STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495397	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Chesapeake	955 Harpersville Rd Newport News, VA 23601

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, staff interview, resident interviews and facility documentation, the facility staff failed to ensure staffing information was posted on one of one unit in a prominent place and readily accessible to all residents, staff and visitors. The findings included:During the initial tour of the facility on 12/2/2025, there was no observation of the daily posting of the nurse staffing information on the nursing unit. On the second day of survey (12/3/2025), no nurse staffing information was observed on the unit. On 12/3/2025 during a medication pass and pour observation, an interview was conducted with an alert resident who stated he did not know how to determine how many staff members were working.On 12/3/2025 at approximately 12:40 p.m. during lunch time, a visitor was interviewed about the nurse staffing. The visitor stated she did not know where that information was located. On 12/3/2025 at 1:00 p.m., a group interview was conducted by another surveyor with five alert and oriented individuals. The surveyor reported that each resident stated that they did not know where to find information about the nurse staffing each day.On 12/3/2025 at approximately 2:15 p.m., an interview was conducted with the Administrator who stated that the nurse staffing information was posted on the unit. The Administrator walked with the surveyor to the nursing station. The Administrator pointed to a sheet of paper that was leaning against the wall near a binder. The Administrator explained that the paper had the name of the facility, the shift, nursing positions and the census number. The writing font was very small and did not clearly state that the number in the center of each shift represented the census.During the end of day debriefing on 12/3/2025, the Administrator and Director of Nursing were informed of the findings that the nurse staffing information was not readily accessible to all residents, staff and visitors. The writing on the form was very small and difficult to see where placed on the counter, There was no indication of the location of the form for those who were not familiar. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. Based on observation, resident interview, staff interview, and facility documentation, the facility's staff failed to ensure residents were aware of their right to contact the Ombudsman to advocate for them and of their right to file a complaint with the state certification agency. The findings included:On 12/03/25, during the group resident interview, none of the five residents (#2, #11, #21, #31, #43), that attended were aware of what or who the Ombudsman was or how to contact them. Also, none of the five residents in attendance were aware that they could make a complaint with the state agency or where they could find the information to do so. An interview was conducted with the facility's Activities Director (AD) and the Administrator on 12/03/25, at approximately 4:00 PM. The Administrator states that Resident Rights are addressed on admission and discussed in Resident Council Meetings and in the Resident Handbook. An interview was conducted with the admissions coordinator (AC) on 12/04/25 at approximately 11:30 AM. The AC stated it was a collaborative effort by all facility staff and leadership to inform residents where to find information on contacting the Ombudsman and/or the state agency, but this is addressed on admission and at Resident Meetings. On 12/04/25, during the end-of-day meeting, the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) were made aware of the findings, and no further information was provided.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations and interviews, the facility staff failed to ensure the survey results book was readily accessible to residents, family members and legal representatives of residents. The findings included:On 12/02/25 at approximately 2:00 PM., during the facility tour, in the main hall leading to the Health Center Unit a sign was observed on the bulletin board that read Survey Book is available upon request in the main office. On 12/03/25, an interview was conducted with the Administrator concerning the survey book accessibility. The administrator stated that they initially had the survey book available to everyone without needing to request access, but it was moved to the office during construction. On 12/03/25, during the end-of-day meeting, the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) were made aware of the findings, and no further information was provided.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, resident interview, staff interview, and facility documentation, the facility's staff failed to ensure residents were aware of how to file a grievance or complaint. The findings included:On 12/03/25, during the group resident interview, none of the five residents (#2, #11, #21, #31, #43), that attended, were aware of the availability, or how to file a grievance or complaint. An interview was conducted with the facility's Activities Director (AD) and the Administrator on 12/03/25, at approximately 4:00 PM. The Administrator stated that Resident Rights, including how to file a grievance or complaint, are addressed on admission and discussed in Resident Council Meetings and in the Resident Handbook. An interview was conducted with the admissions coordinator (AC) on 12/04/25 at approximately 11:30 AM. The AC stated it was a collaborative effort of all facility staff and leadership to inform residents on where to find information regarding their rights and that it is addressed on admission and at Resident Meetings. The facility's policy titled Resident's Rights, was received and reviewed On 12/04/25 during the end of day meeting the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) were made aware of the findings, and no further information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and facility documentation the facility staff failed to provide respiratory care consistent with professional standards of practice for 3 Residents (#19, #1 and #42) in a survey sample of 24 Residents. The findings included:1. The facility staff failed to ensure oxygen nasal canula and concentrator tubing were changed according to the physician's order for Resident #19. Resident #19 was admitted to the facility originally on 06/22/2022 and most recently readmitted on [DATE]. On 12/02/2025 at 01:15 PM, an observation was made of Resident #19's oxygen nasal canula and concentrator tubing dated 11/23/2025; the humidification bottle attached to the oxygen concentrator was not dated. A review of the clinical record revealed that the orders for oxygen read: Clean oxygen concentrator and filter, change tubing weekly (every (Q) 7 days). The MAR (Medication Administration Record) was signed off as changed on 11/16/2025 and 11/23/25. On 12/2/25, an interview was conducted with the Assistant Director of Nursing (ADON), who was asked when the oxygen tubing gets changed. She stated that it is done once a week, on Sunday. When asked about the tubing on Resident #19's oxygen nasal canula and concentrator, she stated that it must have been missed and that they have continued to train on the importance of this. On 12/03/25, an interview with the Director of Nursing (DON) was conducted, and she was asked about the expectation that nursing staff change oxygen and concentrator tubing. She stated that she expected that it would be changed according to policy, which is weekly. When asked if that was done in this case, she noted that it was not. On 12/03/25, during the end-of-day meeting, the Administrator, DON, and ADON were made aware of the findings, and no further information was provided. 2. Resident #1. The facility staff failed to ensure the oxygen concentrator tubing and the humidification bottle attached to the oxygen concentrator were changed according to the physician's order for Resident #1. Resident #1 was originally admitted to the facility on [DATE]. The resident's diagnoses included acute and chronic respiratory failure with hypoxia, unsteadiness on feet, pulmonary fibrosis, and heart failure. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 8/22/25, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated that Resident #1's cognitive abilities for daily decision-making were intact. On 12/2/25 at 1:55 PM, during an observation tour, it was observed that the oxygen concentrator tubing and the humidification bottle attached to the oxygen concentrator for Resident #1 were dated (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/23/25. On 12/2/25 at 2:05 PM an interview was conducted with the Director of Nursing (DON). The DON stated that the date on the oxygen tubing to the concentrator and the humidification bottle attached to the oxygen concentrator for Resident #1 were dated 11/23/25. The DON also stated that the oxygen tubing to the concentrator and the humidification bottle attached to the oxygen concentrator are changed every Sunday and these should have been changed on 11/30/25. A review of the Medication Administration Record (MAR) revealed the following - Oxygen: Mask, Tubing, and Humidifier Change on Sunday – Rinse filters on oxygen concentrator when in use every night shift every Sun. Start Date: 09/03/2025 On 12/4/25 at approximately 5:00 p.m., a final interview was conducted with the Administrator, Director of Nursing, and Assistant Director of Nursing. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information. 3.The facility staff failed to follow the physician orders for the oxygen flow rate, monitor the flow rate and failed to label and date the oxygen tubing for Resident #42. Resident #42 was admitted to the facility originally on 10/09/25, and most recently readmitted on [DATE]. The current diagnoses included; Displaced Intertrochanteric fracture of the left Femur. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/14/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #42's cognitive abilities for daily decision making were intact. A review of the Medication Administration Record (MAR) revealed the following: Oxygen at 2L via Nasal Cannula (NC) every shift for Oxygen therapy beginning 11/08/2025. Oxygen Mask, Tubing and Humidifier Change on Sunday beginning 11/09/2025. The person-centered care plan dated 11/11/25 revealed that Resident #42 was receiving oxygen therapy relating to oxygen shortness of breath (SOB) and hypoxia. The resident's goal was to have no signs or symptoms of poor oxygen absorption, and an intervention was to have oxygen settings at 2 liters via Nasal Cannula as needed. On 12/02/2025 at approximately 2:20 pm., during the initial tour Resident #42 was observed sitting up in her wheelchair receiving oxygen. An observation of the flow rate revealed the resident was receiving 3.5 liters of oxygen via nasal canula, and the resident's oxygen tubing was observed not dated or labeled. The resident said that staff had come in earlier to change her tubing and to increase her oxygen and now she feels comfortable. Shortly thereafter, the Infection Preventionist (IP) entered the room saying to the resident that she was in to change her oxygen tubing. The resident said they came in earlier and changed it. The IP was asked if it was acceptable to not have the oxygen tubing labeled or dated. The IP said it's not acceptable. On 12/04/2025 at approximately 10:11 am, a brief interview was conducted with Resident #42 concerning her oxygen needs. Resident #2 said that she's feeling better this morning. A visual inspection was made of the resident's oxygen flow rate. The flow rate was set at 3.5 liters. On 12/04/2025 at approximately 10:18 am, an interview was conducted with Licensed Practical Nurse (LPN) #2. LPN #2 was asked to verify the resident's oxygen flow rate. Upon visual inspection LPN #2 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said it reads 3.5, let me check her orders. LPN #2 returned saying the orders read that the resident should be getting 2.0 liters of oxygen. LPN #2 was observed entering the resident's room, speaking to the resident, observed walking over to the resident's oxygen machine to adjust the flow rate. The Policy revised 12/2025 read: Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and or nasal catheter. Procedure: Verify there is a medical provider's order for this procedure. The order should specify oxygen source, delivery system, flow rate, and if oxygen should be issued continuously or as needed. Documentation: After completing the oxygen set-up or adjustment the following information should be recorded: The date and time procedure was performed. On 12/03/25 at approximately 5:55 pm., during the end of day meeting the Administrator, DON, and Assistant Director of Nursing (ADON) were made aware of the above findings, no further information was provided. On 12/04/25 at approximately 3:45 pm., during pre-exit, the above oxygen flow rate findings were shared with the Administrator, DON, and Assistant Director of Nursing (ADON). No further information was provided.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, resident interview, and staff interview, the facility's staff failed to offer and provide snacks at bedtime. The findings included:There were no observations during this survey from 12/02/2025-12/04/2025 of snacks being offered or provided to residents. On 12/03/2025, during the resident group meeting/interview, five Residents (#2, #11, #21, #31, #43) stated that they did not receive nor are they offered snacks mid-day or bedtime regularly. The residents said that it is rare to receive snacks at bedtime. The residents also stated that when they do get snacks, it is in connection with a planned activity. An interview was conducted with the Dietary Manager (DM) on 12/03/25. The DM stated snacks are available to all units and residents, but is unsure about the distribution. On 12/04/2025, an interview was conducted with the Administrator, who stated they have snacks available but agreed that snacks are not offered consistently. On 12/04/25, at approximately 5:00 PM, the above findings were shared with the Administrator, Director of Nursing, and Assistant Director of Nursing. No additional information was provided before survey exit.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, staff interview, clinical record review, and review of facility documents, the facility staff failed to cover the catheter bag for 1 of 24 residents (Resident #48), in the survey sample. The findings included:Resident #48 was originally admitted to the facility 8/29/23. The current diagnoses included; urinary tract infection, multiple sclerosis, type 2 diabetes mellitus without complications, major depressive disorder, and muscle weakness. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/10/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #48's cognitive abilities for daily decision making were intact.On 12/2/25 at 3:30 PM during an observation tour it was observed that the catheter bag for Resident #48 was not covered with a privacy bag. On 12/2/25 at 3:35 PM a second observation tour was conducted with the Director of Nursing (DON). The DON observed Resident #48's catheter bag uncovered and stated, there should be a cover over the residents catheter bag. The DON also stated that the reason for this is for the residents privacy and dignity. On 12/4/25 at approximately 5:00 p.m., a final interview was conducted with the Administrator, Director of Nursing, and Assistant Director of Nursing. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, the facility failed to ensure the resident's right to personal privacy and confidentiality of her personal and medical record. Personal privacy includes accommodation, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. The resident has a right to secure confidential personal and medical records. Findings include:The facility failed to ensure privacy and confidentiality of the medical record for 1 resident in survey sample of 24 residents. Resident #49.On 12/2/25, during a clinical record review for Resident #18, a progress note revealed an entry containing the name of another resident, Resident #49. 11/29/2025 21:56 NOTE TEXT: While working at admin desk M.A stated resident (#18) was seated on opposite side of the counter talking with Resident #49 (name redacted). M.A noticed a motion out of corner her eye with the W/C tipping forward. Resident #18 (name redacted) was reaching out towards Resident #49 (name redacted) to pull her closer to her. M.A reached out to Resident #18 (name redacted) and caught her before she landed on floor. Her hands were holding on to the wheelchair, and her legs were stretched in front of her and her bottom was still in the wheelchair. Resident was returned to W/C and was positioned next to M.A within arm's reach.Resident #49 was admitted to the facility on [DATE] with diagnoses to include but not limited to dementia with anxiety, osteoporosis, hypertension, malignant neoplasm of the breast, cardiomegaly and hypertensive chronic kidney disease. Resident #49's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/6/2025 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 07 out of a possible 15 indicating severe cognitive impairment. Section GG 0170coded the resident as requiring supervision or touching assistance for lying to sitting, sitting to standing, chair/bed to chair transfer and toileting. Section GG 0120 coded her as using a walker and or a wheelchair for mobility.Resident #18 was admitted to the facility on [DATE] with diagnoses to include but not limited to rhabdomyolysis (a rare muscle injury where severely damaged or injured skeletal muscles rapidly breakdown), displaced fracture of the first cervical vertebra, pulmonary hypertension, history of pneumonia, depression, heart failure, cognitive communication deficit and osteoporosis. Her most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/7/25 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15 indicating her cognitive abilities are intact. Section GG 0170 coded her a dependent on staff for bathing and dressing and sitting to standing and requiring partial/maximum assistance with sitting to lying and chair/bed to chair transfer.On 12/3/25 at approximately 10:30 AM, the progress note dated 11/29/25 observed in Resident #18's electronic medical record was shared with the Director of Nursing. During the interview the Director of Nursing was asked whether naming another resident in a resident's medical record was an acceptable standard of practice. She replied, No, that is a violation of her right to privacy and confidentiality.According to Lippincott Manual of Nursing for Standards of Practice for Documentation: Under no circumstances should another patient's name be entered into a different patient's medical chart. This is a violation of professional standards, a breach of patient confidentiality (U.S. federal law HIPPA- Health Insurance Portability and Accountability Act), and a major patient safety risk. Professional documentation in a medical record adheres to strict privacy and accuracy standards. Patient-specific records - every entry in a medical record must pertain solely to the individual patient whose chart it is. Confidentiality (HIPPA) - a patient's name, when linked with any health information, is considered Protected Health Information (PHI). Disclosing this information to unauthorized individuals, including other patients, is a serious HIPPA violation, unless specific conditions for disclosure are met (e.g. for treatment among the care team, or with written patient authorization). Lippincott Manual of Nursing for Standards of Practice: Practice Series: Documentation 2007, 1st edition.On 12/4/25, during the end-of-day exit meeting, the Administrator, Director of Nursing, and the Assistant Director of Nursing were made aware of the findings, and no further information was provided.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and clinical record review, the facility staff failed to develop and implement a baseline care plan that included the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care for one (1) of 24 residents (Resident #18) in the survey sample. The findings included: On 12/3/25 during a clinical record review, it was discovered that Resident #18 did not have a baseline care plan. The first care plan was created on 11/10/25, seven (7) days after admission.Resident #18 was admitted to the facility on [DATE] with diagnoses to include but not limited to rhabdomyolysis (a rare muscle injury where severely damaged or injured skeletal muscles rapidly breakdown), displaced fracture of the first cervical vertebra, pulmonary hypertension, history of pneumonia, depression, heart failure, cognitive communication deficit and osteoporosis. Her most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/7/25 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15 indicating her cognitive abilities are intact. Section GG 0170 coded her a dependent on staff for bathing and dressing and sitting to standing and requiring partial/maximum assistance with sitting to lying and chair/bed to chair transfer.On 12/4/25 an interview was conducted with the Director of Nursing on her expectations for completing a baseline care plan and she responded, every resident is to have a baseline care plan written within 24 to 48 hours after they are admitted . According to the Director of Nursing, the Assistant Director of Nursing (ADM#7) is responsible for writing and updating all resident care plans. On 12/425 an interview was conducted with the Assistant Director of Nursing (ADM #7) on what her responsibilities were in developing and revising care plans and she responded, I make sure that every resident has a baseline care plan within 24 to 48 hours after they are admitted here and then write the care plans after completion of the MDS (Minimum Data Set Assessment) and then update them when needed. A request was made for a copy of the baseline care plan for 3 residents in the survey sample. She was unable to locate a baseline care plan for Resident #18. She replied, I must have missed that one.According to her, she is responsible in developing and updating care plans based on the Resident Assessment Instrument Manual (RAI) guidelines and regulations. The regulation on pertaining to baseline care plans states A baseline care plan is to be developed and implemented for every resident within 48 hours of admission.On 12/4/25, during the end of day exit meeting the concerns were reviewed with the Administrator, Director of Nursing and the Assistant Director of Nursing and no further information was provided.

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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 clinical record review, the facility staff failed to ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan was reviewed and revised by an interdisciplinary team for three (3) of 24 residents (Residents #14, #2, and #18) in the survey sample.Findings include: 1. 1. For Resident #14, the facility staff failed to update her comprehensive care plan to reflect her speaking more Italian and her use of an elbow extension splint. Resident #14 was admitted on [DATE] with diagnosis including but not limited to non-traumatic intracerebral hemorrhage, major depressive disorder, hypertensive chronic kidney disease, contracture, iron deficiency anemia, pain, unspecified, vascular dementia, neuromuscular dysfunction of the bladder and cerebrovascular disease. Her most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/28/25 Section C0500 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 03 out of a possible 15 indicating her cognitive abilities are severely impaired. Section GG 0170 coded her for bathing, dressing, sitting to standing, sitting to lying and chair/bed to chair transfer as substantial/maximal assistance.On 12/3/25, Resident #14 was observed in the activity room coloring. An interview was conducted with the Activity Program Assistant (OTHER STAFF #2), who shared that Resident #14 had begun to speak more in Italian due to her cognitive decline. A review of her comprehensive care plan revealed that the care plan focus: The resident has a communication problem r/t cognitive loss//dementia. Date Initiated: 12/02/2025 failed to address how to communicate with Resident #14 when she begins to speak in Italian.On 12/3/25 a review of physician orders revealed that Resident #14 had an order for Elbow Extension Splint, every day Resident should wear elbow extension splint on the left elbow for contracture management; should be worn daily for 2-4 hours; assess skin and monitor splint placement for comfort and to maintain skin integrity for elbow contracture.Resident #14 was observed with an elbow extension splint on 12/2/25, 12/3/25 and 12/4/25. An interview was conducted with the COTA (OTHER #3) regarding Resident #14's splint, and according to the COTA (OTHER STAFF #3) Resident #14 on therapy caseload and Occupational Therapy (OT) is working with her on elbow extension and the nursing staff applies the splint 2-4 hours a day and the time can vary. The Director of Therapy (ADM#5) verified that OT was working with Resident #14 on her left upper extremity strength to facilitate her functional activities and to help improve her range of motion and coordination to help to increase her independence with activities of daily living.2. 2. For Resident #2, the facility failed to update her comprehensive care plan related to new order for Resident is Comfort Care- NO weights, labs, IV's, x-rays (unless suspected fracture), DO Not send to hospital dated 11/4/25 and to monitor intake and output for Congestive Heart Failure.Resident #2 was admitted on [DATE] with diagnosis including but not limited to bed confinement status, anxiety, history of pulmonary embolism, major depressive disorder, iron deficiency anemia, atrial fibrillation with use of anticoagulants, chronic obstructive pulmonary disease, heart failure, type 2 diabetes mellitus with chronic kidney disease and Alzheimer's disease. Her most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of Section C0500 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 11 out of a possible 15 indicating moderate impairment in cognition (she experiences difficulties with daily functioning and memory support). Section GG 0170 coded her for bathing, dressing, sitting to standing, sitting to lying and chair/bed to chair transfer as dependent.During review of Resident #2's physician orders, an order for Resident is Comfort Care- NO weights, labs, IV's, x-rays (unless suspected fracture), DO Not send to hospital was written on 11/4/25 and an order to discontinue incentive spirometry on 12/2/25.A review of her care plan revealed (6) six care plan focuses related to laboratory monitoring (monitor laboratory results) did not reflect NO labs per the Comfort Care order dated 11/4/25Care plans focus for: The Resident has (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495397	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Chesapeake	955 Harpersville Rd Newport News, VA 23601

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	COPD (Chronic Obstructive Pulmonary Disease) had an intervention to Encourage incentive spirometry prophylaxis related to COPD with recurrent exacerbation, 10 breaths every hour while awake dated 10/13/25 - order to discontinue incentive spirometry was written on 12/2/25, the intervention remained on the care planCare plan focus the resident has congestive heart failure with an intervention to monitor intake and output without evidence of monitoring the resident's intake and output.3. 3. For Resident #18, the resident's care plan was not updated to reflect code status after being admitted to Hospice services on 11/24/25, and had not been updated after infections resolved.Resident #18 was admitted to the facility on [DATE] with diagnoses to include but not limited to rhabdomyolysis (a rare muscle injury where severely damaged or injured skeletal muscles rapidly breakdown), displaced fracture of the first cervical vertebra, pulmonary hypertension, history of pneumonia, depression, heart failure, cognitive communication deficit and osteoporosis. Her most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/7/25 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15 indicating her cognitive abilities are intact. Section GG 0170 coded her a dependent on staff for bathing and dressing and sitting to standing and requiring partial/maximum assistance with sitting to lying and chair/bed to chair transfer.A review of Resident #18's physician's orders revealed an order Resident admitted to Amedisys Hospice on 11/24/25 with terminal diagnosis of Alzheimer's Disease and an order DNR (Do Not Resuscitate) dated 11/13/25. A review of Resident #18's care plan revealed the focus of Advanced Directives General: FULL CODE dated 11/10/25.Further review of her care plan revealed: The resident has a urinary tract infection initiated 11/23/25 revised 12/1/25 - no evidence of resident having a urinary tract infection 11/23/25 The resident has pneumonia initiated 11/10/25 revised 12/1/25. Per Infection Control Tracking log pneumonia resolved 11/15/25. Resident is on Enhanced Barrier Precautions for right leg skin abrasions initiated 11/10/25 - no current order for Enhanced Barrier Precautions and during observations 12/2/25, 12/3/25 and 12/4/24 no evidence of signage on door for Enhanced Barrier Precautions or PPE (personal protective equipment) at her door.On 12/4/25 an interview was conducted with the Director of Nursing on her expectations for revising and updating care plans and she responded, Residents care plans should be updated when their condition changes. According to the Director of Nursing, the Assistant Director of Nursing (ADM#7) is responsible for writing and updating all resident care plans. On 12/425 an interview was conducted with the Assistant Director of Nursing (ADM #7) on what her responsibilities were in reviewing and updating/revising care plans and she responded, I make sure that every resident has a baseline care plan within 24 to 48 hours after they are admitted here and then I write the care plans after completion of the MDS (Minimum Data Set Assessment) and then update them when needed.During the interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), care plans for 3 residents were reviewed (Residents #14, #2, and #18) and according to the DON and the ADON the care plans had not been updated to reflect the current condition of the residents. Per the Assistant Director of Nursing, she stated, Yes, I see that those have not been updated.According to the Assistant Director of Nursing, she is responsible for developing and updating care plans based on Resident Assessment Instrument Manual (RAI) guidelines and regulations. The RAI mandates care plan updates whenever a resident's condition changes to reflect the resident's status.According to the Assistant Director of Nursing (ADM#7), the facility staff follow the guidelines for care planning as outlined in the RAI Manual (Resident Assessment Instrument) on care planning.Review of the RAI Manual (Resident Assessment Instrument), October 2023, Pages 4-8 As required at 42 CFR 483.21(b), the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care.On 12/4/25, during the end-of-day exit meeting, the concerns were reviewed with the Administrator, Director of Nursing, and the Assistant Director of Nursing, and no further information was provided.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to follow physician orders for oxygen administration for one (1) of 24 residents in the survey sample, Resident #42.The findings include: The facility staff failed to follow the physician's orders regarding the oxygen flow rate and to monitor it for Resident #42. Resident #42 was admitted to the facility originally on 10/09/25 and most recently readmitted on [DATE]. The current diagnoses included a displaced Intertrochanteric fracture of the left Femur. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/14/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #42's cognitive abilities for daily decision making were intact.A review of the Medication Administration Record (MAR) revealed the following: Oxygen at 2L via Nasal Cannula (NC) every shift for Oxygen therapy beginning 11/08/2025. Oxygen Mask, Tubing, and Humidifier Change on Sunday, beginning 11/09/2025.The person-centered care plan dated 11/11/25 revealed that Resident #42 was receiving oxygen therapy relating to oxygen shortness of breath (SOB) and hypoxia. The resident's goal was to have no signs or symptoms of poor oxygen absorption, and an intervention was to have oxygen settings at 2 liters via Nasal Cannula as needed. On 12/02/2025 at approximately 2:20 pm., during the initial tour, Resident #42 was observed sitting up in her wheelchair receiving oxygen. An observation of the flow rate revealed the resident was receiving 3.5 liters of oxygen via nasal canula. The resident said that staff had increased her oxygen and that she now feels comfortable. On 12/04/2025 at approximately 10:11 am, a brief interview was conducted with Resident #42 concerning her oxygen needs. Resident #2 said that she's feeling better this morning. A visual inspection of the resident's oxygen flow rate was performed. The flow rate was set at 3.5 liters instead of the physician's order of 2.0 liters of oxygen.On 12/04/2025 at approximately 10:18 am, a brief interview was conducted with Licensed Practical Nurse (LPN) #2. LPN #2 was asked to verify the resident's oxygen flow rate. Upon visual inspection, LPN #2 said it read 3.5 liters. LPN #2 left to check the resident's orders. LPN #2 returned, stating the orders indicated the resident should receive 2.0 liters of oxygen via nasal cannula. LPN #2 was observed entering the resident's room, speaking to the resident, then observed walking over to the resident's oxygen machine to adjust the flow rate. The Policy revised 12/2025 read: Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and or nasal catheter. Procedure: Verify there is a medical provider's order for this procedure. The order should specify oxygen source, delivery system, flow rate, and if oxygen should be issued continuously or as needed. Documentation: After completing the oxygen set-up or adjustment the following information should be recorded: The date and time procedure was performed.On 12/03/25 at approximately 5:55 pm., during the end-of-day meeting, the Administrator, DON, and Assistant Director of Nursing (ADON) were made aware of the above findings; no further information was provided. On 12/04/25 at approximately 3:45 pm., during pre-exit, the above oxygen flow rate findings were shared with the Administrator, DON, and Assistant Director of Nursing (ADON). 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 of the kitchen, interviews, and facility document review, the facility staff failed to maintain an effective infection prevention and control program designed to provide a sanitary environment to help prevent the development and transmission of communicable diseases and infections among facility residents.Findings included: On 12/2/25 at 11:40 AM, during an initial tour of the main kitchen, the Assistant Administrator of Culinary Services (ADM# 6) was observed in the main kitchen area without a hairnet, and another employee with a blue uniform top was observed walking through the kitchen without a hairnet. According to the Director of Culinary (ADM# 8) the female observed walking through the kitchen was a server from the Independent Living community. When asked what his expectation was for donning hairnets in the kitchen area, he stated, Everyone should wear hairnets, but she is a server from the independent living area and doesn't work in the health care center, I don't know her nameOn 12/2/25, while exiting the kitchen area, a white bed blanket and a white sheet were observed on the top of a dirty linen bin next to an open basket cart. An interview was conducted with the Chef (Other # 4), and he said, Oh, those are clean and are supposed to be in the clean basket here. As he said that, he was observed taking the white blanket and white sheet from the top of the dirty linen bin and tossing it into the clean open cart. An interview was conducted with the Director of Culinary Services (ADM #8) on what his expectations of maintaining a clean/dirty concept and he responded stating that the laundry staff must have put the blanket and sheet on top of the bin and that they were clean When asked again if he felt this was acceptable in maintaining a clean/dirty concept he stated, Well, I guess it doesn't, we will have to speak with the laundry folks, but this is linens used to wipe up spills on floors and such.On 12/2/25, during the end-of-day meeting with the Administrator and Director of Nursing, they were made aware of the findings. According to the Administrator, she did not feel this was an acceptable practice of good infection control practices. A copy of the facility's infection prevention and control policy was requested. The Director of Nursing provided a copy of the policies.A review of the facility's infection prevention and control policy revealed:Page 1 of 19 Infection control requirement definition: The facility (name redacted) has established and is maintaining an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.Page 2 0f 19 - Infection prevention and control program includes (but not limited to) the following elements - wearing gloves and other personal protective equipment (PPE) OHSA considers head coverings like hairnets as personal protective equipment (PPE) that employees must wear especially in food prep or healthcare settings as it is crucial for preventing contamination (like hair falling into food).On 12/4/25, during the end-of-day exit meeting, the following was reviewed with the Administrator, Director of Nursing, and the Assistant Director of Nursing, and no further information was provided.