern was presented to the survey team prior to the exit conference on 9/05/24.