STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	R-C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

(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 revisit survey to the abbreviated standard survey that ended 2/27/25, was conducted 6/2/25 through 6/4/25. Corrections corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Uncorrected deficiencies are identified within this report. The census in this 120 certified bed facility was 103 at the time of the survey. The survey sample consisted of 6 resident reviews.	{F 000}		
{F 583} SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	{F 583}		6/30/25

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

Electronically Signed | 04/09/2025

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{F 583}	Continued From page 1 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and review of facility documents, the facility's staff failed to ensure a Resident was allowed privacy during wound care for 1 of 6 residents (Resident #106), in the survey sample. The findings included: Resident #106 was originally admitted to the facility 3/31/25 after an acute care hospital stay. The current diagnoses included; Difficulty in walking. The admission, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 04/06/25 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 moderately impaired for daily decision making. The admission, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/06/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible. This indicated Resident #106 cognitive abilities for	{F 583}	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F583: Personal Privacy/Confidentiality of Records 1. Resident #106 no longer resides in the facility. 2. Current residents receiving wound care have the potential to be affected. Reviewed resident records from June 10, 2025, through June 13, 2025, with no discrepancies. 3. Staff Development Coordinator or designee will educate licensed nursing staff on maintaining resident privacy and dignity during wound care. 4. Unit Manager or designee will audit	

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{F 583}	Continued From page 2 daily decision making were intact. In section"G"(Physical functioning) the resident was coded as requiring supervision of one person with oral hygiene, toileting hygiene. Requiring set-up help with eating, upper body dressing, personal hygiene. The care plan dated 4/29/25 read that Resident #106 has a pressure ulcer of the left heel unstageable. The Resident has a risk for worsening wound(s) or the development of additional wounds related to (r/t) chronic health conditions, immobility and incontinence. The Goal for Resident #106, the resident will not develop any further skin impairment thru the review period dated 4/29/25. The interventions for the resident are to assess the resident for risk of skin breakdown and assist the resident to turn and reposition often. On 6/03/25 at approximately 10:52 AM., the Wound Care Nurse/ Registered Nurse (RN) #3 was observed providing wound care on Resident #106 with the residents' room door and entry door from the hallway open to staff and or visitors. During wound care a staff was observed walking by. On 6/03/25 at approximately 11:10 AM., a brief interview was conducted with RN #3 shortly after the wound care for Resident #106 was completed. RN #3 said that she should have closed the door. On 06/04/25 at approximately 5:25 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the	{F 583}	ten residents per week for four weeks to verify the door is closed while residents are receiving wound care to ensure privacy and maintain dignity. All findings will be reported to the QA Committee and the action plan will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists, the review will be conducted on a random basis. 5. Date of compliance: June 30, 2025.	

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{F 583}	Continued From page 3 facility's staff to present additional information but no additional information was provided.	{F 583}		
{F 656} SS=D	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	{F 656}		6/30/25

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{F 656}	Continued From page 4 community was assessed and any referrals to local contact agencies and/or other appropriate 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 observation, staff interview, clinical record review, and review of facility documents, the facility Staff failed to develop and implement a comprehensive person-centered care plan for care and services to maintain the highest practicable well-being for 2 out of 6 residents (Resident #101 and Resident #106), in the survey sample. The findings included: 1.The facility staff failed to develop a comprehensive care plan with interventions that addressed Resident #101 was on Enhanced Barrier Precautions (EHB) due to having wounds. Resident #101 was originally admitted to the facility 03/31/25 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; muscle weakness generalize. The significant change, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 04/06/25 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was	{F 656}	F656: Develop/Implement Comprehensive Care Plan 1. Resident #106 no longer resides in the facility. Resident #101 currently resides in the facility. Enhanced barrier precautions were added to Resident #101□s care plan on June 3, 2025. 2. Current residents with pressure ulcers have the potential to be affected. Reviewed resident care plans with pressure ulcers for enhanced barrier precaution accuracy on June 10, 2025. 3. Regional MDS Coordinator will educate MDS Coordinators and Infection Preventionist on enhanced barrier inclusion requirements. 4. Infection Preventionist or designee will audit five resident care plans weekly for four weeks, focusing on those with pressure ulcers, to ensure enhanced barrier precautions are developed in residents□ care plans. All findings will be reported to the QA Committee and the	

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{F 656}	Continued From page 5 coded for long and short term memory problems as well as severely impaired for daily decision making. The care plan dated 2/12/25 read resident had pressure ulcers to Right heel stage 3 and is at risk for worsening wound(s) or the development of additional wounds related to: cognitive impairment, frequent incontinence, immobility, inability to turn and reposition independently, malnutrition. The Goal for resident #101 is the resident's wound will show s/s (signs and symptoms) of healing thru the review (5/21/25). The interventions are to assess resident for risk of skin breakdown and assist the resident to turn and reposition often. On 6/03/25 at approximately 10:40 AM., a visual observation was made prior to entrance of the residents' room, no Enhanced Barrier Precaution (EBP) Signage nor set up with Personal Protective Equipment was noticed. The Wound Care Nurse/ Registered Nurse (RN) #3 was observed providing wound care on Resident #101 without wearing a gown (PPE). The findings included: 2. The facility staff failed to develop a comprehensive care plan with interventions that addressed Resident #106 should be on Enhanced Barrier Precautions (EHB) due to having wounds. Resident #106 was originally admitted to the facility on 3/31/25 after an acute care hospital stay. The current diagnoses included; Hip Fracture. The admission, Minimum Data Set (MDS) assessment with an assessment reference date	{F 656}	action plan will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists, the review will be conducted on a random basis. 5. Date of Compliance: June 30, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 656}	Continued From page 6	{F 656}		

(ARD) of 4/06/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible. This indicated Resident #106 cognitive abilities for daily decision making were intact.

The care plan dated 4/29/25 read that Resident #106 has a pressure ulcer of the left heel unstageable. The Resident has a risk for worsening wound(s) or the development of additional wounds related to (r/t) chronic health conditions, immobility and incontinence. The Goal for Resident #106, the resident will not develop any further skin impairment thru the review period dated 4/29/25. The interventions for the resident are to assess the resident for risk of skin breakdown and assist the resident to turn and reposition often.

On 6/03/25 at approximately 10:51 AM., a visual observation was made prior to entrance of the residents' room, no Enhanced Barrier Precaution (EBP) Signage nor set up with Personal Protective Equipment was noticed. The Wound Care Nurse/ Registered Nurse (RN) #3 was observed providing wound care on Resident #106 without wearing a gown (PPE).

On 6/03/25 at approximately 11:00 AM., a brief interview was conducted with RN #3 shortly after the wound care for Resident #106 was completed. RN #3 said that she wasn't aware of EBPs.

On 6/03/25 at approximately 12:30 PM., an interview was conducted with the Infection Preventionist (IP) concerning Resident #101 and Resident #106. The IP said that EBPs should be followed due to blood, body fluids and any open

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{F 656}	Continued From page 7 areas. On 6/04/25 at approximately 3:10 PM., a brief interview was conducted with the Regional Minimum Data Set Coordinator (RMDSC). The RMDSC said that the changes should have been updated in the resident's care plan. Enhanced barrier precautions (EBP), with the use of PPE is expanded for everyone's protection. Staff are required to use gown and during high-contact resident care activities that might result in the transfer of multidrug-resistant organisms (MDROs) to staff hands and clothing. MDROs then may be indirectly transferred from resident to resident during these high-contact activities, such as: Dressing, bathing and showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: Central line indwelling urinary catheter (IUC), feeding tube, tracheostomy/ventilator, Wound care: any skin opening requiring a dressing2 https://www.medline.com/strategies/infection-prevention/enhanced-barrier-precautions-for-nursing-homes. On 06/04/25 at approximately 5:25 PM., the above findings were shared with the Administrator, Director of Nursing (DON) and Corporate Consultant. No other information was given.	{F 656}		
{F 658} SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	{F 658}		6/30/25

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{F 658}	Continued From page 8 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and review of facility documents, the facility Staff failed to follow professional nursing standards of quality regarding medication administration for one out of six residents, Resident #106, in the survey sample. The findings included: The facility staff failed to provide orders to remove a Lidocaine Patch. Resident #106 was originally admitted to the facility 3/31/25 after an acute care hospital stay. The current diagnoses included; Hip Fracture. The admission, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/06/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible. This indicated Resident #106 cognitive abilities for daily decision making were intact. The care plan dated 4/29/25 read that Resident #106 has a pressure ulcer of the left heel unstageable. The Resident has a risk for worsening wound(s) or the development of additional wounds related to (r/t) chronic health conditions, immobility and incontinence. The Goal for Resident #106, the resident will not develop any further skin impairment thru the review period dated 4/29/25. The interventions for the resident are to assess the resident for risk of skin breakdown and assist the resident to turn and reposition often.	{F 658}	F658: Services Provided Meet Professional Standards 1. Resident #106 no longer resides in the facility. 2. Current residents with a physician order for a lidocaine patch have the potential to be affected. Reviewed resident orders for lidocaine patches to include orders for removal on June 10, 2025. 3. Director of Nursing or designee will educate all licensed nursing staff on the necessity of having physician orders for both application and removal of lidocaine patches. 4. Director of Nursing or designee will audit five medication orders weekly for four weeks to ensure all lidocaine patch orders include application and removal times. All findings will be reported to the QA Committee and the action plan will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists, the review will be conducted on a random basis. 5. Date of Compliance: June 30, 2025.	

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{F 658}	Continued From page 9	{F 658}		

The April 2025 Physician's Order Summary (POS) read: Lidocaine Patch 4 % Apply to Left lateral heel topically one time a day for pain: 1/2 patch to lateral heel 12hrs on/off for 10 Days (Active 04/14/2025 04/15/2025 04/25/2025).

Lidocaine Patch 4% Apply to Left lateral heel topically one time a day for pain: 1/2 patch to lateral heel 12 hrs on/off for 10 Days -Order Date- 04/14/2025 at 8:56 am., and discontinue on 04/25/25 at 6:50 am.

A review of the Medication Administration Record (MAR) revealed that Resident #106 was applied 10 4% Lidocaine Patches at 8:00 am. but no order was given to remove the 4% Lidocaine Patch.

On 6/03/25 at approximately 1:25 pm., a brief interview was conducted with Resident #106. Resident #106 said that she received her left heel ulcer when the facility doctor pulled off a pain patch on her left heel, taking most of the skin off of her heel.

On 6/03/25 at approximately 10:51 am., a visual observation was made with Registered Nurse #3 providing wound care to Resident's left heel.

On 6/04/25 at approximately 5:02 pm., an interview was conducted with the Regional Nurse Consultant (RNC). The RNC said that there should have been orders to take the pain patch off.

On 06/04/25 at approximately 5:25 pm., the above findings were shared with the Administrator, Director of Nursing (DON) and

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{F 658}	Continued From page 10 Corporate Consultant.	{F 658}		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to ensure residents was provided adequate supervision and a functional assistive device to remain free of accident hazards for one of 6 residents in the survey sample, Resident #105. The findings included: The facility staff failed to provide a functional assistive device and to ensure Resident #105 remained free of accident hazards when the resident walked across a three lane highway located across from the facility where he resided. Resident #105 was assessed to require a wander guard due to an exit seeking behavior and scored as a high risk for elopement on 4/26/25. Resident #105 was originally admitted to the facility 09/09/22 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Unspecified Dementia, Unspecified Severity,	{F 689}	F689: Free of Accident Hazards/Supervision/Devices 1. Resident #105 currently resides in the facility. Resident wander guard was replaced and tested for functionality on April 26, 2025. All facility doors tested for functionality on April 26, 2025. 2. Wander guard residents have the potential to be affected. Reviewed resident wander guards for functionality daily starting April 26, 2025. 3. Staff Development Coordinator or designee will educate all facility staff on elopement/exit-seeking behaviors and search/reporting of missing resident. 4. Director of Nursing or designee will audit all wander guards for functionality daily for four weeks. All findings will be reported to the QA Committee and the action plan will be presented to the QAPI committee for review and	6/30/25

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{F 689}	Continued From page 11 Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and anxiety. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 05/26/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #105 cognitive abilities for daily decision making were moderately impaired. In section"GG"(Functional Abilities Goals) the resident was coded as requiring supervision with bed mobility and transfers. Requiring supervision of one person with toilet use. The person-centered care plan revised on 4/28/25 read the resident is at risk for elopement related to leaving the facility and forgetting to sign out with his Nurse. Has a wander guard to left wrist that expires on 2/2028. The Goal for the resident the resident will not elope thru the review period 5/20/25. The interventions for the resident include: an elopement risk assessment as needed, Redirect from exit, replace elopement band as needed, wander guard on left ankle expires 11/25. A review of the April 2025 Medication Administration Record (MAR) read: Check Wander Prevention patient band every shift to left ankle expires (exp.) 11/2025. Monitor skin integrity to left ankle every shift (qshift) order date. All shifts were checked off by staff. A review of the May 2025 MAR read: Check Wander Prevention patient band qshift to left wrist exp. 02/2028 Monitor skin integrity to left wrist every shift dated 4/28/25 at 11:39 am. All shifts	{F 689}	recommendation. Once the committee determines the problem no longer exists, the review will be conducted on a random basis. 5. Date of Compliance: June 30, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	R-C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 689}	Continued From page 12	{F 689}		

were checked off by staff.

A review of the June 2025 MAR read: Check Wander Prevention patient band qshift to left wrist exp 02/2028 Monitor skin integrity to left wrist every shift.

A review of a Health Status Note dated 4/26/25 at 3:30 pm., read Patient had an elopement across the street. Head to toe assessment completed. No injuries. Summary: history of dementia, epilepsy, alcohol abuse was found wandering across the street from the facility earlier today. According to nursing staff, the patient was last seen at 3:15 PM and he was found across the street at 3:20 PM. He was escorted back to the facility.

A review of a Health Status Note dated 4/26/25 at 4:15 pm., read that "a head-to-toe assessment was conducted, no injuries, patient denies pain and is at baseline. Wander guard removed from L ankle. New wander guard placed to L wrist, tag expires on 2/2028, tested and functional. On call provider notified of elopement, caseworker, patients Responsible Party (RP). They have been notified of the incident."

04/29/2025 13:34 Type: A Medical Progress Note dated 4/29/25 at 1:34 pm., read that Resident #105 "had an incident over the weekend. Patient is elopement risk and wears a wander guard. Wander guard malfunctioned at time point and patient was able to bypass door alarms and make it outside. Was found by staff shortly thereafter not far from the facility and returned unharmed. Patient would benefit from being on a locked dementia unit. No obvious issues today. Patient continues to be a risk related to advanced

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	495418	A. BUILDING _____ B. WING _____	R-C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

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{F 689}	Continued From page 13	{F 689}		

dementia signs and symptoms."

On 6/02/25 at approximately 1:15 pm., a brief interview was conducted with Resident #105 concerning his elopement. Resident #105 was observed resting quietly in his bed, a wander guard was observed on his left wrist. Resident #105 said that he fell a while ago while outside but was unable to verbalize the incident surrounding his elopement.

On 6/02/25 at approximately 3:35 pm., an interview was conducted with Registered Nurse (RN) #4. RN #4 said that as she was coming on her shift at 3:00 pm., she and Licensed Practical Nurse (LPN) #1 noticed that Resident #105 wasn't in his room. "We went across the street and saw him walking across the parking lot. He was very confused; we redirect him, and he came back with us. We checked ankle monitor."

On 6/02/25 at approximately 3:10 PM., an interview was conducted with Certified Nursing Assistant (CNA) #2. CNA #2 said that she came in to work and noticed that the resident wasn't on the floor. CNA #2 also said that someone from dietary informed them that the resident was seen outside of the building.

On 6/02/25 at approximately 3:40 PM., an interview was conducted with Other Staff (OS) #3. OS #3 said that as he was walking across the street with another staff to the sub shop, he noticed Resident #105. OS #3 also said that he informed a staff member, who came and got the resident.

On 6/04/25 at approximately 11:35 am., an interview was conducted with LPN #1 concerning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	R-C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

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{F 689}	Continued From page 14	{F 689}		

the elopement. LPN#1 said that he was informed by a dietary staff that the resident was seen across the street. "I went to get him, and he was at the coffee shop. The facility door didn't alarm." LPN #1 also said that after the door didn't alarm while resident was wearing his wander guard; they check every wander guard in the building.

On 6/04/25 at approximately 12:00 pm., an interview was conducted with OS #2(Dietary Aide). OS #2 said that she took her lunch break around 3:00 pm., crossed the parking lot and was coming back towards the facility when she saw Resident #105 ambulating with a walker eventually crossing the road. "I wasn't sure that it was him because I'm not used to seeing him with a walker." OS #2 also mentioned that to make sure it was him, she went to his room and didn't see him, informing the nursing staff. OS #2 also said that she and LPN #1, went across the road and saw the resident further down near a coffee shop.

The facility's policy "Elopement/Exit-Seeking Behaviors. Dated: 1/29/24. The policy reads: The Elopement Risk Tool Assessment will be used to evaluate a patient's risk of elopement/exit seeking. If a patient is determined to be at risk of elopement/exit-seeking, an intervention using safety/security system, (Wander guard, Roam alert, etc.) will be assessed for appropriateness.

On 06/04/25 at approximately 5:25 PM., the above findings were shared with the Administrator, Director of Nursing (DON) and Corporate Consultant. No additional documents were provided.

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	495418	A. BUILDING _____ B. WING _____	R-C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 868	Continued From page 15	F 868		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.	F 868		6/30/25

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	495418	A. BUILDING _____ B. WING _____	R-C 06/04/2025

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F 868	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure the Infection Preventionist was present for one of 1 QAPI meeting, and failed to meet at least quarterly and as needed to coordinate activties to prevent a repeated quality of care area, Accidents/Supervision under the QAPI program. The findings included: On 6/4/25 at 2:45 PM an interview was conducted with the Administrator and Assistant Administrator. The Administrator stated that he started working in the facility at the end of April 2025 and the last Quality Assurance/Performance Improvement(QAPI) meeting conducted at the facility was on 2/21/25. The Administrator also stated that during the last QAPI meeting on 2/21/25 an Infection Preventionist did not attend the meeting. The Administrator further stated that a QAPI meeting should be conducted every Quarter and the facility is not in compliance with this regulation. The current survey repeated a quality deficiency, Accident/supervision (F689). A review of the QAPI/QAA Committee Agenda/Meeting Topics document dated 2/21/25 read that the Infection Preventionist was not present. Also the date of this meeting was the last QAPI meeting conducted at the facility. The facility's QAPI policy with an effective date of 9/23/24 read: The committee membership includes the Administrator, Director of Nursing, Medical Director, Infection Preventionist, and at least two other Center designated employees.	F 868	F868: QAPI Program and Committee 1. A QAPI meeting with an infection preventionist was convened on June 11, 2025, upon identification of the lapse, to include coordination of activities to prevent a repeated quality of care area to include Accidents/Supervision/Devices. 2. All departments have the potential to be affected during a lapse in QAPI oversight. 3. Regional Vice President of Operations will educate Administrator on CMS requirements for QAPI. 4. Administrator will review the QAPI calendar monthly to ensure meetings occur as scheduled with an infection preventionist present and to coordinate activities to prevent a repeated quality of care area to include Accidents/Supervision/Devices. All findings will be reported to the QA Committee and the action plan will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists, the review will be conducted on a random basis. 5. Date of Compliance: June 30, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 868	Continued From page 17 The policy also read: The QAPI Committee is scheduled to meet a minimum of quarterly. On 6/4/25 at approximately 6:35 p.m., a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing, Regional MDS Coordinator, and Regional Nursing Consultant. 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.	F 868		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880		6/30/25

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	495418	A. BUILDING _____ B. WING _____	R-C 06/04/2025

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F 880	Continued From page 18 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 19 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and review of facility documents, the facility Staff failed to ensure Enhanced Barrier Precaution (EBP) signage was initiated for two out of 6 residents to prevent the spread of infection and the facility staff failed to follow Enhanced Barrier Precautions (EBPs) for these same residents while providing wound care for Resident #101 and Resident #106, in the survey sample. The findings included: 1. The facility staff failed to ensure Enhanced Barrier Precaution (EBP) signage was posted and the facility staff failed to ensure that Enhanced Barrier Precautions (EBP)were followed prior to conducting wound care for Resident #101. Resident #101 was originally admitted to the facility 03/31/25 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; muscle weakness generalize. The significant change, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 04/06/25 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 for daily decision making. The care plan dated 2/12/25 read resident had	F 880	F880: Infection Prevention and Control 1. Resident #106 no longer resides in the facility. Resident #101 currently resides in the facility. Isolation bins and appropriate enhanced barrier precaution signage were placed outside the rooms of residents with pressure ulcers on June 3, 2025. 2. All residents with pressure ulcers have the potential to be affected. Reviewed residents on enhanced barrier precautions to ensure isolation bins and appropriate enhanced barrier precaution signage were in place for residents with pressure ulcers on June 3, 2025. 3. Infection Preventionist or designee will educate all licensed nursing staff on enhanced barrier precautions for residents with pressure ulcers. 4. Infection Preventionist or designee will audit ten residents with pressure ulcers a week for four weeks to ensure proper enhanced barrier precaution signage and isolation bins are in place. All findings will be reported to the QA Committee and the action plan will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists, the review will be conducted on a random basis.	

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F 880	Continued From page 20 pressure ulcers to Right heel stage 3 and is at risk for worsening wound(s) or the development of additional wounds related to: cognitive impairment, frequent incontinence, immobility, inability to turn and reposition independently, malnutrition. The Goal for resident #101 is the resident's wound will show s/s (signs and symptoms) of healing thru the review (5/21/25). The interventions are to assess resident for risk of skin breakdown and assist the resident to turn and reposition often. On 6/03/25 at approximately 10:40 AM., a visual observation was made prior to entrance of the residents' room, no Enhanced Barrier Precaution (EBP) Signage nor set up with Personal Protective Equipment was noticed. The Wound Care Nurse/ Registered Nurse (RN) #3 was observed providing wound care on Resident #101 without wearing a gown (PPE). 2. The facility staff failed to ensure Enhanced Barrier Precaution (EBP) signage and precautions were followed prior to performing wound care for Resident #106. Resident #106 was originally admitted to the facility 3/31/25 after an acute care hospital stay. The current diagnoses included; Hip Fracture. The admission, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/06/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible. This indicated Resident #106 cognitive abilities for daily decision making were intact. The care plan dated 4/29/25 read that Resident #106 has a pressure ulcer of the left heel	F 880	5. Date of Compliance: June 30, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495418	A. BUILDING _____ B. WING _____	R-C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

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F 880	Continued From page 21	F 880		

unstageable. The Resident has a risk for worsening wound(s) or the development of additional wounds related to (r/t) chronic health conditions, immobility and incontinence. The Goal for Resident #106, the resident will not develop any further skin impairment thru the review period dated 4/29/25. The interventions for the resident are to assess the resident for risk of skin breakdown and assist the resident to turn and reposition often.

On 6/03/25 at approximately 10:51 AM., a visual observation was made prior to entrance of the residents' room, no Enhanced Barrier Precaution (EBP) Signage nor set up with Personal Protective Equipment was noticed. The Wound Care Nurse/ Registered Nurse (RN) #3 was observed providing wound care on Resident #106 without wearing a gown (PPE).

On 6/03/25 at approximately 11:00 AM., a brief interview was conducted with RN #3 shortly after the wound care for Resident #106 was completed. RN #3 said that she wasn't aware of EBPs.

On 6/03/25 at approximately 12:30 PM., an interview was conducted with the Infection Preventionist (IP)concerning Resident #101 and Resident #106. The IP said that EBPs should be followed due to blood, body fluids and any open areas.

Enhanced barrier precautions (EBP), with the use of PPE is expanded for everyone's protection. Staff are required to use gown and during high-contact resident care activities that might result in the transfer of multidrug-resistant organisms (MDROs) to staff hands and clothing.

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F 880	Continued From page 22 MDROs then may be indirectly transferred from resident to resident during these high-contact activities, such as: Dressing, bathing and showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: Central line indwelling urinary catheter (IUC), feeding tube, tracheostomy/ventilator, Wound care: any skin opening requiring a dressing2 https://www.medline.com/strategies/infection-prevention/enhanced-barrier-precautions-for-nursing-homes. On 06/04/25 at approximately 5:25 PM., the above findings were shared with the Administrator, Director of Nursing (DON) and Corporate Consultant. The DON said that when a resident has wounds Enhanced Barrier Precautions should be followed.	F 880		