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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility staff failed to ensure resident rights to receive services in the facility with reasonable accommodation of resident needs and preferences for 5 residents in a survey sample of 13 Residents. (Residents #7, #8, #9, #10, #11).Findings include:For Residents #7, #8, #9, #10, #11, the facility staff failed to ensure residents had call bells within their reach to contact staff on 2 occasions on 10/28/25.On 10/28/25 at 12:05pm, initial rounds were conducted where Resident's #7, #8, #9 #10 and #11 were observed in their beds with their call bell on the floor behind the head of their bed.On 10/28/25 at 3:06pm, rounds were conducted to assess call bell placement. Resident's #7, #8, #9, #10 and #11's call bells were still observed on the floor behind the head of the bed.On 10/28/25 at approximately 4:00 pm, during the end of the day meeting with the Administrator, Director of Nursing and the Regional Nurse Consultant, the Director of Nursing was asked what her expectation was on staff's responsibility on ensuring residents had easy access to their call bell. She replied, staff should check and make sure that the call bell is placed within the residents' reach before they leave the residents' room. A request was made to the Director of Nursing and Administrator for a copy of the facility's policy on call bell placement.On 10/29/25 at approximately 3:30PM, an interview was conducted with Nurse RN #1 on her responsibility in call bell placement and she replied, it is my responsibility to always ensure my residents have access to their call bells so they can call us if they need usOn 10/29/25 at 11:50AM, an interview was conducted with Nurse LPN #5 on what her responsibility was in verifying call bell placement for residents and she responded, it is my responsibility to make sure they are within reach before I leave the room and make sure the C.N.A's have them clipped and placed where they can get to them easily.On 10/29/25 at 11:54AM, according to Nurse LPN #4 Unit Manager she stated, it is everyone's responsibility to make sure the residents always have they call bell within their reach, some of them have personal preferences on where they want them to be clipped or attached to the bed, but we need to make sure they can reach them.On 10/29/25 at approximately 11:55 AM, an interview was conducted with C.N.A # 7 who stated, When I am finished giving care to my residents, before I leave their room, I make sure to empty their trash and put their call bell close to them.On 10/29/25 during end of day meeting, when asked for the copy of the facility policy on call bell placement, the Regional Nurse Consultant responded, We do not have a policy addressing call bell placement. When asked what standards of professional practice the facility used, she replied, We use [NAME].According to [NAME], key principles of the [NAME] standards: PATIENT SAFETY: Make fall risk the sixth vital sign. [NAME] Barron [NAME] DNP, RN, [NAME] MSN, RN, DeaToasha D. [NAME] BSN-MHA, RN, [NAME] Berg RN, Nursing2011, April 2011, Volume 41 Number 4, Pages 62 - 64 The core standard, featured in [NAME]'s fall prevention resources, is that the call bell must always be placed within a resident's easy reach. This is especially crucial for individuals at high risk for falls, and staff should provide verbal and visual reminders to use it. Bedside accessibility: A call system must be available at each resident's bedside to summon staff assistance. Room environment checks: During regular patient rounding, nursing staff should ensure that the call light, along with other personal items like tissues and the phone, is within the resident's reach. This is part of a broader falls-prevention strategy. These guidelines align with federal regulations for long-term care facilities, which also mandate that a functioning call system be available at a resident's bedside and in their bathing areas. 10/30/25 during the end of day exit, the Administrator, Director of Nursing and Regional Nurse Consultant were made aware of the concerns, and no further information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Resident interview, facility staff interviews, clinical record review, and facility documentation review, the facility staff failed to maintain a safe, clean comfortable home-like environment for 2 of 3 nursing units (Unit A, Unit B) and in a survey sample of 13 Residents. The findings included: 1. For Resident #2, and unit A, the unit was dirty, in disrepair, and was not safe, not clean, nor homelike. 2. For Resident #3, and unit B, the unit was dirty, in disrepair, and was not safe, not clean, nor homelike. 1. Resident #2 Was admitted to the facility on [DATE] with diagnoses including femur fracture with surgical repair, asthma, pneumonia, anxiety, depression, and Hepatitis C. The Resident required minimal to moderate assistance on 1 staff member for all activities of daily living such as hygiene, and bathing. The Resident's daughter was her responsible party, and decision maker. Resident #2 was found to be alert and oriented to person, and place. The Resident had mild observable cognitive impairment. The Resident was conversational and appropriate in response to questioning. 2. Resident #3 Was admitted to the facility on [DATE] with diagnoses including stroke, anemia, gout, heart attack, diabetes, asthma, atrial fibrillation, and vertigo. The Resident required extensive assistance or was fully dependent on 1 to 2 staff members for all activities of daily living such as hygiene, and bed mobility. The Resident was her own responsible party and found to be alert and oriented to person, place, time, and situation. The Resident had no observable cognitive impairment. The Resident was conversational and appropriate in response to questioning and was a good historian.During an initial tour of the facility and during interviews with Residents on 10-28-25, at 11:40 a.m., multiple Residents complained that their rooms were nasty and falling apart, and that showers were avoided because the showers are so nasty dirty. The surveyors then immediately walked to the shower room for an initial observation and found it to be dirty, mildewed/moldy, foul smelling, had a strong odor of urine and feces, trash and debris littered the floor, tile was chipped, and the grout was black in places on the floor, a white crusted substance was on the floor and walls. None of the shower areas looked as though they were wet or had been used that day to shower Residents. Immediately following the shower room observation, the Resident's rooms were examined. The Resident's room tours included but were not limited to the following being observed; Broken vinyl window blinds were seen. The free standing chests of drawers and hospital bed head and foot boards were broken, swollen in places from moisture and splitting, with rotten splinters and chunks of disintegrating wood and wood particles on the room floors and bed linens. The sinks and toilets were dirty, water would not drain from the sink clogged drains and was left with dirt and debris in them. Floors were dirty and sticky underfoot, encrusted with crumbs, brown debris, and black particles, and made a sucking sound as one walked across it. The base board was peeling and drooping over in places with debris in corners and broken base boards and moldings were also present. Bed divider curtains had brown stains and smeared brown substances on them. A few rooms had no television, no clock, no telephone, no radio and the room had no personal items (other than clothes in the chests of drawers) and nothing personal on the walls. There were holes in walls, spackling compound over some holes and no paint had been applied to cover those repairs with dust on the floor from the sanding of the compound. On 10-29-25 the Director of Maintenance was interviewed and stated he was new to the job and had only been there 2.5 weeks. He agreed that shared maintenance staffing for the 2 buildings (this nursing facility and the Assisted Living facility on the same grounds) had been tight. He further stated that a new technician was hired, and a second one would be coming shortly. This revealed that even with full staff there would only be 3 employees completing all repairs and maintenance for 2 large buildings. The nursing facility had 160 beds. It is unknown how many individual apartments were contained in the larger assisted living building. The maintenance Director stated they were starting to get some priorities taken care of in the facility now as staffing had improved just recently. On 10-29-25, and 10-30-25 during a meeting with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the above concerns and that the living units were not safe, clean and comfortable. At the time of the survey exit the facility Administrator, and Director of Nursing stated they had nothing further to provide.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to maintain an abuse/neglect free environment for 1 Resident (Resident #3) in a survey sample of 13 Residents.The findings included.Resident #3 Was admitted to the facility on [DATE] with diagnoses including stroke, anemia, gout, heart attack, diabetes, asthma, atrial fibrillation, and vertigo. The Resident required extensive assistance or was fully dependent on 1 to 2 staff members for all activities of daily living such as hygiene, and bed mobility. The Resident was her own responsible party and found to be alert and oriented to person, place, time, and situation. The Resident had no observable cognitive impairment. The Resident was conversational and appropriate in response to questioning and was a good historian. On 10/28/25 at 12:15 p. m. Resident #3 was interviewed in the Resident's Room. The Resident was sitting in bed dressed in hospital gown. CNA #6 (Certified Nursing Assistant #6) entered the room and Resident #3 asked is there any milk today? CNA #6 stated, I've told you, no milk at lunch (Resident's name). In a frustrated angry elevated voice, (the CNA had said this before to the Resident). The CNA was loud, curt, and dismissive. This caused the Resident to then whisper while talking to the surveyor out of fear of being overheard by the CNA, stating they have said before that we can't have milk at lunch. The Surveyor then asked the CNA, No milk at lunch is that a rule? CNA #6 replied they have tea and coffee at lunch, in a curt response. The Surveyor then asked, Even if she requested it? CNA #6 responded, Well, I guess if she asked dietary, they might get it. The CNA immediately exited the room and did not retrieve the milk for the Resident. Resident #3 then whispered, asking the surveyor I'm not going to get kicked out am I? The surveyor replied no, and asked does she always speak that way to you? The Resident replied, they all talk like that to us.On 10/28/25 at 12:30 p.m. an interview was conducted with the Dietary manager, who stated residents can request milk at lunch, but it is not routinely given out at lunch, however, it is with breakfast and dinner. She further stated that the Residents could have milk, and it was in the refrigerator on all of the units at the nursing station at all times, but the CNA's had to go and get it. The Refrigerator on the unit was examined and found to contain at least 12 cartons of 2% and whole milk options.CNA #6 willing (repeatedly) withheld readily available goods and services (neglect) from a Resident who requested them from her in the presence of a representative of the State Agency. This was done in an angry manner that resulted in the Resident experiencing fear of retaliation or reproach for asking for those goods and services (abuse). This action had been repeated by this CNA, and others.On 10-29-25 at 11:30 a.m. The Administrator, Corporate Registered Nurse (RN), and Director of Nursing (DON), were made aware of the incident, and stated that it had been reported to them. They had begun an investigation of abuse and notified the State Agency of such. CNA #6 was suspended (thus protecting the Resident) pending the result of their investigation.The facility policy on Abuse was reviewed and revealed their definitions of abuse supported this situation as being identified as an allegation of abuse. The policy steps were followed after the allegation of abuse was made.On 10-30-29 at the end of day debriefing the facility Administrator, DON, and Corporate RN were made aware of the deficient practice and they stated they had no further information to provide.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews and record review, the facility staff failed to ensure appropriate resident care and services were provided in accordance with accepted professional standards of care for 3 residents (Resident #4, #5 and #6) in a survey sample of 13 residents.Findings included:For Residents #4, #5 and #6, the facility staff failed to ensure residents' medications were administered by the physician's orders as evidenced by observing medications at the resident's bedside.For Residents #4, #5 and #6, the facility staff failed to ensure residents' medications were administered by the physician's orders as evidenced by observing medications at the resident's bedside.For Resident #4, she was admitted to the facility on [DATE] with diagnoses including but not limited to: major depressive disorder, hypertension, pain, generalized anxiety, presence of cardiac pacemaker, history of COVID, cardiomyopathy, retention of urine, combined systolic and diastolic congestive heart failure, fibromyalgia, Type 2 diabetes mellitus, atrial fibrillation, ulcerative colitis, old myocardial infarction, non-ST elevation myocardial infarction, chronic ischemic heart disease, asthma, overactive bladder and post-traumatic stress disorder. Resident #4's most recent MDS (Minimum Data Set Assessment) Quarterly Assessment with an ARD (Assessment Reference Date) of 8/21/25 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15 indicating no cognitive impairment. On 10/28/25 at 12:15PM during initial rounds, 2 medicine cups were observed on Resident #4's bedside table. One (1) medicine cup contained 10 round, white tablets and the second medicine cup had 3 green tablets and 1 round red tablet. An interview was conducted with Resident #4 and when asked what was in the medicine cups, she replied, those white tablets are my Tylenol and I don't want all that Tylenol, I am a nurse and I have told them I do not want all that Tylenol, the green tablets are calcium and I just don't need it everyday and the red one is a vitamin. I have told them over and over that I don't want them that much, I told my doctor too. It's malpractice here. I give this place an F the food is poor quality, and the kitchen staff is under educated. When asked if the nurses observed her swallowing her medicines she replied, Oh, honey, I am a nurse and they know I can take it, they sit it down on my table here. I just take what I want and throw the rest in the trash can over there (pointing to the trash can across the room). When asked her how long the pills had been on her overbed table she replied Oh, just past couple days.A review of Resident #4's Medication Administration Record for October was completed which revealed that the resident had an order for, initialed by nurses as taking the medications and confirmed by nurse in the medication cart as: Tylenol Extra Strength Oral Tablet 500 MG give 1000 mg by mouth three times a day related to pain (round, white tablets) Oyster Calcium Oral Tablet 500 MG give 1 tablet by mouth two times a day related to deficiency of other vitamins (green tablets) Multivitamin Oral Tablet give 1 tablet by mouth one time a day related to deficiency of vitamins (red, round tablet)For Resident #5, she was admitted to the facility on [DATE] with diagnoses including but not limited to: hypertension, chronic pain syndrome, unspecified, psychosis not due to a substance or known physiological condition, unspecified mood disorder and overactive bladder. Resident #5's most recent MDS (Minimum Data Set Assessment) Quarterly Assessment with an ARD (Assessment Reference Date) of 8/15/25 coded Section C0500 as 99 indicating the resident was unable to complete the interview. This occurs when the resident is unwilling or unable to answer enough of the questions, making the BIMS result invalid. Section C1000. Cognitive Skills for Daily Decision Making was coded as moderately impaired.On 10/28/25 at 12:35PM during initial rounds, a medicine cup was observed on Resident #5's bedside table. The medicine cup contained 6 tablets - white, round tablets varying sizes and four (4) bottles of eye drops were also observed on the overbed table - 1 bottle was Artificial Tears, label on bottle indicated expired 3/2024,1 bottle was brimonidine, 1 bottle was dorzolamide and 1 bottle was prednisone. When asked her how long the pills had been on her overbed table she replied, I don't know. I don't take them anymore. Resident #5 unable to give any more details.A review of Resident #5's Medication Administration Record for October was completed which revealed that the resident had an order for, initialed by nurses as taking the medications and confirmed by nurse the following medications were in the med cart:Escitalopram 5mg 1 tablet every morning by mouthFurosemide 20mg 1 tablet every morning by mouth Metoprolol 25 mg 1 tablet every morning by mouth Norvasc 10mg1 tablet every morning by mouth Tylenol Extra Strength 500mg 2 tablets every morning by mouth Brimonidine eye drops twice daily - not in the medication cart Dorzolamide eye drops twice daily - not in the medication cart Prednisone eye drops twice daily - not in the medication cartFor Resident #6, she

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and facility documentation, the facility staff failed to ensure residents receive care to prevent the development of pressure ulcers for 1 Resident (Resident #1) in a survey sample of 13 Residents.The findings included: Resident #1, the facility staff failed to provide assessments, ordered treatments and supplements for the prevention and development of new pressure injuries.For Resident #1, the facility staff failed to provide assessments, ordered treatments and supplements for the prevention and development of new pressure injuries.Resident #1 was admitted to the facility on [DATE] from home with diagnoses including but not limited to hypertension, unstageable pressure injury sacrum, moisture associated skin damage to right buttocks, atrial fibrillation gastro-esophageal reflux disease with esophagitis, ventral hernia without obstruction, vitamin D deficiency, lymphedema, pain, sequelae of unspecified cerebrovascular disease, morbid obesity, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, chronic obstructive pulmonary disease, fusion of the spine, lumbar region, arthritis, chronic kidney disease Stage 3, heart failure, venous insufficiency, type 2 diabetes mellitus with diabetic neuropathy, nightmare disorder, peripheral vascular disease, atherosclerotic heart disease of native coronary artery without angina pectoris, specified disorders of the tendon left wrist and generalized anxiety.Resident #1's most recent MDS (Minimum Data Set) Quarterly Assessment with an ARD (Assessment Reference Date) of 5/14/25 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15 indicating no cognitive impairment. Section GG coded the resident as requiring extensive assistance with turning/repositioning, lying to sitting, sit to stand, chair/bed to chair transfer, toileting, bathing and dressing. On 10/29/25, a review of the clinical record revealed that Resident #1 was admitted to the facility on [DATE] from her home accompanied by her daughter. According to the clinical record, the daughter reported the resident was alert and oriented, was able to voice her needs, was wheelchair bond, had several pre-existing wounds (bed sores per daughter's wording) to her buttocks and heels and was incontinent of bowel and bladder. Per clinical record review, Resident #1 was seen and evaluated by the facility's wound care provider {name redacted} Nurse Practitioner-C {name redacted} on 4/1/25. Head to toe evaluation revealed: Sacrum - unstageable full thickness 2.3 x1.5cm x unmeasurable - treatment initiated, reposition per facility protocol. Turn side to side every 1-2 hours if able; recommended debridement of necrosis (surgical removal of dead tissue) to aid in the healing process, the resident and daughter declined debridement. Right buttock - non-pressure wound, partial thickness 3.0 x 5.0 x 0.1cm - moisture associated skin damage - treatment initiated, reposition per facility protocol. Turn side to side every 1-2 hours if able Left scalp - non-pressure area 2.0 x 1.5cm x not measurable (due to presence of dried fibrinous exudate) treatment initiated Bilateral feet - hyperkeratosis and epidermal thickening - treatment initiatedAccording to the clinical record, on 4/2/25 Resident #1 assessed by the facility wound care nurse RN#1 for completion of the Braden Scale Assessment (a scale used to evaluate risk for development of pressure injuries). Resident #1 scored 14 indicating a Moderate Risk for pressure injury development (constantly moist, chairfast, very limited with mobility due to inability to make frequent or significant positional changes independently and potential problem in moving and sliding to some extent against sheets, chair and other devices.Per clinical record review of wound care provider's weekly assessments from 4/1/25 through 5/27/25, Resident #1's sacral pressure injury, right buttock moisture associated skin damage and scalp non pressure area continued to show improvement as evidenced by decreased surface area, depth and drainage until 5/27/25 where the sacral pressure injury showed deterioration as evidence of an increase in surface area and drainage at which time the Nurse Practitioner made changes to the treatment regimen. Per clinical record review, it was noted that Resident #1 did not have an assessment of wounds by either the facility's Wound Care provider Nurse Practitioner or the facility's wound nurse on 5/6/25 or 6/3/25.On 6/9/25, new areas of impaired skin integrity were identified by nurse, assessed by facility wound care nurse and treatment initiated; resident, daughter and nurse practitioner notified of new areas; -Left upper sacrum 2.0 x 2.0 x 0.1cm classified as Stage 2 Partial Thickness, Pressure Injury; -Right buttock 2.2 x 2.2 x 0.1cm, classified as Stage 2 Partial Thickness, Pressure Injury; -Left buttock 2.1 x 2.1 x 0.1cm, classified as Stage 2 Partial Thickness, Pressure InjuryOn 6/11/25, Resident #1 was seen and evaluated by the Wound Care provider Nurse Practitioner - sacrum Stage 3, Pressure Injury, RESOLVED; NEW Left buttock, reclassified as a Stage 3 Full Thickness Pressure Injury measuring 1.7 x 2.1 x 0.1cm, debrided by wound care nurse

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review and facility documentation, the facility staff failed to ensure that residents were free from unnecessary medications for 1 Resident (#2) in a survey sample of 13 residents.For Resident #2 the faciltiy staff failed to ensure that the resident was free from unnecessary drugs related to duplicate drug therapy.Resident #2 was admitted to the facility on [DATE] with diagnoses that include but were not limited to fracture of left femur, COPD (Chronic Obstructive Pulmonary Disease), asthma, chronic respiratory failure, abscess of lung, major depressive disorder, generalized anxiety disorder, acute hepatitis C, and insomnia. Resident #2 had a BIMS (Brief Interview of Mental Status) Score of 11 out of a possible 15 indicating moderate cognitive impairment. Resident #2 was admitted to the facility on [DATE] with orders that included the following:Escitalopram 20 mg daily was DISONTINUED Continue Fluoxetine 25 mg daily Continue Seroquel low dose to assist with sleep. A review of the clinical record revealed that on admission to the facility the order for Escitalopram 20 mg was ordered by attending physician. The discharge order on page 5 of the discharge summary read: Start taking these medications:Melatonin 3 mg at night for insomniaQuetiapine Fumarate 25 mg. [an anti-psychotic] in the evening for mood take 0.5 tab. [1/2 of a tablet or 12.5 mg] On 9/5/25 during the admission process the order was written as follows: Quetiapine fumarate oral tablet 25 mg give 1 tablet by mouth in the evening for mood. 9/5/25 The resident received the incorrect dosage twice (9/6/25 and 9/7/25) before the correction was made to read 0.5 of a 25 mg tablet to equal 12.5 mg, thus causing the resident to be given twice the amount of medication on 2 separate occasions.The Psych Nurse Practitioner ordered the Buspar on 9/15/25 and the following warning was flagged by the pharmacy system The system raised the alert again on 9/15/25 when the physician ordered buspirone HCL 7. 5 mg by mouth 2 times a day for major depressive disorderHas triggered the following drug protocol alerts / warningsDrug to Drug interactionInteraction: Additive serotonergic effects may occur during coadministration of buspirone and escitalopram oxalate 20 mg tramadol HCl and trazadone and the risk of developing serotonin syndrome may be increased.No documentation was present that the MD had been notified, or the pharmacy had been consulted regarding these alerts of drug-to-drug interactions. On 10/30/25 at approximately 11:30 am an interview was conducted with the Psych NP who stated that he did not order the admission medications they were done by the hospital and the attending physician at the facility. He stated that he ordered the Buspar on 9/15/25 for depression. When asked if he was made aware of the warnings of concomitant use of several of the medications, he stated that the facility staff did not contact him regarding pharmacy warnings of drug-to-drug interactions. He stated that he did not order the other medications, so he was not aware of any issues with them. On 10/30/25 an interview was conducted with LPN B who stated that pharmacy alerts will appear when orders are entered into the system that are conflicting or have drug to drug interactions or if a patient has an allergy. LPN B stated that the nurses are supposed to notify the physician to see if the physician wants to keep the medicine or change it to something else. She further stated that they also should consult with the pharmacist as well. On the afternoon of 10/30/25 an interview was conducted with the DON who stated that it is her expectation that nurses are to contact physicians when they have pharmacy alerts for drug to drug interactions and or allergy alerts. The DON also stated that notifying the physicians allows the physician to decide whether the benefit of taking the drug outweighs the risks. When asked if the physicians have access to the progress notes where the pharmacy alerts are written she stated that they did.On 10 /30/25 during the end of day meeting the Administrator was made aware of the finding and no further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 - Some	Ensure that residents are free from significant medication errors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	10/30/2025

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Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** For Resident #2 the facility staff failed to order and administer the correct dose of quetiapine fumarate (Seroquel, an antipsychotic) causing the resident to be given double the amount ordered on 2 occasions, and furthermore failed to notify the physician, or consult with the pharmacy when alerts for drug-to-drug interactions appeared. Resident #2 was admitted to the facility on [DATE] with diagnoses that include but were not limited to fracture of left femur, COPD (Chronic Obstructive Pulmonary Disease), asthma, chronic respiratory failure, abscess of lung, major depressive disorder, generalized anxiety disorder, acute hepatitis C, and insomnia. Resident #2 had a BIMS (Brief Interview of Mental Status) Score of 11 out of a possible 15 indicating moderate cognitive impairment. Resident #2 was admitted to the facility on [DATE] with orders that read:Page 2/8 of discharge summary Anxiety Depression Insomnia- Reported memory problems will require outpatient evaluation. Nursing staff reported that the pt was expressing suicidal thoughts; cleared by psych to come off 1:1 on 8/18/25. Appreciate psychiatry service evaluation Escitalopram 20 mg daily was DISONTINUED Continue Fluoxetine 25 mg daily Continue Seroquel low dose to assist with sleep. A review of the clinical record revealed that on admission to the facility the order for Escitalopram 20 mg was initiated by attending physician, (In spite of the order by hospital psychiatrist to discontinue Escaltiapram and Fluxetine was not ordered)The discharge order on page 5 of the discharge summary read: Start taking these medications:Melatonin 3 mg at night for insomniaQuetiapine Fumarate 25 mg. in the evening for mood take 0. 5 tab. [12.5 mg]On 9/5/25 during the admission process the order for Quetiapine Fumarate was written as follows: Quetiapine fumarate oral tablet 25 mg give 1 tablet by mouth in the evening for mood. 9/5/25 The resident received the incorrect dosage twice (9/6/25 and 9/7/25) before the correction was made to read 0.5 of a 25 mg tablet to equal 12.5 mg, thus causing the resident to be given twice the amount of medication on 2 separate occasions.On admission to the facility the following medications were entered into the pharmacy system: Escitalopram Oxalate oral tablet 20 mg. Give 1 tablet by mouth 1 time a day for depression order date 9/5/25 at 10:47 pmFamotidine oral tablet Give 1 tablet by mouth in the morning for acid reflux order date 9/5/25 at 10:47 pmOmeprazole 20 mg. give 1 tablet by mouth in the morning for acid reflux order date 9/5/25 at 10:47 pmAzithromycin oral tablet 500 mg Give 1 tablet one time a day for infection 28 days 9/5/25 Melatonin Oral table 3 mg Give 1 tablet by mouth at bedtime for insomnia order date 9/5/25 at 9:39 pmTrazodone HCL oral tablet 50 mg give one tablet by mouth at bedtime for depressionQuetiapine fumarate oral tablet 25 mg Give 1 tablet by mouth in the evening for mood order date 9/5/25 at 9:39 pm Upon entering the above-mentioned medication orders, the following alert from pharmacy came up in the system and is printed in the progress notes: 9/6/25 12:21 am - The order you have entered Escitalopram Oxalate 20 mg tablet give 1 tablet one-time for depression has triggered the following drug protocol alerts / warningsDrug to drug interactions:The system has identified a possible drug interaction with the following orders:Omeprazole oral tablet delayed release 20 mg Give 1 tablet by mouth in the morning for Acid RefluxSeverity: ModerateInteraction: Omeprazole may increase the serum concentration of Escatalopram. Additive serotonergic effects may occur during coadministration, and the risk of developing serotonin syndrome may be increased Quetiapine Fumarate oral tablet 25 mg. Give 1 tablet by mouth in the evening for moodSeverity: SEVEREInteraction: Additive QT interval prolongation [qt prolongation is an abnormally long interval between the q and t waves on an electrocardiogram, representing the time it takes the hearts ventricles to contract and relax) may occur during coadministration of escitalopram, a moderate risk QT prolonging agent and Quetiapine Fumarate oral tablet. Azithromycin oral tablet 500 mg Give 1 tablet one time a day for infection 28 daysSeverity: ModerateInteraction: Additive QT interval prolongation may occur during coadministration of escitalopram a moderate risk QT prolonging agent and Azithromycin.Trazadone HCL 50 mg give 1 tablet by mouth at bedtime for depressionSeverity: SEVEREInteraction: Additive serotonergic effects may occur during coadministration of selective serotonin uptake inhibitors (SSRI) and trazodone HCl and the risk of developing serotonin syndrome may be increased. The record revealed that there was no documentation for physician notification of the warnings.On 9/8/25 when the order for Quetiapine was corrected on 9/8/25 the above warnings appeared in the system again. On 9/8/25 the physician also ordered Tramadol 50 mg (a controlled substance; opioid pain medication), and the following warning appeared. The order you have entered tramadol HCL oral tablet 50 mg two times a day related to fractured left femur has triggered the following drug protocol warnings:The system has identified possible

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	495299	A. Building B. Wing	10/30/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and facility documentation the facility staff failed to ensure safe practice for infection prevention for one 5 staff memebers in the kitchen.For the facility, the facility staff failed to ensure that hair covering was worn by all staff entering the kitchen area.On 10/29/25 at approximately 12:15 PM LPN #1 was observed as she walked from hall past surveyor and went into the kitchen. There were no hairnets at this entrance. Surveyor was standing in doorway entrance awaiting staff to get hairnets. LPN #1 was observed going into the kitchen and walking out of the surveyors view to the other side of the kitchen. Surveyor spoke to dietary staff who alerted the dietary manager.LPN #1 walked to the other kitchen entrance where the hairnets are located exited to the hallway and then came to the surveyor and stated Oh! I had the hairnet in my hand and forgot to put it on.On 10/29/25 at approximately 12:25 p.m. an interview was conducted with the dietary Manager who stated anyone in the kitchen must have hair net.On 10/30/25 during the end of day meeting the Administrator was made aware of the concern and no further information was provided.