STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 3/25/25 through 3/27/25. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey: VA00062557 - Substantiated without a deficiency VA00062826- Substantiated with a deficiency The census in this 60-certified-bed facility was 52 at the time of the survey. The survey sample consisted of 12 resident reviews.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		4/30/25

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

Electronically Signed | 04/23/2025

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F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility staff failed to ensure resident equipment was kept clean for 1 of 12 residents (Resident #7), in the survey sample. The findings included: Resident #7 was originally admitted to the facility 09/17/2021 after an acute care hospital stay. The current diagnoses included advanced dementia, paranoid schizophrenia, and severe protein-calorie malnutrition. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/10/25 coded the resident as not having the ability to complete the Brief Interview	F 584	F-584 1.Resident #7 floor mats were dirty. Staff cleaned Resident #7 floor mats were cleaned upon identification 2.A room-to-room audit of residents rooms who have floor mats was conducted to ensure cleanliness by NHA. 3.The Director of housekeeping and nursing staff will be in-serviced on maintaining a clean comfortable environment by NHA. 4.The administrator/designee will complete random audits weekly x4 weeks and then monthly x2 months to maintain a clean comfortable environment. Results of the audits will be reviewed by the QAPI committee monthly x3 months. Any	

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F 584	Continued From page 2 for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making abilities. The resident's person centered care plan with a revision date of 10/25/24 had a problem which stated "I am at risk for falls related to cognitive impairment, poor safety awareness, and psychotropic medication use". The goal stated "I will not fall and injure myself through next care plan review". The interventions included two mats left and right side of bed for safety/fall risk". On 3/25/25 at 12:50 PM, Resident #7 was observed in a low bed with bilateral mats. The mat between the resident's bed and the roommate's bed was observed with dark stains on it as well as bread crumbs, debris and shoe prints. The fall mats were also observed on 3/26/25 with dark stains, shoe prints, debris and staff standing on the one between the two beds. On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and Vice President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team. The Director of Nursing stated the mats had been removed and new ones put in place. She also stated that staff had been educated that they were not to be walked on and that the environmental services staff would be paying more attention to the fall mats for all residents with them, for they are to be cleaned and disinfected on a regular schedule and removed when they are no longer in good repair.	F 584	discrepancies will be addressed and re-education provided as needed. 5. AOC- 04/30/25	

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F 656	Continued From page 3	F 656		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		4/30/25

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F 656	Continued From page 4 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, family interview, and staff interviews, the facility staff failed to develop person-centerd care plan for a percutaneous endoscopic gastrostomy (PEG) tube for 1 of 12 residents (Resident #8), in the survey sample. The findings included: Resident #8 was originally admitted to the facility 03/03/2023 after an acute care hospital stay. The current diagnoses included vascular dementia and chronic gastric outlet obstruction status post PEG tube placement. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/01/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This indicated Resident #8's cognitive abilities for daily decision making were severely impaired. On 3/25/25 at approximately 12:43 PM during the initial tour an interview was conducted with Resident #8's daughter who was visiting. The daughter lifted the resident's top which revealed a PEG tube. The PEG's external bumper was observed to be position too far from the	F 656	F-656 1.DON reviewed resident #8 care plan. has a percutaneous endoscopic gastrostomy (PEG) tube that we developed a person centered care plan on 4/16/25 and new order received for peg tube. 2.DON/designee completed an audit of residents with percutaneous endoscopic gastrostomy (PEG) tube and currently no other residents have an Peg tube at this time. 3.DON/designee has educated MDS and all licensed nurses on ensuring the development of individualized comprehensive care plans. 4.DON/designee to conduct weekly care plan reviews on all residents with Peg tubes weekly x4 then monthly x2. Results of all audits will be reviewed by the QAPI committee monthly x3 months. Any discrepancies will be addressed and reeducation provided as necessary. 5. AOC- 04/30/25	

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F 656	Continued From page 5 abdominal skin and the insertion site had leakage and presented with small red and raised irritation. The daughter removed gauze from the closet and wiped the site dry, afterwards she applied a split drain sponges around the insertion site. A review of the resident's person centered care plan failed to have a problem secondary to the PEG tube and a review of the current physician's orders failed to reveal an order for the PEG tube, but here were orders for management of the PEG. The orders included one dated 7/15/24 to cleanse and place a dressing to the PEG tube site every day and an order dated 5/08/24 which stated PEG tube - flush with thirty milliliters of water every eight hours for patency. On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and Vice President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team, and they had no comments and voiced no concerns.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide hygiene care for dependent residents for 2 of 12 residents (Residents #2 and #6), in the survey sample.	F 677	F-677 1.Residents #2 and #6 facial hair was shaved by nursing staff, shaved on 3/27/25 Resident #6 was given a shower 3/27/25 @ 1430.	4/30/25

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F 677	Continued From page 6 The findings included: 1. The facility staff failed to remove unwanted hair from the neck and chin of Resident #2. Resident #2 was originally admitted to the facility 12/11/24 after an acute care hospital stay. The current diagnoses included; end stage renal disease, type 2 diabetes mellitus with hyperglycemia, essential hypertension, and muscle weakness. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/18/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were intact. On 3/25/25 at 12:45 PM an interview was conducted with Resident #2. It was observed that Resident # 2's was rubbing her fingers through a large amount of hair on her neck and chin. Resident #2 stated, "I wish they would shave this hair off of my neck and chin." Resident #2 also stated, "they have never asked me if I want to have this hair shaved off of my neck and chin." On 3/27/25 at 12:05 PM an interview was conducted with Resident #2. It was observed that Resident # 2 still had a large amount of hair on her neck and chin. Resident #2 stated, "I wish they would clean me up and shave me." Resident #2 also stated, "I feel so dirty and just want them to clean me and shave me." On 3/27/25 at 2:51 PM an interview was	F 677	2.DON/Designee conducted a 100% audit of all residents to ensure facial hair is groomed and all residents have a schedule for showers x2 weekly. 3.The DON/designee will educate all CNAs on the importance of providing ADL care and making sure facial hair is well groomed and showers are offered with appropriate documentation. IDT Team will be educated to observe on their rounds of any residents that have unwanted or unkept facial hair and to be reported during stand-up meeting. 4.DON/designee will complete 10% random audits daily Monday-Friday x4 weeks and then monthly x2 months to ensure residents are well groomed. Weekly audits on showers x4 weekly monthly x2. Results of the audits will be reviewed by the QAPI committee monthly x3 months. Any discrepancies will be addressed and re-education provided as needed. 5. AOC- 04/30/25	

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F 677	Continued From page 7	F 677		

conducted with Certified Nursing Assistant (CNA) #1. CNA #1 stated, "I saw the hair on her neck and chin. I will be honest with you, I did not ask her if she wanted me to shave her today and I should have." CNA #1 also stated, "I should have shaved her today and I will before I leave if you want me too."

On 3/27/25 at 6:11 PM an interview was conducted with the Administrator. The Administrator stated, "We will be shaving the resident."

The Care Plan with an initiated date of 12/23/24 read that Resident #2 has a physical functioning deficit related to: Mobility impairment, Self care impairment. The goal is resident will improve my current level of physical functioning. The intervention for Resident #2 was Personal Hygiene assistance of (dependent) 1 person.

In section "GG" (Functional Abilities) the resident was coded dependent with Personal Hygiene: the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands(excludes baths, showers, and oral hygiene).

On 3/27/25 at approximately 8:30 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional Director of Clinical Services, and Regional Vice President of Operations. 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.

2. The facility staff failed to provide showers to a

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F 677	Continued From page 8	F 677		

dependent resident (Resident #6).

Resident #6 was originally admitted to the facility 1/9/25 after an acute care hospital stay. The resident's current diagnoses included a stroke resulting in left hemiplegia, spatial neglect of left side, left visual deficit and obstructive sleep apnea. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/15/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #6's cognitive abilities for daily decision making were moderately impaired. In section "GG0130" (Self-Care) of the 1/15/25 MDS assessment the resident was coded as requiring substantial/maximal assistance with shower/bathe.

An interview was conducted with Resident #6 on 3/26/25 at approximately 2:06 PM. The resident stated he was admitted to the facility in early January, and he had received only one shower since his admission. He stated he was told that two showers were scheduled weekly for each resident. The resident further stated he believed if he showered more he would feel better. The resident also stated he was to be shaved on 3/26/25 but he assumed the staff ran out of time because they did not come back to shave him. The resident stated on 3/27/25 at 10:30 AM that CNA #3 stated she would be giving him a shower and shave later on 3/27/25.

A review of the Shower/Bathe documentation on the Documentation Survey Reports revealed no showers were provided in January 2025, one was documented on 2/4/25 and one was documented on 2/18/25 with the resident providing all care

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F 677	Continued From page 9 after he was set-up and the March documentation stated he received showers 3/3/25, 3/6/25, and 3/10/25. The resident identified CNA #6 as the staff member who provided him with the one shower and denied that CNA #5 had provided him with any showers. All shower/bathe entries by CNA #5 were coded the resident was dependent and a shower was provided. On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and Vice President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team and they had no comments and voiced no concerns.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to assess and monitor a surgical wound on a resident's right breast after a breast biopsy was completed; which contributed to the resident becoming septic and hospitalized for 1 of 12 residents (Resident #1), in the survey sample.	F 684	F-684 1.Resident #1 was discharged from the facility 11/11/24. 2.DON/designee assessed and reviewed other residents with surgical wounds and currently no surgical wounds reside in the facility. Any new admissions will be reviewed daily Monday-Friday, admitted	4/30/25

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F 684	Continued From page 10 The findings included: Resident #1 was initially admitted to the facility on 4/16/24 and discharged on 11/11/24. The resident did not return to the nursing facility. The current diagnoses included major depressive disorder. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 04/21/24, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of 15. The care plan dated 4/27/24 read Resident #1 had open areas related to dermatitis of the right buttock and perineum. The goal for Resident #1 is open areas will be free of infection and healing state through the next care plan review on 05/01/2024. The interventions for Resident #1 were: Encourage proper nutrition. If a resident refuses a meal, offer an alternative and provide medication/treatment as ordered by the physician, observe for effectiveness, and use pressure-reducing seats/mattresses as necessary. A general note read: A physician visit was conducted by the facility Physician's Assistant (PA) on 11/11/24, the day of transfer from the nursing facility to the hospital admission. The chief complaint was sepsis. The resident had an elevated temperature and was hypotensive (90/60). Fluids and resuscitation were ordered. "Although the provider doubted her sacral ulcer as the cause of her fever. No other source was identified at this time. A wound care consult was ordered. And local wound care was continued."	F 684	with or surgical site to ensure appropriate assessments and treatments are in place and attending practitioners will be notified of all outside procedures. 3.Regional Nurse educated DON on policy and procedure non-pressure skin condition record., assessment and monitoring of post-surgical wounds. DON/designee will educate all licensed nurses on policy and procedure non-pressure skin condition record., assessment and monitoring of post-surgical wounds. 4.DON/designee will audit residents that have post-surgical wounds and review all new admissions Monday-Friday x4 weeks then monthly x2. Results of all audits will be reviewed by the QAPI committee monthly x3 months. Any discrepancies will be addressed and reeducation provided as necessary. 5. AOC- 04/30/25	

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F 684	Continued From page 11	F 684		

According to medical records and Family Member #1, the resident had a biopsy of her right breast on 10/22/24.

A review of a general progress note on 11/11/24 at 9:00 AM., read: "Resident alert/verbal/responsive with difficulty understanding mumbling of words, eyes dazed in bed, head of bed up no signs and symptoms (s/s) of aspiration, skin clammy, hot/warm to touch, observed not eating breakfast vital signs (v/s) Temperature=100.7, blood pressure (bp)= 93/46, Pulse =93, Respiration =18, Oxygen 02= 83% with return 1min 94% 02 applied as ordered blood sugar (b/s) 86, lung sounds slightly diminished on left, right side clear, cap refill less than 3 seconds, and within normal limits with active bowel sounds large bowel movement."

The progress note dated 11/11/24 at 9:10 AM read: "PA in the facility and updated orders given, unable to do Intravenous (IV). At 9:15 AM, the company called, spoke to staff, and requested midline stat confirmation number given at 9:25 AM., Responsible Party (RP) updated per his request wants resident sent to the Emergency Room/ ER/Treatment 9:30 AM., Message left via PA answering machine along with phone number waiting call back. 09:30 AM., 911 called 9:45 AM., Resident left via stretcher going to the hospital. Resident remains alert/verbal/responsive prior to departure, all peri care done Assistant Director of Nursing (ADON)/Unit Manager (UM) updated, at 11:30 AM., RP updated of departure."

A review of the hospital records dated 11/11/24 at approximately 2:08 PM., read that the patient

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	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12	F 684		

expressed concern that she was not getting adequate care and was not feeling safe at the facility. According to the History and Physical (H&P) the patient was diagnosed with Sepsis (mostly due to draining of the right breast).

On 3/25/25 at approximately 2:15 PM, an interview was conducted with family member (FM) #1 concerning his loved one. FM #1 said that when his mom came into the hospital, she smelled bad from the infections. He also said that she had had a breast biopsy a few weeks before coming here.

On 3/26/25 at approximately 2:50 PM, an interview was conducted with Certified Nursing Assistant (CNA) #1. CNA #1 said that on 11/10/24, before the staff called 911, the resident was seen sleeping a lot. The resident started feeling bad after eating her breakfast. She was nauseated and refused her lunch. CAN#1 said, "The next mornings she didn't look herself, she would open her eyes and not speak, she didn't eat breakfast that morning (11/11/24). LPN #3 helped me turn the resident in because she had a foley catheter. While giving her a bath I noticed a small area on her butt cheek. We put a protective cream on it. She would always have a bowel movement when receiving activities of daily living (ADL) care. Other CNAs said she had a milky substance coming from her breast."

On 3/27/25 at approximately 3:45 PM, an interview was conducted with the Physician Assistant (PA). The PA said that the right breast drainage had been ongoing for some time. The PA also said that he was not informed the resident had a breast procedure done requiring steri strips.

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	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

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F 684	Continued From page 13	F 684		

An interview was conducted on 3/27/25 at approximately 4:00 PM with Corporate Staff #2, the DON, and the facility Administrator. The administrator said that Resident #1 had a work-up for a breast mass, intermittent discharge, and an inverted nipple at the diagnostic center on 10/22/24. The Administrator said, "We saw no progress notes. We should monitor for s/s of infections." The PA and the Medical Director were contacted via telephone during this interview. The DON said, "If they came back with no orders (The Diagnostic Breast Center), you would call the hospital." Corporate Staff #2 asked the PA, "Did you see anything?" The PA said he wasn't aware at all that the resident had a biopsy until the resident went out to another facility (after hospital admission, the resident was discharged to another facility). The PA was asked what the facility was doing to monitor and care for the resident's right breast. The PA said, "That was outpatient. I was not aware of a discharge at that time."

On 3/27/25 at approximately 4:25 PM, a document was presented by Corporate Staff #2. Corporate staff #2 said that the document could not be found in the Medical Records under Point Click Care (PCC) a cloud-based electronic health records (EHR) system; it could only be found under Point Click Care Connect (Optimize care collaboration by connecting to a national-level health data network with hospitals, active resident and patient records, to exchange timely clinical data). The PA and staff present said they were not aware of this system until now. Corporate Staff #2 said that the staff would be educated on Point Click Care Connect because they can access it. The surveyors were not able to retrieve

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	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

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F 684	Continued From page 14	F 684		

any notes or documents as they were not informed of this system until 3/27/25. The retrieved document from Point Click Care Connect was presented to the surveyors by Corporate Staff #2, dated 10/29/24 at 9:45 AM, that read: "Called patient and gave negative biopsy results. Patient very happy with the results, patient has no signs of infection around the biopsy site. Steri strips on and precautions reviewed per protocol. Post operative Biopsy results-Unspecified lump in right breast, subareolar. Pathology from right breast twelve o'clock radius subareolar margin demonstrates benign squamous epithelium with focal acute and chronic inflammation, including giant cells, suggestive of ruptured cyst. Findings are benign. At minimum suggest a 3 month follow-up."

On 3/27/25, at approximately 4:50 PM, Licensed Practical Nurse (LPN) #3 was interviewed. LPN #3 said that she noticed the discharge coming from the resident's right breast and notified the doctor.

The above findings were shared with the Administrator, Corporate Consultant, and Regional Vice President of Operations on 3/27/25 at approximately 7:45 p.m. The facility's staff was offered an opportunity to present additional information, but no additional information was provided.

Steri-Strips (Butterfly Bandage)
Steri-Strips and butterfly bandages are thin, sticky bandages that cover small cuts and some surgical incisions. You apply them across your cut (running in the opposite direction) to help the two sides of your skin stay tightly closed. This helps prevent bacteria from getting in. Seek medical

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	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

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F 684	Continued From page 15	F 684		

care immediately at the first sign of a wound infection.
https://my.clevelandclinic.org/health/treatments/steri-strip-butterfly-bandage

Incision & Surgical Wound Care
An incision is an opening of your skin after surgery. Your surgeon will close this surgical wound with stitches (sutures), staples or adhesives (Steri-Strips). A dressing goes over the closed incision. You'll need to keep your incision clean to prevent infection. Your healthcare provider will give you instructions to take care of your wound.

What is incision and surgical wound care?
Incision and surgical wound care are instructions that you follow to prevent infections and help your body heal. You get these instructions after a surgery or procedure where a surgeon or healthcare provider made an incision (entry point) to access the inside of your body. You'll need to clean and protect your incision site until it heals completely. If you notice any pain, swelling, warmth around the site, or fluid oozing out of your wound, visit a healthcare provider, as you may have an infection.

Adhesives: Adhesives include special tapes and glues that use their stickiness to hold your skin together. A healthcare provider may choose adhesives to close wounds from needles (percutaneous wounds), pediatric wounds or apply them in addition to deep sutures. Adhesives are painless. A common adhesive tape is Steri-Strips®
https://my.clevelandclinic.org/health/treatments/15709-incision-care

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	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

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F 690	Continued From page 16	F 690		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		4/30/25

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	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

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F 690	Continued From page 17 Based on observations, resident interview, staff interviews, and clinical record review, the facility staff failed to provide required care to prevent complications while utilizing an indwelling catheter for 1 of 12 residents (Resident #4), in the survey sample. The findings included: Resident #4 was originally admitted to the facility 03/01/24 after an acute care hospital stay. The current diagnoses included neurogenic uropathy with urinary retention. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 03/09/25 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making abilities. At section H0100 A - the resident was coded for requiring use of an indwelling catheter. A physician order dated 3/6/24 stated Foley Catheter 16 french with a 5 milliliter balloon every shift related to urinary retention. The person centered care plan dated 9/13/24 had a problem which stated "I have a Foley catheter 16 french with a 5 milliliter balloon related to a neurogenic uropathy with urinary retention". The goal stated "I will not experience an infection until next review". The interventions included "Position catheter below bladder, ensure tubing has no kinks, and secure for safety". On 3/25/25 at 1:37 PM Resident #4 was observed in bed with a bedside drainage bag and	F 690	F-690 1.Resident #4 had an indwelling catheter anchor replaced by DON on 3/27/25. 2.An audit of residents with Indwelling Catheters has been conducted by the DON/Designee to confirm that all have an anchor in place. DON procured a new type of catheter stabilizer. 3.DON/designee educated all nursing staff that all indwelling catheters should have a clean stable anchor in place. 4.DON/designee will audit 100% of indwelling catheters weekly x4 then monthly x2 to ensure all foley catheters have an anchor in place. Results of the audits will be reviewed by the QAPI committee monthly x3 months. Any discrepancies will be addressed and re-education provided as needed. 5. AOC- 04/30/25	

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	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

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F 690	Continued From page 18	F 690		

yellow urine in the tubing. An interview was conducted with Resident #4 regarding the indwelling catheter. The resident pulled back her linens and revealed the upper indwelling catheter tubing. The stat lock (a device to stabilize an indwelling catheter) was observed wrapped around the catheter tubing at the point of the aspiration port. Again on 3/26/25 at 12:49 PM the resident's tubing was observed unstabilized and the stat lock was observed wrapped around the tubing.

This information was obtain from the Internet on 3/31/25 - If urinary catheters are not secured appropriately, they can lead to severe trauma of a patient's urethra, potential damage to bladder neck, infection and inflammation, pain and irritation, possible bypassing, accidental dislodging of a catheter and a cleaving (condition whereby the catheter splits the penile or labial tissues).
https://pubmed.ncbi.nlm.nih.gov/24335791/

On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and Vice President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team, and the Director of Nursing stated her observation on 3/27/25 also revealed the catheter tubing was unsecured. The Director of Nursing further stated that the stat locks supplied by the facility were not of a good quality and the catheter was likely to become unsecured because of the adhesive on the product, therefore she authorized the central supply personnel to order a different indwelling catheter stabilizer.

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	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

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F 693	Continued From page 19	F 693		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, family interview, and staff interviews, the facility staff failed to properly care for a percutaneous endoscopic gastrostomy (PEG) tube for 1 of 12 residents (Resident #8), in the survey sample. The findings included: Resident #8 was originally admitted to the facility 03/03/2023 after an acute care hospital stay. The current diagnoses included vascular dementia and chronic gastric outlet obstruction status post	F 693	F-693 1.Resident #8 has a Peg Tube area cleaned and external bumper positioned toward abdominal skin by DON on 3/27/25. 2.DON/designee audited all residents with peg tubes, no other residents currently have a peg tube at this time. 3.DON/designee has educated all license nurses regarding assessing peg tube site to be free of excessive drainage, have a bandage and ensure external bumper is	4/30/25

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	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

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F 693	Continued From page 20 PEG tube placement. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/01/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This indicated Resident #8's cognitive abilities for daily decision making were severely impaired. On 3/25/25 at approximately 12:43 PM during the initial tour an interview was conducted with Resident #8's daughter who was visiting. The daughter lifted the resident's top which revealed a PEG tube. The PEG's external bumper was observed to be position too far from the abdominal skin and the insertion site had leakage and presented with small red and raised irritation. The daughter removed gauze from the closet and wiped the site dry, afterwards she applied a split drain sponges around the insertion site. A review of the resident's person centered care plan failed to have a problem secondary to the PEG tube and a review of the current physician's orders failed to reveal an order for the PEG tube, but here were orders for management of the PEG. The orders included one dated 7/15/24 to cleanse and place a dressing to the PEG tube site every day and an order dated 5/08/24 which stated PEG tube - flush with thirty milliliters of water every eight hours for patency. On 3/27/25 at approximately 10:14 AM the resident's PEG site was observed again after the resident lifted her shirt, The area was again very wet and the split drain sponge was disheveled around the tubing. An interview was conducted with Certified Nursing Assistant (CNA) #6 on	F 693	towards abdominal skin and notify provider with any changes. 4.DON/designee to conduct weekly audits of all peg tubes to ensure they are clean weekly x4 then monthly x2. Results of the audits will be reviewed by the QAPI committee monthly x3 months. Any discrepancies will be addressed and re-education provided as needed. 5. AOC- 04/30/25	

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	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 693	Continued From page 21 3/27/25 at approximately 10:21 AM. CNA #6 stated it was not the CNA's responsibility to clean Resident's #8's PEG site and apply the sponges. CNA #6 stated her role was to let the nurse know if changes were observed or if the PEG appeared to need care. On 3/27/25 at approximately 1:37 PM an interview was conducted with Resident #8's hospice nurse. The hospice nurse stated the residents PEG tube insertion site was irritated because of a fungus and an antifungal had been ordered. On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and Vice President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team. The Director of Nursing stated they had obtained new orders for the residents PEG insertion site.	F 693		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, and clinical record review, the facility staff failed to	F 695	F-695 1.Resident #6 was shaved on 3/27/25 and	4/30/25

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	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

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F 695	Continued From page 22 necessary respiratory care and services for 1 of 12 residents (Resident #6), in the survey sample. The findings included: Resident #6 was originally admitted to the facility 1/9/25 after an acute care hospital stay. The resident's current diagnoses included a stroke resulting in left hemiplegia, spatial neglect of left side, left visual deficit and obstructive sleep apnea. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/15/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #6's cognitive abilities for daily decision making were moderately impaired. The physician's order summary had an order dated 1/20/25 for a C-PAP at previous home settings at bedtime for acute and chronic respiratory failure with hypercapnia and as needed. The person centered care plan with a problem dated 1/29/25 which stated alteration in respiratory status due to sleep apnea. The goal read the resident will have adequate gas exchange as evidenced by no adventitious breath sounds, absence of respiratory distress, and absence of shortness of breath thru the next review. The interventions included monitor to ensure the C-PAP mask in place at nighttime/sleeping time. An interview was conducted with Resident #6 on 3/26/25 at approximately 2:06 PM. The resident stated he utilized a C-PAP (a machine which keeps your airways open while you sleep). The	F 695	CPAP mask was reapplied securely and machine checked for appropriate functioning by nursing staff. 2.Residents with CPAPs/BiPAPS were observed to confirm the mask is secure and machine functioning properly. 3.CNAs educated on shaving residents if indicated and all licensed nurses educated on proper application of CPAP/BIPAP mask and to ensure it fits and machine functions properly. 4.DON/designee to conduct weekly audits of all CPAP/BIPAP machines to ensure functioning properly and fits the face appropriately weekly x4 then monthly x2. Results of the audits will be reviewed by the QAPI committee monthly x3 months. Any discrepancies will be addressed and reeducation provided as needed. 5. AOC- 04/30/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

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F 695	Continued From page 23 resident stated some nights the C-PAP is not applied at all and other times it is misapplied. The resident stated that sometimes the staff applies the C-PAP while he is asleep and he is awaken by water entering his nose or splashing all over him. The resident stated as a result of the water splashing he had to remove the mask because he was no longer capable of draining the tubing and repositioning the C-PAP mask himself. The resident stated that no one asked him why he removed the C-PAP, if they had he would explained that it was not applied appropriately to remain in place, for the water should not have been inside the tubing. On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and Vice President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team and the Corporate Nurse Consultant stated they identified the resident needs to be shaved more often so they can get the good fit of the C-PAP mask.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		4/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

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F 761	Continued From page 24 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility staff failed to secure resident medications on 3/27/25. The findings included: On 3/27/25 at approximately 10:47 AM Licensed Practical Nurse (LPN) #2 was observed passing medications on the 200's hall. LPN #2 went from room to room for seven rooms pulling and administering the medications. In between pulling the medication and administering it to the residents the medication cart was left unlocked making the medications accessible to unauthorized individuals. At 11:06 AM the Administrator was observed coming onto the 200's hall with a visiting male and female to visit a resident. The Administrator observed the unattended, unlocked medication cart in the hallway and went over to it and closed	F 761	F-761 1.The licensed nurse #2 identified leaving the medication cart unlocked was removed and sent home. The Unit Manager took over medication administration at the time of discovery. 2.All medication carts were checked by DON to ensure no medication unsecured. 3.DON/designee educated all licensed nurses the importance of locking medication carts when not in use for the safety of the residents. Licensed nurse #2 was educated on locking carts when not in use for the safety of all residents. 4.DON/designee will audit 100% of medication carts Monday-Friday x4 weeks then monthly x2. Results of the audits will be reviewed by the QAPI committee monthly x3 months. Any discrepancies will be addressed and re-education provided as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 25 the locking mechanisms without saying anything to LPN #2, who was inside a resident's room. When LPN #2 returned to the medication cart, he pulled at a medication drawer but it did not open, he looked around but said nothing. LPN #2 was observed removing the medication cart key from his pocket, unlocked the medication cart and resumed pulling medications for other residents. On 3/27/25 at approximately 4:05 PM LPN #2 was sought for an interview but he was not located. The Director of Nursing stated he was gone for the day. On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and Vice President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team, and they had no comments and voiced no concerns.	F 761	5. AOC- 04/30/25	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		4/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

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F 842	Continued From page 26	F 842		

that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 27 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, it was determined that facility staff failed to maintain a complete record for 1 of 12 residents in the survey sample; Resident #1 The findings included: Resident #1 was originally admitted to the facility on 4/16/24 and discharged on 11/11/24. The current diagnoses included major depressive disorder. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 04/21/24, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of 15. The care plan dated 4/27/24 read Resident #1 had open areas related to dermatitis of the right buttock and perineum. The goal for Resident #1 is for open areas to be free of infection and in a healing state through the following care plan review on 05/01/2024. The interventions for Resident #1 were: Encourage proper nutrition. If	F 842	F-842 1.Resident # 1 was discharged from the facility on 11/11/24, facility was unable to secure the record. 2.The facility will do a 30-day lookback starting on 2/27/25 all transfer ins and outs. 3.Administrator/designee in-serviced medical records to ensure facility to receive records and scan in records to PCC. DON/designee will educate all licensed nurses on Point Click Care Connect and on how to use and review medical records. 4.DON/designee will audit visit notes weekly x4 weeks then monthly x2. NHA/designee will audit weekly x4 then monthly x2. validation that medical records have been uploaded to PCC under documents. Results of the audits will be reviewed by the QAPI committee monthly x3 months. Any discrepancies will be addressed and re-education provided as needed. 5. AOC- 04/30/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

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F 842	Continued From page 28	F 842		

a resident refuses a meal, offer an alternative and provide medication/treatment as ordered by the physician, observe for effectiveness, and provide pressure-reducing seats/mattresses as necessary.

According to medical records and Family Member #1, the resident had a biopsy of her right breast on 10/22/24.

An interview was conducted on 3/27/25 at approximately 4:00 PM with Corporate Staff #2, the DON, and the Facility Administrator. The administrator said that Resident #1 had a work-up for a breast mass, intermittent discharge, and an inverted nipple at the diagnostic center on 10/22/24. "We saw no progress notes." We should monitor for s/s of infections. The PA and the Medical Director were contacted by telephone during this interview. The DON said that "if they came back with no orders (The Diagnostic Breast Center) you would call the hospital). Corporate Staff #2, asked the PA "did you see anything." The PA said he wasn't aware at all that the resident had a biopsy until the resident went out to another facility (after hospital admission, the resident was discharged to another facility). The PA was asked what the facility was doing to monitor and care for the resident's right breast. The PA said, "That was outpatient. I was not aware of a discharge at that time."

On 3/27/25 at approximately 4:25 PM, a document was presented by Corporate Staff #2. Corporate Staff #2 said that the document could not be found in the Medical Records under Point Click Care (PCC) a cloud-based electronic health records (EHR) system; (Optimize care collaboration by connecting to a national-level

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

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F 842	Continued From page 29 health data network with hospitals, active resident and patient records, to exchange timely clinical data). The PA and staff present said they were not aware of this system until now. Corporate Staff #2 said that the staff would be educated on Point Click Care Connect because they can access it. The surveyors could not retrieve any notes or documents as they had not been informed of this system until 3/27/25. The retrieved document from Point Click Care Connect was presented to the surveyors by Corporate Staff #2, dated 10/29/24 at 9:45 AM, which read: "Called patient and gave negative biopsy results. Patient very happy with the results, patient has no signs of infection around the biopsy site. Steri strips on and precautions reviewed per protocol. Post operative Biopsy results-Unspecified lump in right breast, subareolar. Pathology from right breast twelve o'clock radius subareolar margin demonstrates benign squamous epithelium with focal acute and chronic inflammation, including giant cells, suggestive of ruptured cyst. Findings are benign. At minimum suggest a 3 month follow-up." On 3/27/25 at approximately 7:45 p.m., the above findings were shared with the Administrator, Corporate Consultant and the Regional Vice-President of Operations. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following:	F 849		4/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

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F 849	Continued From page 30	F 849		

(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.
(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 31	F 849		

(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 32	F 849		

(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 33 attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation staff interviews and a clinical record review, the facility staff failed to establish/provide collaborative care (Hospice) for	F 849	F-849 1.Resident #7/#8/#12 NHA/designee had collaborated with hospice agencies, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 34 3 of 12 residents (Resident #7, 8, and 12), in the survey sample. The findings included: 1. Resident #7 was originally admitted to the facility 09/17/2021 after an acute care hospital stay. The current diagnoses included advanced dementia, paranoid schizophrenia, and severe protein-calorie malnutrition. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/10/25 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making abilities. A physician order dated 2/12/24 stated (name of the hospice agency) to evaluate and treat. A hospice agency document dated 2/14/24 stated the resident elected hospices services 2/14/24. A review of the resident's clinical record failed to reveal collaboration between the facility and the hospice agency in development of a plan of care between the facility and the hospice agency and evidence of the hospice agency's participation in the resident's interdisciplinary care plan meeting. On 3/27/25 at 1:37 PM an interview was conducted with the resident's visiting hospice primary care nurse. The hospice nurse stated she does not participate in the resident care plan meetings at this facility and the facility's staff is not permitted to participate in their biweekly care planning meetings. The hospice nurse further stated she does not combine her care documents	F 849	have been scheduled for care plan meetings. DON/designee obtained an order for hospice services for residents #8. 2.DON/designee conducted an audit of the resident of hospice services to ensure collaboration of care and services with an interdisciplinary care plan. NHA/designee has scheduled meetings with hospice companies to set expectations of the facility with hospice services. 3.Administrator/designee will educate clinical leadership, medical records and social service on the importance of getting timely and proper documentation from the hospice companies. 4.DON/designee will audit all hospice residents to ensure notes, care plans are up to date and easily accessible to staff weekly x4 then monthly x2. Results of the audits will be reviewed by the QAPI committee monthly x3 months. Any discrepancies will be addressed and re-education provided as needed. 5. AOC- 04/30/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 35	F 849		

and assessments with the facility's documents because hospice documents are kept in a book at the nurse's station. She also stated the facility can call the hospice agency's office and request other documentation they would like.

A review of the resident's clinical record revealed some dates the hospice disciplines visited the resident and general forms of what they did such as "assessments, case manage, wound care and refill medications", no specifics or details regarding the resident's care was documented.

An interview was conducted with the facility's Social Services Director (SSD) on 3/27/25 at approximately 5:20 PM. The SSD stated she had no documentation to support that the hospice agency participated in Resident #7's care plan conferences but she would make sure they were invited and participated going forward.

On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and Vice President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team, and they had no comments and voiced no concerns.

2. Resident #8 was originally admitted to the facility 03/03/2023 after an acute care hospital stay. The current diagnoses included vascular dementia and chronic gastric outlet obstruction status post PEG tube placement.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/01/25 coded the resident as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 36	F 849		

completing the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This indicated Resident #8's cognitive abilities for daily decision making were severely impaired.

A physician's order dated 7/19/24 stated to consult (name of the hospice agency) to evaluate related to unspecified intestinal obstruction, unspecified as to partial versus complete obstruction.

A document completed by a hospice agency representative on 7/21/24 titled Hospice IDG comprehensive assessment and Plan of Care Update Report revealed the resident was a new admission for hospice services. The resident's record has no order to be admitted for hospice services. Otherwise there is only a progress note of a care plan meeting dated 7/24/24 which stated the resident recently entered hospice services. The participants did not include a representative from the hospice agency.

On 3/27/25 at 1:37 PM an interview was conducted with the resident's visiting hospice primary care nurse. The hospice nurse stated she does not participate in the resident care plan meetings at this facility and the facility's staff is not permitted to participate in their biweekly care planning meetings. The hospice nurse further stated she does not combine her care documents and assessments with the facility's documents because hospice documents are kept in a book at the nurse's station.

The hospice nurse also stated until recently she did not provide wound measurements to the facility because they were hospice measurements and not for the facility. The hospice nurse stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 37	F 849		

the facility's staff requested the wound assessment documents therefore they were provided by the hospice office A review of the resident's clinical record revealed some dates the hospice disciplines visited the resident and general forms of what they did such as "assessments, case manage, wound care and refill medications", no specifics or details regarding the resident's care was documented.

An interview was conducted with the facility's Social Services Director (SSD) on 3/27/25 at approximately 5:20 PM. The SSD stated she had documentation to support the hospice agency participated in Resident #8's care plan conferences on 1/3/24 and 11/6/24, but the hospice agency did not participate in the care plan conferences in between 1/3/24 and 11/6/24 or the most recent care plan conference on 2/5/25.

On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and Vice President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team, and they had no comments and voiced no concerns.

3. The facility's staff failed to provide a Hospice Care Plan, nurses notes and other dispositions for Resident #12. Resident #12 was originally admitted to the facility 1/13/23 and readmitted 1/18/25 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; End Stage Renal Disease.

The significant Minimum Data Set (MDS)

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F 849	Continued From page 38	F 849		

assessment with an assessment reference date (ARD) of 1/24/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #12 cognitive abilities for daily decision making were severely impaired.

The person-centered care plan dated 1/27/25 read Resident #12 is on hospice relating to end of life care. The Goal for Resident #12 Patient will be comfortable and have needs meet. The interventions for Resident #12 were: Evaluate effectiveness of medications/interventions to address comfort and Respect patient and family wishes.

In Section "O" Special Treatments and Programs. K1= Coded resident as receiving Hospice Care.

A care plan review note dated 02/05/2025 at 2:31 PM., read:
Resident had her care plan meeting. In attendance was the SSD, MDS, and UM. Resident declined to attend. Resident is staying at the facility for LTC and has a code status of DNR.

According to the above care plan meeting note. Hospice was not in attendance.

On 3/27/25 at 1:37 PM an interview was conducted with the resident's visiting hospice primary care nurse. The hospice nurse stated she does not participate in the resident care plan meetings at this facility and the facility's staff is not permitted to participate in their biweekly care planning meetings. The hospice nurse further stated she does not combine her care documents and assessments with the facility's documents

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F 849	Continued From page 39	F 849		

because hospice documents are kept in a book at the nurse's station. She also stated the facility can call the hospice agency's office and request other documentation they would like.

An interview was conducted with the facility's Social Services Director (SSD) on 3/27/25 at approximately 5:20 PM. The SSD stated she had no documentation to support that the hospice agency participated in Resident #12's care plan conferences, but she would make sure they were invited and participated going forward.

On 3/27/25 at approximately 7:45 p.m., the above findings were shared with the Administrator, Corporate Consultant and the Regional Vice-President of Operations. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.