STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norview Heights Rehabilitation and Nursing	827 Norview Avenue Norfolk, VA 23509

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on resident interview, staff interviews, clinical record review, and review of facility documents, the facility staff failed to ensure a resident was free from staff coercion and harassment for 1 of 2 residents (Resident #1), in the survey sample. The findings included: Resident #1 was originally admitted to the facility 6/22/23 and had not been discharged from the facility. The resident's diagnoses included Major depressive disorder, recurrent, mild, generalized anxiety disorder, borderline personality disorder, PTSD and stroke with right hemiplegia. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/3/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were intact. The active care plan had a problem dated 8/2/23 which stated the resident has an ADL self-care performance deficit related to CVA. The goal stated the resident will improve his current level of function in activities of daily living (ADL) through the review date, 8/6/24. The interventions included the resident is totally dependent on staff to provide bath/shower as necessary. The resident requires contact guard assist by staff to turn and reposition in bed as necessary. The resident is totally dependent on staff for dressing. The resident requires extensive assist to maximize independence with personal hygiene and oral care. The resident is totally dependent on staff for toilet use and the resident requires contact guard assist by staff for transferring. On 7/15/24 at approximately 6:27 PM an interview was conducted with Resident #1 upon the resident's request. The resident was observed to be extremely restless, shifting his body greatly, speaking rapidly and forcefully as he described his experiences regarding harassment by the some of the facility's staff. The resident stated Licensed Practical Nurse (LPN) #1 belittled him (talked about his inability to provide specific services for himself as a negative deficit) in the corridor where other residents and visitors could hear her. The resident stated the administrative staff separated LPN #1 from employment within the facility. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 stated LPN #1 currently had a daughter (Certified Nursing Assistant (CNA) #2 who is employed in the facility and the daughter continuously does things to coerce him to react. Resident #1 stated CNA #2 is not assigned to provide care to him anyone because he made a [NAME] not to have her assigned to him and it was honored. Resident #1 stated CNA #2 made remarks about him such as he was having frequent incontinence episodes so staff would have to provide incontinence care for him because he enjoys it sexually, he had threatened her, he had a gun in the facility, and she filed a criminal complaint against him. Resident #1 also stated that on 6/11/24 the Administrator had his room deep cleaned, which included removing all his personal effects from the room for cleaning and then called the facility staff had the police to take him from the facility to the hospital for a mental evaluation. The resident stated the hospital transfer made it impossible for him to secure his personal effects so others could not take them. The resident also stated he was discharged back to the facility at approximately 10:00 PM with no identified findings concerning his mental health and no new medications. The resident stated after an inventory many of his personal items were identified as missing and the facility's staff failed to take responsibility for them. Resident #1 stated that the Administrator had consistently made attempts to discharge him from the facility first for non-payment and once his spouse obtained the Medicaid benefits, the Administrator issued another discharge to him dated 6/14/24 to a local hotel for which the facility was to pay for two days. The 6/14/24 discharge notice stated the reason for the discharge was to maintain safety for other residents in the facility. Resident #1 stated the Administrator did not expound on how he was endangering other individuals in the facility. An interview was conducted with CNA #1 on 7/16/24 at 1:16 PM. CNA #1 stated she had not observed Resident #1 with alcohol, marijuana, or a gun in the facility but, she had overheard other staff talking about the resident having a gun in his room. An interview was conducted with CNA #2 on 7/16/24 at 1:29 PM. CNA #2 began crying when asked if she felt safe while working in the facility. CNA #2 stated she did not feel safe because Resident #1 harasses her every day by makes dog sounds when he sees her, talks about gang members, puts his middle finger up when he sees her coming in to work, and talks about suiting her. CNA #2 stated she obtained a restraining order against the resident because she fears he may stand and grab her and break her neck or his spouse may have a gun in the large bags she brings into the facility. CNA #2 concluded with she felt Resident #1 had a personal vendetta against her. A review of CNA #2's educational records revealed that she had not been educated on dealing with residents with disruptive or challenging behaviors. An interview was conducted with the Staff Development Coordinator who stated CNA #2 had not received the in-service on working with residents with disruptive or challenging behaviors because it had not been offered since she was hired but it is due to be offered soon. An interview was conducted with CNA #3 on 7/16/24 at 1:44 PM. CNA #3 stated Resident #1 became angry because an LPN talked about his disability in the presence of others. CNA #3 stated she had recognized a change in the resident's behavior since the incident, approximately June 2024. CNA #3 stated going outside to smoke calms the resident down. CNA #3 stated if there was a gun in the resident's room they would have seen it by now as often as the staff goes in and out of his personal belongings. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Licensed Practical Nurse (LPN) #2 on 7/16/24 at approximately 2:16 PM. LPN #2 stated Resident #1 stated he was going to purchase a gun and send it to his wife and some staff felt it was possible she would bring it to the resident. LPN #2 stated that LPN #1 and Resident #1 were cordial at first for she had been his nurse for a while, and she believes the resident felt disrespected by LPN #1 and ever since the event occurred Resident #1 had displayed an increase in negative behaviors. LPN #2 stated she had not observed a gun in the resident's room. On 7/17/24 a final interview was conducted with the Administrator, Director of Nursing (DON), Staff Development Coordinator, Unit Manager, and Regional Director of Nursing. The Administrator stated she asked CNA #2 on 7/16/24 not to obtain another restraining order against Resident #1 and she felt going forward they would be capable of developing strategies for working with the resident to achieve his goals.