STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026
NAME OF PROVIDER OR SUPPLIER Newport News Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 12997 Nettles Drive Newport News, VA 23602	

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 0600 Level of Harm - 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 staff interviews, resident interviews, facility document review and clinical record review, the facility staff failed to protect a resident's right to be free from physical abuse by a staff member for one Resident (Resident #114), in a survey sample of 46 Residents. The witnessed incident of physical and verbal abuse resulted in Resident #114 suffering psychosocial harm as evidenced by emotional distress and a decline in cooperation of care, which was harm for the resident. The facility self-identified the non-compliance and implemented a plan of correction that achieved past-noncompliance. The findings include:A certified nurse's aide (CNA #5) hit Resident #114 and used derogatory language when incontinence care was attempted after the resident refused/resisted the care. Resident #114 (R114) was admitted to the facility with diagnoses that included severe chronic kidney disease, diabetes, hypertension, deep vein thrombosis, myocardial infarction, history of pulmonary embolism, diabetic retinopathy, delirium, dementia with agitation, pulmonary edema and spondylosis. The minimum data set (MDS) dated [DATE] assessed R114 with severely impaired cognitive skills. R114's admission assessment dated [DATE] documented the resident had clear speech, was able to make herself understood, was sometimes able to understand instructions, had pleasant mood, no observed behaviors, was always incontinent of bowel/bladder, had no skin impairments and that the resident was ambulatory with use of a walker. Nursing documented daily skilled notes on 5/9/25, 5/10/25 and 5/11/25 listing the resident no voiced complaints, with no resistance to care or refusals noted. A change of condition form dated 5/12/25 at 9:30 a.m. documented the primary nurse caring for R114 witnessed a certified nurse's aide (CNA) hit the resident during incontinence care and the resident reacted with paranoid/aggressive behaviors following the incident. This change in condition form documented, The resident was in her bed being changed by the assigned aide and the resident became aggressive and swinging at the aide, broke her necklace. The aide had the nurse come in the room. The assigned nurse witnessed the aide punch the resident x 2 in her lower back both fist. (sic) This change of condition form documented the CNA was removed from the room, escorted to the administrator's office and immediately suspended. The facility documented R114 demonstrated aggression, refused to be assisted/changed, refused physical assessment and ran into the hallway with no pants following the incident. The form documented the resident would not allow anyone to touch her and sat in a chair in the hall with a sheet placed over her legs and that the administrator, resident's family member and the nurse practitioner (NP) were notified. The NP assessed R114 immediately following the incident. The NP note dated 5/12/25 documented, .Patient was seen today upon request of DON [director of nursing] and nurse. Staff report patient has (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
	495340	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newport News Nursing & Rehab	12997 Nettles Drive Newport News, VA 23602

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F 0600 Level of Harm - Actual harm Residents Affected - Few	become increasingly confused, agitated, and combative for staff .seen outside in the hallway sitting in a chair. She is currently soiled wearing a disposable brief, however she will not allow staff to change her. Patient is unaware of her self, surrounding, or location. She reports she is trying to get a hold of her father which is why she was attempting to leave the room . The NP documented that she was unable to complete a thorough review of systems or physical exam due to the resident's mental status and listed the resident as agitated, combative with staff, refusing care and disoriented to person, place and time. The NP assessed the resident with dementia with agitation and delirium. The NP listed the resident was on the medication Seroquel nightly for agitation/delirium prior to admission, entered a new order for the anti-anxiety medication Ativan 0.5 mg (milligrams) every 24 hours if needed for acute agitation during next five days, ordered a urinalysis and culture to rule out infection, non-drug behavioral management strategies and psychiatry consultation. Nursing notes documented that the resident's family member came to the facility on 5/12/25 at 10:55 a.m. in response to the incident. Nursing documented R114 calmed after talking with the family member, returned to the room and then allowed staff to clean/change the resident with assistance of family. R114's vital signs were assessed, skin assessment completed with no impairments, pain or signs of injury or pain noted. Social services documented an attempt to talk to R114 on 5/12/25 at 1:36 p.m. following the incident. This note documented the resident stated she did not want to talk to any social worker. Nursing documented the resident calmed after the family arrived 5/12/25, resumed taking medicines and allowed staff members to provide care and services. A nursing note dated 5/13/25 documented the resident attended out of room activities, including exercises with other residents and listed, her mood was calm and happy. Daily skilled nursing notes on 5/13/25 and 5/14/25 documented the resident as oriented to person/place, with no aggressive behaviors, as conversive with staff, with calm/pleasant mood, ambulating in halls and with no pain. A nursing note dated 5/15/25 documented, .the resident has been calm and cooperative these last two days but there is confusion. She has no c/o [complaints of] pain. 5/13/25 and 5/14/25 I assessed he [the] skin and no new bruising noted .family are supportive and coming to visit her . Psychiatry assessed R114 on 5/16/25 regarding the altercation with a CNA on 5/12/25. The psychiatry progress note dated 5/16/25 documented, Patient states the CNA came from behind, grabbed, and started hitting her. She states she had to defend herself and staff intervened . Psychiatry documented the resident was recently started of Seroquel during hospitalization (prior to admission to the facility) due to delirium. Psychiatry documented under review of systems, .Denies feeling depressed, anxious or agitated, Denies any insomnia, Reports appetite to be good, No reported hallucinations or delusions, No reported suicide ideation, intent plan, No reported restlessness or irritability, No reported intrusive thoughts, No reported fatigue, No reported loss of interest in activities, Reported memory loss, No reported phobias or fears, racing thoughts . The psychiatry NP documented R114 as stable with orders to continue monitoring and current plan of care with no changes in treatment ordered. R114's medication administration record (MAR) documented no administration of the as needed Ativan prescribed for acute agitation during the five days following the incident. The urinalysis with culture ordered on 5/12/25 was negative for an infection. R114's clinical record documented ongoing assessment with the combative behaviors and resistance to care noted after diagnosis/treatment of a urinary tract infection on 5/19/25. The resident's plan of care was updated on 5/12/25 to include problems, goals and interventions related to maintaining psychosocial well-being due to physical (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 0600 Level of Harm - Actual harm Residents Affected - Few	abuse. The facility's investigation of R114's abuse incident of 5/12/25 was reviewed and documented that CNA #5, who was witnessed hitting the resident, was immediately removed from the room, taken to the administrator's office and suspended. The abuse incident was reported to the responsible party, medical provider, state survey agency, adult protective services, ombudsman, state department of health professions and law enforcement on 5/12/25 as required. The investigation documented skin assessments on all residents with BIMS (brief interview of mental status) score of 8 or below and interviews with all other residents that were cared for by CNA #5. Investigation findings were reported to the state agency and documented that CNA #5 voiced that she became upset that her necklace was broken while performing personal care for R114. The investigation documented CNA #5 was aware that R114 did not want to be changed and that care was attempted because the resident was scheduled for therapy and needed to be cleaned. The investigation documented CNA #5's actions agitated R114, that RN #3 witnessed CNA #5 hit R114 with abuse substantiated and CNA #5 terminated. The facility's investigation documented the following written statements from registered nurse (RN#3) that witnessed the incident and CNA #5 that was witnessed hitting and using derogatory language in front of the resident. RN #3's written statement dated 5/12/25 documented, .I was called in the [R114's] room by the Aide [CNA #5] on assignment stating 'Can you come help me. She's [R114] try to fight me.' I entered into the room and saw the aide trying to remove the patients brief. The .paint [patient] expressed that she wanted the Aide to stop and to leave her alone. I asked the Aide to step out but she refused stating 'she broke my grandma chain and its somewhere in the bed or her breif [brief].' The aide then pushed the patient on her side stating 'She's shitty and I need my chain.' the patient tried to roll back over then the Aide punched the patient in her thigh/back twice and said 'I just don't care anymore' . (sic) A written statement from CNA #5 dated 5/12/25 documented, I went into [R114's room] after I picked up the breakfast trays to get her cleaned up for therapy. I explained to her what I was doing + she started getting combative with me. I tried to explain to her that she cant hit me + that I was trying to help her get cleaned up for the day. She continued to hit me. She grabbed my necklace + broke it + my nametag too. I then went + got the nurse to help me. She still was fighting + I was trying to grab her arms + explain that she cant hit me + that I was trying to help her. She kept refusing for me to clean her up even after the nurse tried to explain as well that she was dirty. (sic) On 3/5/26 at 9:05 a.m. the administrator, administrator in training (AIT) and the director of nursing (DON) were interviewed about R114's abuse and actions taken in response. The current administrator was not employed at the facility at the time of the incident. The DON stated that RN #3 immediately reported on 5/12/25 that she witnessed CNA #5 hit R114 when CNA #5 attempted to perform incontinence care after the resident stated she did not want to be changed. The DON stated R114 grabbed CNA #5's shirt during the incident and broke the CNA's necklace. The DON stated CNA #5 then pushed the resident and punched the resident in the back/thigh twice with her fist as witnessed by RN #3. The DON stated RN #3 told CNA #5 to get out of the room and she was escorted to the administrator's office. The DON stated she went to the unit and R114 was standing in the hall and would not return to her room. The DON stated she and staff members stayed with the resident and finally got the resident to sit. The DON stated R114 was agitated, confused, would not allow staff to assess or change her and that staff stayed with the resident in the hall. The DON stated she went to the office and interviewed CNA #5 about what happened with the administrator at that time and AIT (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	present. The DON stated she asked CNA #5 if she hit R114 and that CNA #5 responded, Yes. The DON stated CNA #5 was upset that the resident broke her grandmother's necklace. The DON stated she informed CNA #5 that hitting the resident was abuse, that she was suspended and CNA #5 was then escorted out of the building. The DON stated she returned to check on R114 and after the resident's family arrived, the resident returned to her room and allowed staff members to clean, change and assess her. The DON stated the family came within an hour of the incident and were instrumental in getting the resident cleaned/changed as the resident did not want staff to clean her. The DON stated she assessed the resident with no pain, and a skin assessment revealed no signs of physical injury. The DON stated the police were notified and came the same day. The DON stated the NP assessed R114 following the incident and the resident was later assessed by psychiatry. The DON stated the family member reported the resident had been combative and resistive to care at times prior to admission to the facility. The DON stated psychiatry assessed the resident with baseline cognitive status and that the resident was aware that she had been hit by a staff member. The DON stated the resident required no additional medication in response to the incident and did not display fear of staff in the days following the incident. The DON stated the resident ambulated with a walker, was out of the room and attended a group activity with other residents the next day. The DON stated interviews were immediately conducted with alert/oriented residents in addition to skin assessments for all other residents with no abuse findings. The DON stated education was initiated on 5/12/25 for all staff in response to the incident. The DON and AIT stated there had been no history of any concerns with CNA #5's performance prior to this incident and resident interviews revealed she was well-liked by residents. The AIT stated that CNA #5 was terminated as a result of this incident. The AIT presented a copy of a state and national criminal background for CNA #5 with no findings and signed acknowledgment of code of ethics and employee handbook that included abuse prevention policies completed in June 2024. The administrator at the time of this incident and RN #3 that witnessed the abuse were not available for interview as they no longer worked at the facility. The facility's policy titled Abuse, Neglect, Exploitation & Misappropriation (revised 11/16/22) documented, It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property.Employees of the center are charged with a continuing obligation to treat residents so they are free from abuse.No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and/or misappropriation of property against any resident.Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish.Physical Abuse includes.hitting.slapping.punching.Verbal Abuse may be considered a form of mental abuse. Verbal abuse incudes the use of oral, written, or gestured communication, or sounds, to resident within hearing distance.Mental and Verbal Abuse include.Harassing a resident.mocking, insulting, ridiculing.Yelling or hovering over a resident, with the intent to intimidate.Acts of abuse directed against residents are absolutely prohibited. The facility presented the following plan of correction for abuse initiated on 5/12/25 in response to this incident 1. Corrective Action for Affected Resident - Immediately upon receiving the allegation on 5/12/25, the resident was protected from further potential harm. A licensed nurse completed a full skin-to-skin (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	

head-to-toe skin assessment to identify any injuries or changes in condition. No injuries were identified at the time of assessment. The DON reviewed the clinical findings and supervised continued monitoring of the resident following the incident to ensure safety. CNA #5 named in the allegation was immediately removed from resident care duties, suspended pending the facility's investigation in accordance with the facility's abuse prevention policy.

2. Identification of Other Residents Who May Have Been Affected - Review of all staff assignments was completed on 5/12/25. Interviews were conducted with residents assigned to the alleged staff member. Review was conducted of all clinical documentation for residents receiving care during the shift. Additional skin-to-skin head-to-toe nursing assessments were completed for all residents who received care from CNA #5. All assessments were conducted by licensed nursing staff with oversight by the DON.

3. Systemic Changes Implemented - Immediate re-education of 100% of facility staff regarding abuse prevention and mandatory reporting requirements. Education included review of the facility's zero-tolerance abuse policy, reinforcement of professional conduct expectations during resident care, increased supervisory rounds by nursing leadership during resident care activities and review of reporting expectations with all department heads.

4. Monitoring Plan with Specific Dates – The DON or designee will monitor compliance through observational audits and skin-to-skin head-to-toe assessments according to the following schedule: Week 1 monitoring audit 5/19/25; week 2 monitoring 5/26/25; week 3 monitoring 6/2/25; week 4 monitoring 6/9/25. June 16, 2025 – Final review of the 4-week monitoring period. These audits include direct observation of CNA-resident care interactions and random skin-to-skin head-to-toe nursing assessments. Results will be reviewed by the DON. Following completion of the 4-week monitoring period ending 6/16/25, the results will be reviewed during the facility's Quality Assurance and Performance Improvement (QAPI) meeting to determine if additional monitoring is required.

5. Correction date was 6/13/25.

The surveyor verified that R114's abuse incident was reported to the state survey agency, department of health professions, adult protective services, law enforcement in addition to the medical provider and family representative. There was evidence that the abuse prevention policies for reporting and investigating the incident were followed. Documentation was provided of resident interviews and skin assessments as listed in step 1 of the correction plan with no further abuse identified. Documentation was provided of staff education that started on 5/12/25 on abuse/neglect policies, professional conduct during care and abuse reporting. Skin assessments of residents care for by CNA #5 were documented in addition to weekly monitoring CNA-resident care and ongoing skin audits. The QAPI meeting agenda for August 2025 included review of the substantiated staff to resident abuse incident of 5/12/25, with staff member termination noted.

On 3/5/26 starting at 11:48 a.m., multiple staff members on each nursing unit were interviewed and voiced education had been provided regarding abuse prevention, reporting and professional conduct during care with staff aware of abuse protocols for prevention, reporting and expectations for conduct during care. The survey team deemed the plan of correction was implemented as listed.

During the current survey, resident interviews, family interviews, a resident group/council interview, staff interviews and record reviews conducted with no reports of resident abuse and no deficiencies cited for resident abuse since 6/13/25.
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F 0600 Level of Harm - Actual harm Residents Affected - Few	This deficiency was cited as past non-compliance.