

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2025
NAME OF PROVIDER OR SUPPLIER Deep Creek Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1017 George Washington Highway North Chesapeake, VA 23323	
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 - Many	Provide and implement an infection prevention and control program. Based on interview and facility policy review, the facility failed to ensure an effective water management program was developed and implemented to prevent the growth of opportunistic waterborne pathogens, including Legionella, which had the potential to affect all residents residing in the facility. According to the Midnight Census report, dated 09/15/2025, the facility census was 89. Findings included: A facility policy titled, Legionella Water Management Program, revised 07/2017, revealed Our facility is committed to the prevention, detection, and control of water-borne contaminants, including Legionella. The policy also revealed a section titled, Policy Interpretation and Implementation that specified, 1. As part of the infection prevention and control program, our facility has a water management program which is overseen by the water management team. 3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. 5. The water management program includes the following elements: a. An interdisciplinary water management team; b. A detailed description and diagram of the water system in the facility, including the following: 1) receiving; 2) cold water distribution; 3) heating; 4) hot water distribution; and 5) waste; c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including: 1) Storage tanks; 2) Water heaters; 3) Filters; 4) Aerators; 5) Showerheads and hoses; 6) Misters, atomizers, air washers, and humidifiers; 7) Hot tubs; 8) Fountains; and 9) Medical devices such as CPAP machines, hydrotherapy equipment, etc. d. The identification of situations that can lead to Legionella growth, such as 1) Construction; 2) Water main breaks; 3) Changes in municipal water quality; 4) The presence of biofilm scale or sediment; 5) Water temperature fluctuations; 6) Water pressure changes; 7) Water stagnation and 8) Inadequate disinfection. G. A diagram of where control measures are applied, and j. Documentation of the program. During an interview on 09/19/2025 at 2:52 PM, the Maintenance Director stated the facility had a water management plan prior to his employment as the Maintenance Director approximately two years prior and no current testing was being performed to monitor areas for potential sources of Legionella. The Maintenance Director stated he performed checks of the water temperatures and monitored the ice machine, but he did not document that. The Maintenance Director also acknowledged he did not have a diagram or list of any areas that could be potentially at risk of being a source of waterborne bacteria and stated, This is an old building, and I don't have a clue about the plumbing. During an interview on 09/19/2025 at 4:53 PM, the Director of Nursing (DON) stated she felt that the water management plan was overseen by administration. She stated she expected the facility to develop and implement a water management plan as part of the infection control program. During an interview on 09/19/2025 at 1:57 PM, Administrator (ADM) #1 stated they no longer had a water management program after the previous administrator shut that down when the facility turned off the water fountain in the front of the building. During an interview on 09/19/2025 at 4:36 PM, the previous interim Administrator (ADM) #2 stated the facility should have an implemented water management program. He stated the facility previously had one in place until they removed all the fountains that should have extended through the entire inside and outside of the facility and included anywhere water could become stagnant in order to prevent the spread of waterborne bacteria.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility policy review, the facility failed to maintain an effective pest control program. Specifically, observations were made of pest activity on 2 of 2 units and in the conference room, kitchen, and communal bathroom. Findings included: A facility policy titled, "Pest Control," revised 05/2008, revealed a section titled, "Policy Interpretation and Implementation" that specified, "This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents." The policy also indicated, "6. Maintenance services assist, when appropriate and necessary, in providing pest control services." A Commercial Pest Control Service Agreement, dated 10/10/2023 and signed by a facility representative on 11/07/2023, indicated, "This agreement is for an initial period of twelve months from the date of the first service and unless canceled by the purchaser, will automatically continue on a monthly basis until canceled by either party upon thirty day notice." The document indicated the service frequency was monthly and included that the interior and exterior of the building would be serviced every three months, in January, April, July, and October. Additional interior services would be provided monthly. The document's "Terms and Conditions" indicated the services were conditioned upon payment in full of the initial charge and all regular service charges and that failure to pay such charges would result in cancellation of the plan. A document titled, "Greenbrier Regional Medical Center (GRMC) Maintenance Log" revealed observations of pest activity occurred as follows: - 12/13/2023: Southeast Unit room [ROOM NUMBER] - roaches observed in the bathroom. - 03/2024-04/2024: Southeast Unit room [ROOM NUMBER]W and room [ROOM NUMBER]W - ants observed. - 04/2024: Southeast Unit Rooms 105, 203, 209, and 213 - ants observed. - 06/2024: Southeast Unit room [ROOM NUMBER] - ants observed. - 07/2024: Southeast Unit room [ROOM NUMBER] - two separate entries indicated ants were observed and were observed all over the room. - 02/2025: Southeast Unit room [ROOM NUMBER] - ants observed. - 04/2025: Southeast Unit room [ROOM NUMBER] and room [ROOM NUMBER] - ants observed. - 06/2025: Southeast Unit room [ROOM NUMBER] and room [ROOM NUMBER] - ants observed. - 07/2025: Southeast Unit room [ROOM NUMBER] and room [ROOM NUMBER] - ants observed. Invoices dated from 11/2023 through 08/2025 indicated the facility received and was billed for pest control services for all months except January 2024, June 2024, September 2024, November 2024, and March 2025 through September 2025. (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Observations on 09/16/2025 beginning at 9:08 AM revealed one wall-mounted fly trap with an illuminated bulb in the administrative hall near the front lobby. A second wall-mounted fly trap with an illuminated bulb was noted in the hall near the courtyard. A third wall-mounted fly trap with a bulb that was not illuminated was in the hall across from the courtyard. Each door to the courtyard was observed to have an industrial air blower mounted above the doors. During a Resident Council meeting on 09/16/2025 from 11:15 AM to 11:45 AM, six (Residents #20, #26, 55, #61, #77, and #84) of six residents who attended the meeting reported ongoing pest activity in their rooms, described as ants, flies, gnats, and spiders. During the survey, pests were observed as follows: - 09/16/2025 at 11:15 AM: a spider was observed in the public bathroom. - 09/16/2025 at 11:25 AM: flies were observed in the dining room during a Resident Council meeting. - 09/16/2025 at 2:56 PM: flies were observed in the conference room. - 09/16/2025 at 4:30 PM: gnats were observed at the 200/300/400 hall nurses' stations. - 09/17/2025 at 1:51 PM: flies were observed at the 300/400 hall nurses' stations. - 09/18/2025 at 11:05 AM: flies were observed at the 200, 300, and 400 hall nurse's station. During an interview on 09/16/2025 at 2:51 PM, Administrator (ADM) #1 stated that the facility did not have a current pest control contract because the vendor required the facility to provide a credit card to keep on file due to a history of late payments on the account. The facility did not agree to provide a credit card, so the pest control company's services ceased after February 2025. During a phone interview on 09/16/2025 at 4:28 PM, the Executive Administrative Assistant (EAA) for the facility's prior pest control service revealed that the facility signed an initial pest control contract on 10/10/2023, and the first monthly pest service was provided on 11/10/2023. The EAA stated the facility's contract was terminated after services were provided on 02/28/2025 because of non-payment. The EAA stated the facility was notified via email of the status, and the account was then paid in full. The EAA stated that she contacted the facility to renew the contract and resume the pest control services but did not receive a return call from the facility. During an interview on 09/17/2025 at 3:33 PM, the Maintenance Director stated he was the facility contact for the pest control provider and was responsible for addressing any pest activity reported between monthly pest services. He stated that if pest activity was reported between monthly pest services, he sprayed the facility to kill the pests with products he purchased independently through a vendor available to the public. The Maintenance Director stated he was aware there was a lapse in pest services, but he was not sure why the lapse occurred. He stated the facility was in transition with different administrators, and he thought the reason for the lapse in pest services may have been a lack of payment. He further stated that the last pest control service was provided s in February 2025 and he was aware pest control services were not provided by the vendor for the last few months. The Maintenance Director stated he was aware of two resident rooms in the facility where recurrent pest activity was identified and had been difficult to manage. The Maintenance Director also stated that he had a replacement bulb for the wall mounted fly light traps, but he had not yet been (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	able to replace the bulb. During a follow-up interview on 09/17/2025 at 3:56 PM, ADM #1 stated that if residents observed pest activity in the facility, he expected them to notify staff, so the pest activity was addressed by the Maintenance Director with appropriate pest control products. He stated that if that did not resolve the pest problem, then a pest service provider would be contacted. The ADM stated if staff witnessed pest activity, he expected staff to report to their supervisor and have it discussed in morning meeting and resolved that day by the Maintenance Director. ADM #1 stated that he expected the Maintenance Director to resolve the pest issue and to contact the pest control vendor if he could not resolve the pest issue. The Administrator said he expected pest control services to be provided to maintain an effective pest control program. During an interview on 09/17/202 at 2:53 PM, the Director of Nursing (DON) stated she expected staff to record in the maintenance logbooks at each nursing station any pest activity observed or to report pest activity directly to the Maintenance Director. The DON stated that she expected the Maintenance Director to review the maintenance logbooks daily, address any concerns, and report on the follow-up during the morning meetings. The DON stated that if the Maintenance Director could not resolve the pest activity, then he should coordinate with management and contact the pest control vendor for the pest activity to be addressed. The DON stated that she was aware of the facility's current pest activity, described as "gnats," from discussions during the facility's morning meetings. The DON said she expected the facility to provide and maintain a pest control program that minimized pest activity. During an interview on 09/17/2025 at 3:16 PM, the former Interim Administrator (ADM #2) stated that he was the Administrator for the facility from July 2025 until Friday, 09/12/2025, and that he was aware of residents who had voiced concerns in August 2025 regarding flies in the facility. He stated the flies were coming from the door to the smoking patio. He stated that residents propped the smoking patio door open, which allowed pests to enter the facility. He stated staff were educated to monitor the door to the smoking patio to ensure the doors were closed and not held open for extended periods of time. He stated he was not aware that the pest control contract was terminated. He stated the facility received an email from the pest control provider for the account to be paid in full, and payment was made. He said after he observed pest activity in the facility in the last month, he spoke to the Maintenance Director about pest services and was told that pest services from the vendor were on hold due to lack of payment. ADM #2 stated he contacted the corporate payable clerk and verified that the facility's bill was paid, so he expected the pest control vendor to resume services, but he did not contact the pest control vendor to verify the status of current services for the facility. 2. During a tour of the kitchen on 09/17/2025 at 11:15 AM, a fly was observed flying around in the kitchen. During an interview on 09/17/2025 at 11:15 AM, the Certified Dietary Manager (CDM) stated that there were flies in the kitchen periodically. The CDM stated the occasional observations of pests in the kitchen were no comparison to the seriousness of pests observed in the rest of the building. He stated that to minimize the flies in the kitchen, staff were to ensure the double entry doors that led to the exterior of the building near the back parking area were kept closed and staff used rolled up parchment paper to swat the flies.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to follow up on pharmacy recommendations for 2 (Residents #66 and Resident #98) of 5 residents reviewed for unnecessary medications. Findings included: A facility policy titled Medication Regimen Reviews, revised 05/2019 revealed a section titled Interpretation and Implementation that specified, 1. The Consultant Pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication. 8. Within 24 hours of the MRR, the Consultant Pharmacist provides a written report to the Attending Physician for each resident identified as having a non-life-threatening medication irregularity. The report contains: the residents' name, the name of the medication, the identified irregularity; and the pharmacist's recommendation. 11. If the Physician does not provide a timely or adequate response, or the Consultant Pharmacist identifies that no action has been taken, and he/she contacts the Medical Director (if the Medical Director is the physician of record) or the Administrator. 1. An admission Record revealed the facility admitted Resident #66 on 12/08/2022. According to the admission Record, Resident #66 had a medical history that included diagnoses of bipolar disorder and major depressive disorder. A quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 08/05/2025, revealed Resident #66 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderately impaired cognition. Review of a Consultant Pharmacist Medication Regimen Review (MRR) Active Recommendations Lacking a Final Response document, for outcomes entered between 05/01/2025 and 05/31/2025, dated 06/02/2025 indicated, Resident #66 was receiving midodrine for orthostatic hypotension (low blood pressure when standing) every 8 hours. The document indicated, It is recommended for the first dose to be given 30-60 minutes before arising and then at 3 to 4 hourly intervals throughout the day. The document also indicated holding the dose if the resident would be lying down for any length of time was advised. Further, The last dose should NOT be taken within 4 hours before going to bed due to the potential to cause supine HYPERTension [high blood pressure]. Please consider rescheduling midodrine administration to be given at 5am, 1pm, and 5pm to minimize risk for adverse effects. No response was listed under the recommendation status. A Nursing Recommendations/Nurse Manager Report, for recommendations created between 07/01/2025 to 07/28/2025, dated 07/28/2025, indicated the following for Resident #66: - The resident was receiving levothyroxine (a thyroid medication) for hyperlipidemia (high cholesterol), as noted in the MAR (medication administration record) of the medical record. The report indicated that the facility records (physician orders sheet, MAR and/or ICD 10 code [International Classification of Diseases, 10th Revision, a globally used diagnostic coding system]) should be updated to reflect the rationale for the current use of this medication. The document revealed the Follow-Through section was blank. - Please remove pain level monitoring for aspirin order. This order is not being used for pain and therefore does not required [sic] a pain level to be recorded. Removing the requirement from the order will save on nursing time during the med-pass [medication pass]. The document revealed the Follow-Through section was blank. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident was receiving a routine order for midodrine for hypotension with no hold order documented. Please consider adding hold parameters to this order to evaluate if the dose is necessary. The document revealed the Follow-Through section was blank. A Note to Attending Physician/Prescriber dated 08/21/2025 revealed, Resident #66 was receiving the antipsychotic medication quetiapine 150 milligrams (mg) at night (HS) for bipolar disorder. The note indicated that an antipsychotic medication should be used only for an appropriate diagnosis as determined by Center for Medicare and Medicaid Services (CMS) regulations. Further, the document indicated Please use options below to assess: Medication is being used for (select one below): Schizophrenia, Schizoaffective disorder, Huntington's, and Tourette's. The document revealed no diagnoses had been selected by the provider. Resident #66's Order Summary Report, including all active orders dated 09/17/2025, revealed the following physician orders: - Midodrine HCl (hydrochloride) oral tablet 5mg started on 06/15/2025. Instructions directed staff to give one tablet by mouth every 8 hours related to other hypotension. No other instructions were listed. - Levothyroxine sodium oral tablet 150 mcg (micrograms) started on 02/23/2025. Instructions directed staff to give one tablet by mouth one time a day related to hyperlipidemia. - Quetiapine fumarate oral tablet 150mg started on 05/14/2025. Instructions directed staff to give one tablet by mouth at bedtime for bipolar disorder. Resident #66's Medication Administration Record (MAR) dated 09/2025 and current as of 09/17/2025 revealed an order for midodrine that was timed for administration at 0600 (6:00 AM), 1400 (2:00 PM) and 2200 (10:00 PM). No hold instructions were listed. During an interview on 09/17/2025 at 2:58 PM, the Director of Nursing (DON) stated that when she received pharmacy recommendations, she was required to delegate them on to the appropriate person for follow-up. She stated if the recommendation required a provider response, she would forward the recommendation to the physician (MD) or physician's assistant (PA) for review. The DON stated if the recommendation required a response from the nursing department, she was to forward the document to the unit manager to address. The DON reviewed the recommendations for Resident #66 and confirmed the recommendations had not yet been addressed. The DON stated although she was unaware there was a concern with pharmacy recommendation responses, she expected pharmacy recommendations to be addressed timely. During a telephone interview on 09/17/2025 at 5:01 PM, the Pharmacy Consultant (PC) stated she was assigned to the facility in July 2025. The PC stated she was aware of changes in the leadership at the facility and that the facility had fallen behind in addressing her recommendations. The PC stated if a recommendation was urgent, she would address it immediately with the facility's DON and/or the Administrator. During an interview on 09/19/2025 at 4:41 PM, the former interim Administrator (ADM) #2 stated he expected MRR recommendations to be addressed in a timely manner. 2. An admission Record revealed that Resident #98 was admitted to the facility on [DATE], with a recent readmission date of 08/26/2025. According to the admission Record, the resident had a (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medical history with diagnoses that included a pressure ulcer of the sacral region, stage 4; paraplegia; central cord syndrome at unspecified level of cervical spinal cord; other specified depressive episodes; contractures of muscle, left lower leg; contracture of muscle, multiple sites; stiffness of the right shoulder; and stiffness of the left shoulder. A quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date of 08/06/2025, revealed Resident #98 had a Brief Interview for Mental Status (BIMS) of 15, which indicated the resident had intact cognition. The MDS assessment also revealed the resident had physical impairments of both the upper and lower extremities bilaterally, received scheduled and as-needed pain medications, and had experienced occasional pain in the previous five days described as moderate. A Care Plan Report, initiated on 04/11/2025 and revised on 04/18/2025, revealed a focus area that indicated Resident #98 had an activity daily living (ADL) self-care performance deficit related to activity intolerance, limited mobility, musculoskeletal impairment, quadriplegia, and pain in the left leg contracture and sacral area. Interventions directed staff the resident had contractures of their left lower leg that required staff to provide skin care to keep clean and to prevent skin breakdown. The Care Plan Report revised 04/18/2025, that included a focus area that indicated the resident was on pain medication therapy related to disease process for wounds, depression, and contractures. Interventions, initiated on 08/19/2025, directed staff to administer analgesic medications as ordered by the physician and monitor/document side effects and effectiveness every shift. Resident #98's Order Summary Report, dated 09/18/2025, that included active orders on 07/31/2025, contained an order started on 06/27/2025 for Voltaren External Gel 1% (Diclofenac Sodium), that included instructions to apply to bilateral shoulders/neck topically two times a day for pain &ndash; moderate arthritis. A Nursing Recommendations/Nurse Manager Report, for recommendations created between 07/01/2025 and 07/28/2025 and dated 07/28/2025, revealed that on 07/24/2025, the pharmacist completed a medication regimen review (MRR) for Resident #98. The document indicated that the order for Voltaren External Gel was missing the dose to be measured by the dosing card. The pharmacist gave examples such as lower extremity e.g. (exempli gratia, for example) knee: Topical Gel 1% (OTC or Rx): Apply 4 g [grams] to each affected area up to 4 times daily; maximum dose per joint. 16g/day, maximum total body dose (all combined joints), 32 g/day. Please provide DOSE. Resident #98's Order Summary Report, dated 09/18/2025, that included active orders on 08/31/2025, contained an order dated 08/26/2025 for Voltaren External Gel 1%, that included instructions to apply to bilateral shoulders/neck topically two times a day for pain &ndash; moderate arthritis. During an interview on 09/17/2025 at 2:58 PM, the Director of Nursing (DON) stated that when she received pharmacy recommendations, she was required to delegate them on to the appropriate person for follow-up. She stated if the recommendation required a provider response, she would forward the recommendation to the physician (MD) or physician's assistant (PA) for review. The DON stated if the recommendation required a response from the nursing department, she was to forward the document to the unit manager to address. The DON reviewed the recommendations for Resident #66 and confirmed the recommendations had not yet been addressed. The DON stated although she was unaware there was a concern with pharmacy recommendation responses, she expected pharmacy recommendations to be addressed timely. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 09/17/2025 at 5:01 PM, the Pharmacy Consultant (PC) stated she was assigned to the facility in July 2025. The PC stated she was aware of changes in the leadership at the facility and that the facility had fallen behind in addressing her recommendations. The PC stated if a recommendation was urgent, she would address it immediately with the facility's DON and/or the Administrator. During a follow-up interview on 09/19/2025 at 3:40 PM, the DON stated she expected the pharmacy recommendations to be followed. She stated she was not provided with the older pharmacist's recommendations when she started four days prior and received only the previous month's recommendations. The DON indicated she would need to review Resident #98's record to determine what area needed to be treated with the medication and modify the order to reflect where to apply the medication and include instructions to follow the dosing on the box or the physician's order. During an interview on 09/19/2025 at 4:36 PM, the previous interim Administrator (ADM) #2 stated he expected the pharmacy recommendations to be reviewed with the provider and ensure they were addressed.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility document review, and facility policy review, the facility failed to provide residents with advanced beneficiary notices, with enough information to make informed decisions, for 2 (Resident #45 and Resident #46) of 3 residents sampled for beneficiary notices. Findings included: An undated facility policy titled Skilled Nursing Facility (SNF) Notices of Non-Coverage specified delivery requirements included, Correct form must be given and properly completed. 1. An admission Record indicated the facility admitted Resident #45 on 01/11/2025. According to the admission Record, the resident had a medical history that included diagnoses of sequelae of cerebral infraction (stroke) and chronic respiratory failure with hypoxia (failure of the lungs to adequately exchange oxygen from the air to the bloodstream). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/20/2025, revealed Resident #45 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS assessment also revealed Resident #45's end date of the most recent Medicare stay was on 03/20/2025. Resident #45's Care Plan Report included a focus area initiated 07/24/2025 that indicated the resident had impaired cognition or impaired thought process due to dementia. Interventions directed staff to communicate with the resident/family/caregivers regarding the resident's capabilities and needs. The Care Plan Report also included a focus area initiated on 01/19/2025 that indicated the resident had a communication problem related to aphasia, difficulty understanding others, and difficulty making decisions, making self-understood and had slurred speech. Interventions directed staff to monitor and document the resident's ability to express and comprehend language, memory reasoning ability, and problem-solving ability. A SNF Beneficiary Notification Review indicated Resident #45's Medicare Part A skilled services episode started on 01/11/2025, and their last covered day of Part A services was to end on 03/20/2025. The SNF Beneficiary Notification Review indicated the facility had initiated the discharge from Medicare Part A services when benefit days were not exhausted. A Notice of Medicare Non-Coverage [NOMNC]-CMS [Centers for Medicare & Medicaid Services]-10123-NOMNC form revealed the document was signed by Resident #45 on 03/14/2025. The document did not include what Medicare Part A services were to end. A Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) CMS-10055 form revealed the document was signed by Resident #45 on 03/14/2025. The document indicated that, beginning on 03/20/2025, the resident may have to pay out of pocket for care. The form did not include the reason the care was no longer going to be provided, nor did it provide an estimate of the cost the resident may have to pay per day if they wished for services to continue. 2. An admission Record indicated the facility admitted Resident #46 on 11/01/2006 with a recent readmission on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of metabolic encephalopathy (condition when the brain does not receive adequate oxygen or nutrients) and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body that affects the arm, leg or face) following cerebral infraction (stroke) affecting right dominant side. A five-day Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 07/02/2025, revealed Resident #46 had a Brief Interview of Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS assessment did not include an end date of the most recent Medicare stay. Resident #46's Care Plan Report included a focus area initiated 09/15/2024 that indicated the resident had a communication problem related to unclear speech, difficulty understanding others, and difficulty making their needs known. Interventions directed staff to ask yes/no questions if appropriate, use simple, brief, consistent words, and use alternate communication tools as needed. A SNF Beneficiary Notification Review indicated Resident #46's Medicare Part A skilled services episode started on 06/30/2025, and their last covered day of Part A services was to end on 07/30/2025. The SNF Beneficiary Notification Review indicated the (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Deep Creek Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1017 George Washington Highway North Chesapeake, VA 23323	
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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility had initiated the discharge from Medicare Part A when benefit days were not exhausted. The document also revealed a Skilled Nursing Facility [SNF] Advance Beneficiary Notice [ABN] of Non-Coverage (SNF-ABN Form CMS [Centers for Medicare & Medicaid Services] 10055) had not been provided to the resident. A Notice of Medicare Non-Coverage-CMS-10095 form indicated a verbal authorization was obtained from Resident #46 and the document was signed by staff on behalf of the resident on 07/28/2025. The document indicated the residents' services were to end on 07/30/2025 but did not indicate what Medicare Part A services were to end. During an interview on 09/16/2025 at 10:59 AM, the Business Office Manager (BOM) stated that the Social Service Director (SSD) got notification from the resident's insurance company of services ending. She stated that the BOM was responsible for maintaining a copy of the notices in a binder once the last covered day was identified, and a copy of the discharge letter was signed by the resident or their representative. During an interview on 09/17/2025 at 8:27 AM, the Social Services Director (SSD) stated that she was responsible for completing and issuing the ABN and the NOMNC notices to the resident or representatives if the resident was going home, but stated if the resident stayed in the facility, she did not provide them any forms. The SSD reviewed the NOMNC provided to Resident #45 and confirmed that the form did not contain the type of services which were to end. She stated that Resident #45 was also issued an ABN but confirmed that the reason Medicare may not pay for services and the estimated cost for the services were not included on the document. The SSD stated that therapy typically provided her with a document that indicated why the service was ending, but she did not transcribe that information on the forms that were issued to Resident #45. She stated that regarding the estimated cost, she did not have knowledge of that information and could not include it on the document. The SSD then stated that all areas of each form should be fully completed for the resident or family to make informed choices. The SSD stated that she was unsure why Resident #46's Medicare Part A services ended but thought it was ended by the resident's insurance company. The SSD reviewed the NOMNC provided to Resident #46 and acknowledged Resident #46 was not provided with the ABN document at the same time. She then stated that the NOMNC issued to Resident #46 should have included what services were to end and Resident #46 should have been provided with an ABN document. SSD then stated that all areas of each form should be fully completed for both Resident #45 and Resident #46 in order for the resident or resident's representative to make an informed choice. During an interview on 09/19/2025 at 5:01 PM, the Director of Nursing (DON) stated she was unaware there were concerns with the issuing of ABN documents. She stated her expectation was that they meet state and federal requirements, and the forms were accurate and issued timely. During an interview on 09/19/2025 at 4:44 PM, Administrator (ADM) #2 stated he was unaware there were any concerns with the issuing of ABN documents. He said he expected the ABNs to be completed, issued, and reviewed with the resident/representative at least 48 hours prior to each resident's discharge from Medicare Part A services. He stated that all appropriate areas should be completed on the form.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview, record review, and facility policy review, the facility failed to ensure a Level 1 Preadmission Screening and Resident Review (PASARR) was completed for 2 (Resident #66 and Resident #6) of 2 residents reviewed for PASARR. Findings included: A facility policy titled admission Criteria, dated 03/2019, indicated the Policy Interpretation and Implementation included, 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payor source, to determine if the individual meets the criteria for MD, ID, or RD. b. If the Level I screen indicates that the individual may meet the criteria for MD, ID, or RD, he or she is referred to the state PASARR representative for Level II (evaluation and determination) screening process. The policy also specified, 2. The social worker is responsible for making referrals to the appropriate state-designated authority. 1. An admission Record revealed the facility admitted Resident #66 on 12/08/2022. According to the admission Record, Resident #66 had a medical history that included diagnoses of bipolar disorder and major depressive disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/05/2025, revealed Resident #66 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated moderate cognitive impairment. Resident #66's Care Plan Report included a focus area initiated 07/26/2025 that indicated the resident was planned for a long-term stay with no plans for discharge. Resident #66's medical record revealed no evidence of completion of a Level I or a Level II PASARR screening. During an interview on 09/16/2025 at 12:35 PM, the Administrator (ADM #1) reviewed the electronic medical record and stated there were no PASARR Level I or Level II forms available for Resident #66. The Administrator stated the resident was admitted to the facility under an exemption, as the COVID-19 public health emergency was still in effect at that time. The Administrator confirmed neither PASARR Level I nor Level II had been completed for Resident #66 since admission. The Administrator stated the social services department was responsible for the completion and submission of all PASARRS. During an interview on 09/17/2025 at 1:50 PM, the Social Services Director (SSD) stated she was responsible for completing PASARR Level II and was not familiar with who was responsible for ensuring the PASARR Level I was completed. The SSD stated she was familiar with Resident #66 and had submitted a request with the State Agency for a PASARR Level II and got a response that the resident did not meet PASARR Level II criteria. During an interview on 09/17/2025 at 2:47 PM, the SSD stated she had misspoken during her prior interview and a PASARR Level II had not been completed or submitted to the State Agency for Resident #66. The SSD stated she was not aware a PASARR Level I was not completed for Resident #66. During an interview on 09/17/2025 at 2:47 PM, the Director of Nursing (DON) stated she was not (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aware of who was responsible to ensure the PASARR Level I was completed upon admission. The DON stated it was her expectation that the PASARR Level I and Level II were completed timely, were accurate, and that referrals were made to the State Agency when a resident required a PASARR Level II. During an interview on 09/18/2025 at 9:01 AM, the Admissions Director (AD) stated she began employment at the facility approximately three weeks prior. She indicated each resident was required to have a PASARR Level I completed prior to admission to the facility. She stated if they did not have a PASARR Level I completed upon arrival, she would refer the admission to the DON. During an interview on 09/19/2025 at 4:41 PM with ADM #1 and the Executive Director (ADM #2), ADM #2 stated his expectation was that the PASARR process be completed timely and according to regulations. 2. An admission Record indicated the facility initially admitted Resident #6 on 07/12/2018 and readmitted the resident on 10/17/2022. According to the admission Record, the resident had a medical history that included diagnoses of unspecified mild dementia with agitation, generalized anxiety disorder, other specified depressive episodes, disorganized schizophrenia, and unspecified dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/01/2025, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. The MDS indicated that the resident was taking antipsychotic and antianxiety medications. Resident #6's Care Plan Report included a focus area initiated 12/01/2024 that indicated the resident used psychotropic medications related to schizoaffective disorder, anxiety, depression, and dementia. Resident #6's medical record revealed no evidence of a Level I PASSAR screening. During an interview on 09/19/2025 at 4:25 PM, the Social Service Director (SSD) reviewed Resident #6's medical record and stated Resident #6 did not have a Level I PASSAR completed. She stated that a Level I PASSAR should have been completed at the time of the resident's admission, when there was a change in the resident's medical care, or a new diagnosis. The SSD stated she was unsure who was responsible for completing the screening for a PASARR Level I. She stated that she thought it would be the Director of Nursing (DON). During an interview on 09/19/2025 at 4:38 PM, Administrator (ADM) #2 stated that a PASSAR Level I should be completed timely and accurately.		

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to develop a care plan to address smoking for 1 (Resident #59) of 3 residents sampled for smoking. Findings included: The facility policy titled, Smoking Policy-Residents, revised 01/2020, indicated, This facility shall establish and maintain safe resident smoking practices. The policy also specified, 8. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan. An admission Record revealed the facility admitted Resident #59 on 03/12/2025. According to the admission Record, the resident had a medical history that included diagnoses of multiple sclerosis and generalized muscle weakness. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/19/2025, revealed Resident #59 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Physician Encounter notes dated from 03/17/2025 to 09/16/2025 indicated that Resident #59 was a current daily smoker. The Encounter notes indicated that smoking cessation was advised. Resident #59's Care Plan Report included a focus area initiated 09/18/2025 during the survey that indicated the resident used tobacco. Interventions directed staff to conduct a Smoking Safety Evaluation upon admission and as needed (PRN). There was no evidence that a care plan to address smoking was developed prior to 09/18/2025. During an interview on 09/18/2025 at 7:20 AM, Resident #59 stated they smoked non-mentholated organic cigarettes. Resident #59 stated that once they were up and dressed, they would go outside and smoke just before or after lunch and would stay outside all day, as they liked to be outside. Resident #59 stated they were not supervised and could smoke independently. Resident #59 stated they kept their cigarette and lighter in their nightstand when in their room and on their person when out of the room. Resident #59 stated that there was no instance where they had left their room without their cigarettes and lighter. During an interview on 09/18/2025 at 7:38 AM, Administrator (ADM) #1 stated that there were no designated smoking times and everyone, with the exception of one resident, was independent with smoking. During an interview on 09/19/2025 at 4:44 PM, ADM #2 stated that a care plan drew a picture of the resident. He stated that his expectation was that for residents who were assessed as individuals who smoked, this information should be reflected in their care plans and appropriate interventions should be in place. During an interview on 09/19/2025 at 5:01 PM, the Director of Nursing (DON) stated that everyone should have a care plan in place to address each person's individual concerns. She stated that Resident #59 should be offered a cessation program, and there was a due process. She stated that her expectation was that there was a care plan in place related to smoking when it had been identified that a resident smoked.		