STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495324	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seaside Hhc @ Atlantic Shore	1200 Atlantic Shores Drive Virginia Beach, VA 23454

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, resident interview and staff interview, the facility staff failed to ensure previous survey results were posted in a place readily available to residents, families and visitors.The findings included:On 11/25/2025 at 1:00 p.m., a group interview was conducted with four alert and oriented residents. All four stated that they were not aware that they could see the results of the previous survey. They stated they did not know where the results were located. A large bulletin board was located in the entry hallway across from the receptionist's desk in the nursing center. There was a notice on the bottom of the bulletin board which stated Survey Results Located: _____(Assisted Living and Nursing Home names redacted) Reception Desk and _____ (Nursing Home Name redacted) Nurses Station. Please inquire to see a copy of the results. Thank you.There was a silver 3 part letter organizer noted in front of a black binder. There were papers listed as Resident Comment Cards standing in the letter organizer and were obscuring the words on the front of the black binder.After the Group interview/Resident Council meeting conducted on 11/25/2025, the Administrator was asked about the availability of the previous survey. She stated the survey results were available at the receptionist's desk in a blue binder. The Administrator was informed of the statements from the residents during the group interview. The Administrator went into the hallway and pointed to the sign on the bulletin board. The Administrator was informed that the survey results are supposed to be available to the residents, family and visitors. They should not have to inquire to see a copy as instructed per the sign. The Administrator stated that the Social Worker informed residents of the location of the survey results during their admissions. On 11/25/2025 at approximately 3:50 p.m., an interview was conducted with the Social Worker who stated the survey results were located on the receptionist's desk in a blue binder. The Social Worker stated residents should know the location because she did tell them upon their admissions. The Social 'Worker stated she was going to change the wording on the sign to make sure residents knew they did not have to ask to see the results. She also stated she would discuss the location of the survey results in the next Resident Council meeting. During the end of day debriefing on 11/25/2025, the findings were discussed with the Administrator and Director of Nursing. They stated residents should know where the survey results were located and not have to ask to see them. No further information was provided.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and a clinical record review, the facility staff failed to review and revise the person-centered care plan for 1 of 21 residents (Resident #3) in the survey sample. The findings included: Resident #3 was initially admitted to the facility on [DATE] and readmitted on [DATE] after an acute care hospital stay. The resident's diagnoses included pneumonia, heart failure, and dementia. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 11/3/25, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated that Resident #3's cognitive abilities for daily decision-making were severely impaired. A review of Resident #3's person-centered care plan revealed a problem dated 10/27/25, which stated the resident had congestive heart failure. The goal stated that the resident would be free of peripheral edema through the review date, 2/3/26. The interventions included: monitor/document and report as need any signs/symptoms of congestive heart failure: dependent edema of legs and feet, periorbital edema, shortness of breath upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate, lethargy and disorientation and daily weight- notify MD for weight gain of 3 pounds (lbs), or more in 24 hours or weight gain of 5 lbs, or more in one week.A review of the resident's Physician's Order Summary (POS) revealed an order dated 11/21/25 for a weight upon admission and weekly times four, every 7 days.An interview was conducted with the Director of Nursing (DON) on 11/25/25 at approximately 5:07 PM. The DON stated that the order dated 11/21/25 and the care plan dated 10/27/25 were different, and she would speak with the Provider to clarify which is most appropriate for the resident.On 11/25/25 at approximately 5:15 PM, a final interview was conducted with the Administrator and the DON. The above concern was addressed, and an opportunity was given for the facility's staff to address and supply information they believed was pertinent to the findings. They offered no comments and voiced no concerns.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and a clinical record review, the facility staff failed to implement customary routines, interests, preferences, and choices for 1 of 21 residents (Resident #3) who exhibited episodes of inappropriate behaviors during activities of daily living (ADL) in the survey sample. The findings included: Resident #3 was initially admitted to the facility on [DATE] and readmitted on [DATE] after an acute care hospital stay. The resident's diagnoses included dementia. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 11/3/25, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated that Resident #3's cognitive abilities for daily decision-making were severely impaired.In section F0400. Interview for Daily Preferences: the resident was coded as stating that it was very important to choose his own bedtime, to have his family or a close friend involved in discussions about his care, to have a place to lock his things to keep them safe, and to choose what clothes to wear.In section GG0130. Self-Care: the resident was coded as requiring partial/moderate assistance with eating, oral hygiene, upper body dressing, and personal hygiene, and substantial/maximal assistance with toileting hygiene, shower/bathe, lower body dressing, and putting on/taking off footwear.A review of Resident #3's person-centered care plan revealed a problem dated 10/27/25, which stated the resident had impaired cognitive function and/or impaired thought processes related to dementia. The goal stated that the resident would be able to communicate basic needs on a daily basis through the review date, 2/3/26. The interventions included keeping the resident's routine consistent and trying to provide consistent caregivers as much as possible in order to decrease confusion.Resident #3 was observed seated outside the facility, accompanied by his spouse, on 11/25/25 at approximately 1:10 PM. The resident was observed attempting to get up and frown. The spouse brought the resident back inside the facility and stated it was too windy outside.A review of the nurse's notes dated 11/23/25 at 1:23 PM stated that during ADL care, the resident touched the staff's breast and punched her in the stomach. The nurse's note stated that redirection was ineffective. Another nurse's note dated 11/24/25 at 9:27 AM said that the resident was combative and sexually inappropriate to staff and the spouse during ADL care. The nurse's note also stated that redirection was ineffective. Another nurse's note dated 11/24/25 at 10:41 AM stated that an order was given for Seroquel Oral Tablet 25 MG. Give 0.5 tablet by mouth every 12 hours as needed for severe agitation, unable to be redirected for safety. An interview was conducted with the Director of Nursing (DON) on 11/25/25 at approximately 5:07 PM. The DON stated that the resident had exhibited behaviors during care twice on 10/28/25, and there were two additional episodes of inappropriate behaviors during ADL on 11/23/25 and 11/24/25. The DON also stated that redirection was the only documented intervention, and it had not been effective. The DON further stated that Resident #3 allowed her to provide his ADL care that afternoon without an incident, and they would explore additional options to encourage the resident's tolerance with care. She stated that the spouse shared that the resident was not a morning person; therefore, allowing him to sleep later would be implemented as they explore and implement other interventions. The DON also stated that the Psych Physician comes in on Fridays, and the resident would be assessed for the use of the prescribed antipsychotic medication. On 11/25/25 at approximately 5:15 PM, a final interview was conducted with the Administrator and the DON. The above concern was addressed, and an opportunity was given for the facility's staff to address and supply information they believed was pertinent to the findings. They offered no comments and voiced no concerns.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation and facility document review, the facility staff failed to ensure drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles, to include the expiration date.Findings include:The facility staff failed to ensure medications and COVID-19 test kits were within expiration date for eleven (11) COVID-19 kits in the medication room and three (3) bottles of Lorazepam liquid (an anti-anxiety medication used to treat symptoms of anxiety) with open date on the box or bottle in the medication refrigerator.On 11/24/25, an Inspection of the Medication Room was completed which revealed ten (10) COVID-19 test kits ([NAME] brand) with expiration date 4/2025 and one (1) kit (iHealth brand) with expiration date 4/25/25 in the cabinets.On 11/24/25, an inspection of the Medication Room refrigerator was completed which revealed three (3) bottles of Lorazepam liquid: 1 bottle dispensed 7/2/25 - open, not dated upon opening 1 bottle dispensed 5/23/25 - open, not dated upon opening 1 bottle dispensed 6/11/25 - open, not dated upon openingPer instructions on the box, the medication is to be discarded 90 days upon openingAt 12:20 PM, an interview was conducted with LPN-2 on how a nurse would know when to discard the bottle as the instructions on the box read discard 90 days after opening and she replied, the nurse should date the bottle once opening.At 12:30 PM, an interview with LPN-1 was conducted on how a nurse would know when to discard the bottle as the instructions on the box read discard 90 days after opening and she responded, the nurse is to date the bottle when she opens it.At approximately 1:15 PM, an interview was conducted with the Director of Nursing (ADM-2) on her expectations of following manufacturer's guidelines for expiration of multi-dose vials and she stated, the nurse is to date the bottle upon opening She provided a copy of the facility's policy Medication Labeling and Storage. Page 2: Medication Labeling, 5. Multi dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.The Administrator (ADM-1) provided a copy of the facility's policy #ASCA-HC-000 entitled COVID -19 testing. Page 2 Antigen Tests bullet point #3 Discard tests and tests components that have exceeded the expiration date or show signs of damage or discoloration.On 11/24/25, at the end of day, the Administrator (ADM-1) and Director of Nursing (ADM-2) were made aware of the concerns, and no further information was provided.

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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 observations, staff interviews, record reviews, and facility document reviews, the facility staff failed to maintain an effective infection control program that included a comprehensive surveillance system and effective infection control practices to prevent communicable diseases or infections in the one (1) nursing unit.Findings included: 1. The facility lab tech failed to remove personal protective equipment appropriately upon exiting the resident room, and facility staff failed to follow the facility's policy for the surveillance and monitoring of infection control practices and monitoring of infectious disease trends. On 11/24/25, a female was observed exiting a resident's room wearing a white disposable gown. She was observed walking to the nurse's station, looking at documents on the nurse's desk, and then walking back down the hall while wearing the white disposable gown. An interview was conducted with the Director of Nursing, who was coming down the hall, regarding her expectations for staff when donning/doffing personal protective equipment (PPE). She responded, That was the lab tech; everyone is to remove their gowns and gloves before leaving the room, and never wear personal protective equipment in the hallway. I saw that and spoke to her about removing the gown before leaving the room. On 11/24/25 at approximately 2:10 PM, an interview was conducted with the Lab Tech regarding donning/doffing (putting on and taking off) personal protective equipment. She replied, Yes, you put on the gown and gloves when you enter and take them off before you leave. On 11/24/25 at approximately 2:20 PM, an interview was conducted with LPN-1. The LPN was asked when she dons and doffs personal protective equipment (put on and take off), and she replied, We put on the gown and gloves when we go into a room with isolation and remove them before we leave that room. On 11/24/25 at 3:00 PM, an interview was conducted with C.N.A-2 on when to don and doff personal protective equipment (put on and take off), and according to the C.N.A., Staff are to put on the gown and glove when going into the room before touching the resident and then to remove them before leaving the room. The Administrator provided a copy of the facility's donning and doffing policy for personal protective equipment. Review of the facility's policy Sequence for Donning and Removing Personal Protective Equipment (PPE) revealed: Sequence for Removing Personal Protective Equipment (PPE) states except for respirator, remove PPE at doorway or in anteroom. Remove respirator after leaving patient room and closing the door. 2. On 11/24/25 an interview with the Infection Preventionist (ADM-3) was conducted on the facility's Infection Control Tracking log and according to her the surveillance/tracking was in their electronic medical record system. A request for a copy of the past 3 months of surveillance/tracking logs was made and per the Infection Preventionist (ADM-3) she stated that they were not complete. The Administrator provided a copy of the facility's Infection Prevention and Control Program policy. A review of the policy revealed: Page 1, #4 - The elements of the infection prevention and control program consist of coordination/oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. Page 2, #7 - Surveillance a. Process surveillance (adherence to infection prevention and control practices) and outcome surveillance (incidence and prevalence of healthcare acquired infections) are used as measures of the Infection Prevention and Control Program (IPCP) effectiveness. Page 2, #7 - Surveillance b. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring adherence, to infection prevention and control practices, and detecting unusual pathogens with infection control implications. Page 2, #9 - Data Analysis a Data gathered during surveillance is used to oversee infections and spot trends. Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes #4 All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: resident name and medical record number, unit and room number, date symptoms appeared, name of antibiotic, start and stop date of antibiotic, pathogen identified, site of infection, date of culture, total days of therapy, outcome and any adverse (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	events. On 11/24/25 at approximately 3:30 PM, the Director of Nursing was made aware of the concerns that the infection control surveillance/tracking logs were not complete per facility policy, and no further information was provided.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on staff interviews, record review, and facility document review, the facility staff failed to establish an effective infection prevention and control program (IPCP) that included an antibiotic stewardship program with antibiotic use protocols and a system to monitor antibiotic use for facility residents.Findings include: The facility staff failed to consistently monitor the assessment of antibiotic use.On 11/24/25 at approximately 1:45 PM, an interview was conducted with RN-2 on the facility's antibiotic stewardship program, and she replied, I am not sure as I don't know what that is, (name of the Infection Control Nurse) handles all of that.On 11/24/25 at approximately 2:10 PM, an interview was conducted with LPN-1 on did the facility have an antibiotic stewardship program and she replied Well, I don't know. I don't know what that is?On 11/24/25 at approximately 2:20 PM, an interview was conducted with the Infection Preventionist (ADM-3) on the facility's Infection Prevention and Control Program (IPCP). According to her the facility had identified gaps in the facility's IPCP policies on surveillance and tracking and Antibiotic Stewardship for the required assessment of antibiotic use since the previous Infection Preventionist left a few weeks ago and that they had written a Performance Improvement Plan (PIP).A review of the Performance Improvement Plan (PIP) revealed Area of Concern:-Antibiotic Stewardship practices are not consistently followed, including completion of required Infection Screening Evaluation and Antibiotic Time-Out at 48-72 hours after initiation.- Documentation and reassessment of ongoing antibiotic need, indication, and duration are incomplete or missing.Action Plan included:-Goal of Ensure all antibiotic time-outs and infection control screenings are completed-Action steps Review all antibiotic orders daily; complete Infection Control Screening Evaluation and time-out documentation within 24-48 hours -Evidence of completion Audit logs and MAR review The review of the Performance Improvement Plan (PIP) failed to provide evidence that the facility had corrected the Area of Concern as there was no evidence to support this was done for week 1 dated 11/4/25, week 2 dated 11/11/25 and week 3 dated 11/18/25 and the PIP was initialed by the Director of Nursing and Infection Preventionist.At approximately 3:00 PM, an interview was conducted with the Director of Nursing on the facility's Performance Improvement Plan (PIP) for Infection Monitoring Survey Readiness and she replied that she was surprised that the facility had not been consistently assessing antibiotic therapy and that they had developed the PIP. When asked where the Infection Screening Evaluations and Antibiotic Time-Outs were for current residents with orders for antibiotics she was not able to provide evidence that they had been completed.The Administrator provided a copy of the facility's policy entitled Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes. A review of the policy revealed:1. As part of the facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist (IP), or designee.2. The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics (including susceptibility, duration of therapy and culture results and clinical findings do not indicate continued need for the antibiotic)3. At the conclusion of the review, the provider will be notified of the review findings.4. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include the resident's name and medical record number, unit and room number, date symptoms appeared, name of antibiotic, start and stop date of antibiotic, pathogen identified, site of infection, date of culture, total days of therapy, outcome, and any adverse events.On 11/24/25 at approximately 3:30 PM, concerns were shared with the Director of Nursing, and no further information was provided.