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	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newport News Nursing & Rehab	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 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** 49455 Based on staff interview, clinical record review, and review of facility documents, the facility staff failed to administer a medication per physician order for one of nine residents, (Resident #8) in the survey sample. The findings included: Resident #8 was admitted to the facility on [DATE] after an acute care hospital stay. The diagnoses included syncope, seizure disorder, diabetes mellitus (DM), alcohol dependence, and human immunodeficiency virus disease (HIV). The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/31/23, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #8 cognitive abilities for daily decision making were intact. In section I(active diagnosis) the resident was coded for seizure disorder. An interview was conducted with Licensed Practical Nurse (LPN) #1, on 11/6/24 at approximately 1:04 PM. LPN #1 stated that she was not able to give Resident #8 his Keppra (levetiracetam) on 12/26/23 because it was not available, and they were waiting on it to come from the pharmacy. An interview was conducted with the Director of Nursing (DON) on 11/6/24 at approximately 2:30 PM, who provided a list of medications that were available in the Omnicell on the days Resident #8 missed doses and acknowledged, the form of medication that was needed for the resident was not available. Review of Resident #8's order summary dated 12/24/23 included an order for levetiracetam 7.5 milliliters (ml) twice daily to treat seizures. Review of Resident #8's medication administration record (MAR) for December 2023 reflects the resident not receiving scheduled levetiracetam on 12/25/23 at 5:00 PM and 12/26/23 at 9:00 AM. For unadministered doses, nursing staff documented a number nine that meant to see progress notes. Review of the progress note for 12/25/23, indicated the nurse was waiting on pharmacy and could not pull medication from the Omnicell. Review of the progress note from 12/26/23, indicated the nurse called pharmacy and was told the levetiracetam would be sent out on the first run that day. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medications available in the Omnicell on 12/25/23 and 12/26/23, was levetiracetam 500 mg tablets. No liquid levetiracetam was available in the Omnicell. The facility's policy titled Administering Medications, with a revision date of 4/2019, indicated medications were to be administered in accordance with prescriber orders. On 11/7/24 at approximately 3:15 PM, the above findings were shared with the RVPO, Administrator, Administration Support, Administrator in Training, Director of Nursing, and Corporate Nurse Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49917 Based on resident interview, staff interview, clinical record review, and review of facility documents, the facility staff failed to protect a resident from leaving the premises or a safe area without the facility's knowledge and supervision for 1 of 9 residents (Resident #4) in the survey sample. The findings included: Resident #4 was originally admitted to the facility 5/4/23. The resident's diagnoses included unspecified dementia, cognitive communication deficit, anxiety disorder, peripheral vascular disease, and type 2 diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/11/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring (-) out of a possible 15. An interview was conducted on 11/7/24 at 3:47 PM with the MDS Coordinator. The MDS Coordinator stated that the (-) means the Brief Interview for Mental Status (BIMS) was not completed. The MDS Coordinator also stated that this was due to the Social Services Department not completing the interview. The MDS Coordinator also voiced that Resident #4's cognitive abilities for decision making are impaired and the resident has cognitive deficits. On 11/4/24 at 1:30 PM an interview was conducted with Resident #4. Resident #4 stated that he believes he cut his wander guard off and left the facility to walk to his apartment. Resident #4 also stated that he really cannot remember much and does not know why he is here. On 11/6/24 at 4:30PM an interview was conducted with the Director of Nursing (DON). The DON stated that on 10/5/24 during the 10:00 PM rounds, the nurse working discovered Resident #4 was not in his room. The DON also stated that the staff initiated the elopement process and called the local authorities. The DON voiced that the Assistant Director of Nursing (ADON) called Resident #4's cell phone number at 11:26 PM on 10/5/24 and the resident informed her that he was at the Advance Auto store. Local authorities were notified and Resident #4 was brought back to the facility. On 11/7/24 at 2:10 PM an interview was conducted with the Regional [NAME] President of Operations (RVPO). The RVPO stated that Resident #4 eloped due to the resident cutting off the wander guard and the staff not supervising the resident to prevent the elopement. A review of Resident #4's nurses note dated 10/6/24 at 3:14 AM read that Resident #4 left the facility without notifying staff and signing out LOA. The nurses note also read that Resident #4 stated that he was at Advance Auto and left because he was told he had to leave. Resident #4 returned back to facility at 11:38 PM. On 11/7/24 at 3:00 PM an interview was conducted with the Nurse Practitioner (NP). The NP stated that Resident #4's cognitive level changes daily. The NP also stated that Resident #4 has a significant psychiatric mental health history. The NP further stated that Resident #4 does not have judgement regarding safety awareness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #4's nurses note dated 12/10/23 at 4:51 PM read: please be advised the (Psychiatric) Psy NP request the wander guard stay on based on the resident at times becomes confused and at risk to elope. A review of Resident #4's Psychiatric mental health progress note dated 8/1/24 at 4:03 PM read: Recommended wander guard due to patients poor insight, judgement and psychiatric history. He is noted with poor safety awareness as well. On 11/7/24 at approximately 4:12 PM, a final interview was conducted with the Administrator, two Assistant Administrators, Director of Nursing and Regional Director of Clinical Services. They had no further comments and voiced no concerns regarding the above information. The Facility's Missing Patient/Resident document with a revision date of 8/1/20 read: An elopement occurs when a patient/resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so, placing the patient/resident at risk for harm or injury.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 49455 Based on facility record review, the facility staffed failed to have an Administrator present for a quarterly quality assurance performance improvement (QAPI) meeting. The findings included: The facility's attendance sheet for the quarterly QAPI meeting dated 9/24/2024, was missing evidence of an Administrator being present. An interview was conducted with the Regional [NAME] President of Operations (RVPO) on 11/7/2024 at approximately 11:20 AM. The RVPO said that he had been functioning as the facility's Administrator since the previous administrator left a few weeks ago. The RVPO shared a copy of the facility's quarterly QAPI meeting sign in sheet for 9/24/24. After it was noted that there was no Administrator's signature, the RVOP was asked if he was sure this was a quarterly meeting and he responded, yes. The facility's policy titled Quality Assurance Performance Improvement Program effective on 11/30/2014, revised on 10/24/22, list the Executive Director (Administrator) as one of the four members who must be present on the QAPI committee. On 11/7/24 at approximately 3:15 PM, the above findings were shared with the RVPO, Administrator, Administration Support, Administrator in Training, Director of Nursing, and Corporate Nurse Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.