# DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495369	B. WING		<u> </u>	06/22/2017	
	PROVIDER OR SUPPLIER	ER AT PATRIOTS COLONY		6000	EET ADDRESS, CITY, STATE, ZIP CODE PATRIOTS COLONY DRIVE LIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE COMPLETION	
F 000	INITIAL COMMEN	ΤS	FO	000		·	
	conducted 6-20-17 complaint was inve Corrections are red						
F 157 SS=D	at the time of the si consisted of 13 cur (Residents #1 throu record reviews (Re		F 1	57		7/24/17	
	(g)(14) Notification	of Changes.					
	consult with the res	nmediately inform the resident; sident's physician; and notify, or her authority, the resident then there is-	:				
	` •	olving the resident which I has the potential for requiring on;					
	mental, or psychos deterioration in hea	ange in the resident's physical, ocial status (that is, a alth, mental, or psychosocial threatening conditions or ns);					
·	a need to discontin	treatment significantly (that is, ue an existing form of dverse consequences, or to form of treatment); or					
LABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE	(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

07/17/2017

#### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	C	X3) DATE SURVEY COMPLETED
		495369	B. WING			06/22/2017
	PROVIDER OR SUPPLIER  NVALESCENT CENTE	R AT PATRIOTS COLONY		STREET ADDRESS, CITY, STATE, ZIP C 6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B	(X5) BE COMPLETION ATE DATE
F 157	Continued From pa	ge 1	F 15	57		
		ansfer or discharge the acility as specified in				
	(14)(i) of this sectionall pertinent information	otification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the				
		t also promptly notify the sident representative, if any,				
	(A) A change in roo as specified in §483	m or roommate assignment 3.10(e)(6); or	:			: : :
	(B) A change in res State law or regulat (e)(10) of this section	ident rights under Federal or ions as specified in paragraph on.	:			
	update the address phone number of th	at record and periodically (mailing and email) and the resident representative(s). NT is not met as evidenced				
	Based on staff inte review, and clinical failed to notify the p party (RP) of medic Resident (Resident the state agency (O Certification) and th	rview, facility documentation record review, the facility staff physician and Responsible ration omissions for one s #3) and failed to report to office of Licensure and the RP of an injury of unknown lent (Resident #12) in the 6 residents.		1. Resident #12 s family provider were notified of the unknown origin by director of March 9, 2017. Resident # resident #10 is responsible and the provider were notification omissions that or clinical manager on July 3,	e injury of of nursing 31:s and e represer ied of the occurred 2017.	g on ntative by
		the facility staff failed to notify RP, of medication omissions.		<ol><li>All residents are at risk notify responsible represen providers of medication adr</li></ol>	tative and	t l

PRINTED: 07/17/2017

	IMENT OF HEALTH RS FOR MEDICARE	& MEDICAL SERVICES		(		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION ING	(X3) DATE	E SURVEY PLETED
		495369	B. WING		06/2	22/2017
NAME OF I	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE		
TUE 001		D 47 D47D4070 001 011/		6000 PATRIOTS COLONY DRIVE		
THE CO	NVALESCENT CENTE	R AT PATRIOTS COLONY		WILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION OATE
F 157	Continued From pa	ge 2	: · F1:	57		
	2. For Resident # 1: report an injury of u Agency.  The Findings includ  1. Resident #3, was 1-19-17. Diagnose: Hypertrophy, urinar dementia, congestive fibrillation, and urine Resident #3's most set) with an ARD (a 4-27-17 was coded.	2, the facility staff failed to nknown origin to the State ed: ed: admitted to the facility on sincluded; Benign Prostatic y tract infections, vascular we heart failure, atrial e retention. recent MDS (minimum data ssessment reference date) of as a quarterly assessment.		omissions and to notify OLC for unknown origin. All current residence have MAREs starting 6/23/2017 for omissions and appropriate notifications. All current residence injuries starting 6/23/17 will be appropriate notifications to OLC appropriate.  3. The licensed nurses will recreeducation by July 24, 2017 b DON/designee regarding the protification of responsible party providers for omission of medic departments will be re-educated process for reporting injuries of origin immediately to the	dents will 7 audited  Its with audited for as  ceive y the rocess for and ation. All d on the unknown	
	cognitive impairmer his own daily life de coded as needing e one to two staff mer daily living, and was Review of Resident eMAR (electronic m record), Nursing proprinted MAR with no Resident was not ac medications, on the no notes document.	ded as having severe and was not able to make cisions. Resident #3 was also extensive to total assistance of a hospice patient.  #3's physician's orders, redication administration administration agress notes, and the facility of the provided that the diministered the following following days. There were ad by staff in the clinical sions other than "unavailable"		Administrator/DON to assure cowith timely reporting to the OLC  4. The DON/ designee will audresident MARs and nurses note for 4 weeks and then 2 weekly weeks to ensure accuracy in documentation, notification to reparties and providers. Administration will review all reports of injuries unknown origin to assure investing and reporting is completed at meeting. All discrepancies for a party notification, provider notification, provider notification.	dit 4 es weekly for 8 esponsible rator/DON of tigation norning responsible	

for the pyridium in the MAR notes.

5-5-17 Pyridium (urinary tract infection) 200 milligrams to be given two times daily for 3 days.

The medication was omitted, and the reason

given for the omission was documented in the MAR notes, as, "waiting on pharmacy delivery; OLC reportable events will be reviewed at the QA meeting by the DON/designee for evaluation of compliance and ongoing for

monitoring for continuous improvement

analysis after the implementation.

#### DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICALL SERVICES

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				<u> JMB NO</u>	<u>. 0938-0391</u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495369	B. WING			06/	<b>/22/201</b> 7	
NAME OF F	PROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP CODE		-	
THE COM	VALESCEN⊺ CENTE	R AT PATRIOTS COLONY			6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION OATE	
F 157	Continued From pa	ae 3	F1	157	,			
	med not in stat box	", and a second note stated No nursing notes document						
	(milligrams) three ti (8:00 a.m. to 10:00 (urinary retention) 0 (8:00 a.m. to 10:00 omitted and no reas	gestive heart failure) 20 mg mes weekly in the morning a.m.), and Tamsulosin 0.4 mg daily in the morning a.m.). Both medications were son was given as to why. sing notes for this day.						
	revealed that becau	of Resident #3's clinical record use of the Resident's cognitive evidence that he ever refused						
	omission was not a nurse responsible fo unknown, as no sig	ible for the 5-5-17 medication vailable during survey. The or the 5-26-17 omissions, was nature existed in the record ere were no nursing notes on						
	progress notes were May, and June of 20 that the responsible ever made aware the omissions occurred pyridium was discouschedule, meaning the order was never dose of pyridium co	ress notes, and nursing re reviewed in their entirety for 017. There was no indication re party, nor the physician was not these medication. It. As no one was notified, the nitinued on the original one dose was missed, and refully completed. The omitted ould have been administered at se of treatment, however, this instituted.					• • • • • • • • • • • • • • • • • • •	
	Resident #3's care	plan was reviewed, and stated						

"administer medications as ordered".

#### DEPARTMENT OF HEALTH AND HUMA `ERVICES CENTERS FOR MEDICARE & MEDICALL SERVICES

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AND PLAN OF CORRECTION  A95369  NAME OF PROVIDER OR SUPPLIER  THE CONVALESCENT CENTER AT PATRIOTS COLONY  (X4) ID  (X4) ID  (X5) ID  (X6) ID  (X7) ID  (X7) ID  (X7) ID  (X7) ID  (X8)	CENTER	42 FOR MEDICARE	& MEDICAID SERVICES			OMB MC	<u>). 0938-0391</u>
THE CONVALESCENT CENTER AT PATRIOTS COLONY    (X4)   ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG   TAG				1 ' '			TE SURVEY MPLETED
SUMMARY STATEMENT OF DEFICIENCIES   DEFICIENCY   PREFIX   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX   TAG   PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY PULL   PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION BOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)    F 157   Continued From page 4   F 157			495369	B. WING		06	i/22/2017
X41 D    SUMMARY STATEMENT OF DEFICIENCIES   PROVIDERS PLAN OF CORRECTION   PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES   PROVIDERS PLAN OF CORRECTION   PREFIX TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE    TO CONTINUE THE PROVIDER PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE    PROVIDERS PLAN OF CORRECTION   PREFIX TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE    PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE    PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE    PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE    PROVIDERS PLAN OF CORNECTIVE TAGO   PREFIX TAGO    PROVIDERS PLAN OF CORNECTIVE TAGO	NAME OF F	PROVIDER OR SUPPLIER				Ē	
FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 157 Continued From page 4  On 6-21-17 at 2:30 p.m., the Director of Nursing (DON) and Administrator were interviewed, and stated they would look into the discrepancy. The DON delivered a copy of the E-MAR, physician progress notes, and nursing progress notes for May and June 2017. When interviewed the DON stated that the medications could have been administrator do not enter time per day meds to be given at a different time than what was originally planned, so that they would not be missed, then she stated "it is what it is."  The Director of Nursing (DON) and Administrator provided the facility policy which stated to verify the medication is being administered at the proper time, prescribed dose, and by the correct route. Resolve any concerns about the medication with the provider, prescriber, and/or staff involved with the patient's care.  The administrator and DON (director of nursing) were informed of the failure of the staff to ensure notification of the physician, and RP that medications were omitted on 2 occasions for Resident #3, at the end of day debriefings on 6-21-17 and 6-22-17. No further information was provided by the facility.  2. Resident #10, was admitted to the facility on 9-1-15. Diagnoses included; Fractured left leg,	THE CON	NVALESCENT CENTE	R AT PATRIOTS COLONY				_
On 6-21-17 at 2:30 p.m., the Director of Nursing (DON) and Administrator were interviewed, and stated they would look into the discrepancy. The DON delivered a copy of the E-MAR, physician progress notes, and nursing progress notes for May and June 2017. When interviewed the DON stated that the medications could have been administered, and the doctor could be called to ok administration of one time per day meds to be given at a different time than what was originally planned, so that they would not be missed, then she stated "it is what it is."  The Director of Nursing (DON) and Administrator provided the facility policy which stated to verify the medication is being administered at the proper time, prescribed dose, and by the correct route. Resolve any concerns about the medication with the provider, prescriber, and/or staff involved with the patient's care.  The administrator and DON (director of nursing) were informed of the failure of the staff to ensure notifications were omitted on 2 occasions for Resident #3, at the end of day debriefings on 6-21-17 and 6-22-17. No further information was provided by the facility.	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE
(DON) and Administrator were interviewed, and stated they would look into the discrepancy. The DON delivered a copy of the E-MAR, physician progress notes, and nursing progress notes for May and June 2017. When interviewed the DON stated that the medications could have been administration of one time per day meds to be given at a different time than what was originally planned, so that they would not be missed, then she stated "it is what it is."  The Director of Nursing (DON) and Administrator provided the facility policy which stated to verify the medication is being administered at the proper time, prescribed dose, and by the correct route. Resolve any concerns about the medication with the provider, prescriber, and/or staff involved with the patient's care.  The administrator and DON (director of nursing) were informed of the failure of the staff to ensure notification of the physician, and RP that medications were omitted on 2 occasions for Resident #3, at the end of day debriefings on 6-21-17 and 6-22-17. No further information was provided by the facility.  2. Resident #10, was admitted to the facility on 9-1-15. Diagnoses included; Fractured left leg,	F 157	Continued From pa	ige 4	F 1	57		
		(DON) and Adminis stated they would be DON delivered a coprogress notes, and May and June 2017 stated that the med administered, and the administration of origiven at a different aplanned, so that the she stated "it is what the she stated "it is what The Director of Nurprovided the facility the medication is be proper time, prescri route. Resolve any medication with the staff involved with the staff involved with the staff involved with the continuous were on Resident #3, at the 6-21-17 and 6-22-1 provided by the facility the facility the medications were on the provided by the facility the provided by the facility the staff involved with the staff involved with the staff involved with the staff involved with the staff involved by the facility that the facility that the staff involved by the staff inv	strator were interviewed, and book into the discrepancy. The popy of the E-MAR, physician d nursing progress notes for 7. When interviewed the DON dications could have been the doctor could be called to oke time per day meds to be time than what was originally be an expected by would not be missed, then at it is."  Trising (DON) and Administrator or policy which stated to verify eing administered at the ibed dose, and by the correct or concerns about the provider, prescriber, and/or the patient's care.  The policy which staff to ensure the failure of the the				
domonia, and dopression:			included; Fractured left leg,				

Resident #3's most recent MDS (minimum data

#### DEPARTMENT OF HEALTH AND HUMA REVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

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CENTER	RS FOR MEDICARE	& MEDICAL SERVICES			(	<u>OMB NO</u>	<u> 0938-0391 )</u>
	T DF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION		ATE SURVEY OMPLETED
		495369	B. WING			0	6/22/2017
	PROVIDER OR SUPPLIER  NVALESCENT CENTE	R AT PATRIOTS COLONY		600	REET ADDRESS, CITY, STATE, ZIP CODE 0 PATRIOTS COLONY DRIVE LLIAMSBURG, VA 23188	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	(X5) COMPLETION OATE
F 157	3-29-17 was coded assessment. Resid moderate cognitive was also coded as assistance of one sactivities of daily liv patient.	ssessment reference date) of as a significant change full dent #10 was coded as having impairment. Resident #10 needing extensive to total taff member to performing, and was a hospice	: : : :	157			
	eMAR (electronic m record), Nursing pro printed MAR with no Resident was not a medication, on the notes documented	#10's physician's orders, nedication administration ogress notes, and the facility otes, revealed that the dministered the following following days. There were no by staff in the clinical record ther than "unavailable" on notes;					
	be given every day 10:00 a.m.). The m the reason given fo documented in the on 5-5-17, and simple administered (other	nicrograms subcutaneously to in the morning (8:00 a.m. to nedication was omitted, and r the omission was MAR notes, as, "Not available"					
	omission LPN E sta event. The nurse w 6-6-17 omission wa	ble for the 5-5-17 medication ated she had no memory of the tho was responsible for the s not available during survey. Ing notes describing either					
		ress notes, and nursing e reviewed in their entirety for					

May, and June of 2017. There was no indication

#### DEPARTMENT OF HEALTH AND HUMA \* `ERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUC	TION			E SURVEY PLETED
		495369	B. WING				06/:	22/2017
	PROVIDER OR SUPPLIER  NVALESCENT CENTE	R AT PATRIOTS COLONY		6000 PATRIOT	ess, city, state, zi is colony drive URG, va 23188		<del></del>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	OVIDER'S PLAN OF ( H CORRECTIVE ACT -REFERENCED TO T DEFICIENC	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 157	ever made aware the omissions occurred. Resident #10's care stated "administer in On 6-21-17 at 2:30 (DON) and Administrated they would lo DON delivered a coprogress notes, and May and June 2017 stated that the mediadministered, and the administered, and the administration of ongiven at a different to planned, so that the she stated "it is what The Director of Nursprovided the facility the medication is be proper time, prescri route. Resolve any medication with the staff involved with the The administrator a were informed of the notification of the phemedications were of Resident #10, at the	e party, nor the physician was nat these medication I.  e plan was reviewed, and medications as ordered".  p.m., the Director of Nursing strator were interviewed, and pook into the discrepancy. The physician dinursing progress notes for I. When interviewed the DON ications could have been the doctor could be called to ok the time per day meds to be time than what was originally be would not be missed, then at it is."  sing (DON) and Administrator is policy which stated to verify eing administered at the ited dose, and by the correct is concerns about the provider, prescriber, and/or the patient's care.  and DON (director of nursing) the failure of the staff to ensure the hysician, and RP that is mitted on 2 occasions for the end of day debriefings on 17. No further information was		57				

3. For Resident # 12, the facility staff failed to

#### DEPARTMENT OF HEALTH AND HUMA PERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICALL SERVICES			<u> </u>	0	<u>MB NO</u>	. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION		(X3) DAT	TE SURVEY MPLETED
		495369	B. WING				  06/	/22/2017
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP	CODE		
THE CON	NVALESCENT CENTE	ER AT PATRIOTS COLONY			PATRIOTS COLONY DRIVE			
WALID	SUMMARY STA	ATEMENT OF DEFICIENCIES		VVILL	LIAMSBURG, VA 23188	OBBECTION		245)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<b>&lt;</b>	PROVIDER'S PLAN OF CI (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD HE APPROPE	BE	(X5) COMPLETION DATE
F 157	Continued From pa	age 7	F 1	57				
• • • •	<del>-</del>	unknown origin to the State		J1				
	admitted to the facil diagnoses of, but no Arthritis, Alzheimer' Hypertension, Hypo	37 year old female, was ility on 3/27/2013 with the ot limited to, Rheumatoid 's Disease, Dysphagia, othyroidism, Gastroesophageal steoporosis, Anxiety, Major e and Psychosis.						
	quarterly assessme Reference Date (AF coded Resident # 1 for Mental Status) o cognitive impairmer in need of extensive person assistance i Resident # 12 was o assistance of one stand total assistance	inimum Data Set (MDS) was a cent with an Assessment RD) of 3/9/2017. The MDS 2 with a BIMS (Brief Interview of 8/15 indicating severe nt; the resident was coded as e to total help with two staff in activities of daily living. coded as requiring extensive staff person for bed mobility e of two staff persons for scoded as always incontinent er.						
	6/22/17. Review of 3/9/2017 at 7:00 AM during the early more (Certified Nursing Amass on rt (right) for know how she acquipain to the mass. Malmost encapsulate resident's armband and caused it to be color, measuring 6 of	al record was conducted on the Nurses notes dated of revealed documentation that bring rounds, the CNA assistant) "discovered large orearm. Resident does not uired this mass and denied any was is palpable and hard, ed. When discovered, was in the middle of the mass dented. mass is bruised in cm x 10 cm on the upper cm at the lower mass. Rcare						

(communication form) has been filled out,

#### DEPARTMENT OF HEALTH AND HUMA TERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

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CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES			<u> </u>	<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495369	B. WING			06/22/2017
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	
				6000	PATRIOTS COLONY DRIVE	
THE CO	NVALESCENT CENTE	ER AT PATRIOTS COLONY		WIL	LIAMSBURG, VA 23188	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COMPLETION
F 157	Continued From pa	ane 8	: : E1	157		
1 101	•	<del>-</del>	Г	.57		
		visors have been notified. Will				
	continue to monitor					
		e documentation in the Nurses				
		ass during the rest of the				
	month of March 20	17.	:			
	On 6/22/2017 at 3:	30 PM, an interview was				!
		Director of Nursing (DON)				
		s made aware of the area on	!			
		m and that it looked like a				
		spected it. The DON stated				
		tion, she thought the area				
		y because it was consistent	1			;
		nt # 12's arm would be located	:			
	if it was leaning aga	ainst the side rail when the				
		turned. The DON stated she				
		njury to the State Agency as an				
		origin because the injury could				
		it appeared to be consistent				
		tion of where the resident's				
		essed on the side rail during				
		ioning. The DON stated she				•
		# 12's Responsible Party				; ;
		aughter) about the mass and ought it happened. The DON				•
		to "make sure the daughter	1			
		iss before she came in to visit	:			:
		eally ugly" and she "didn't want				•
		alarmed." The DON stated				
		ent the conversation she had				
		le Party. The DON was asked				
		f the Physicians Progress				
	Notes and any other	er information regarding the				:
		sident # 12's arm since the	i			
	surveyor could not	readily access the system.	1			
			1			:
		05 PM, the DON presented a	1			•
	copy of the Progres	ss Note written by the Nurse	:			

Practitioner on 3/9/2017.

#### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			``	<u> </u>	<i>J.</i> 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		ÍTE SURVEY IMPLETED
		495369	B. WING	<b>3</b>		06	6/22/2017
NAME OF F	PROVIDER OR SUPPLIER			[5	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE CO	NVALESCENT CENTE	R AT PATRIOTS COLONY			6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	ΞIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	revealed document the Nurse Practition today due to hema swelling extending patient has dement history. She denies left arm around whit to anterior surface, has not fallen and r X-ray was ordered.  Review of the X-ray revealed document swelling/prominence mid aspect of the a foreign body. There tissue calcification a wrist." The impress swelling or mass as evaluation is recommed degenerative disease. Thorough review of there was no documented motification of the DON stated the reported the mass of injury of unknown or documented notification.	icians Progress Notes ation on 3/9/2017 of a visit by her who wrote "patient seen toma on right forearm with up to elbow. Unclear etiology, ia and is unable to provide a pain, smiles and waves her ch has large purple hematoma Nurse reports that patient no other incidents known." An are report dated 3/10/2017 ation of "soft tissue e overlying the proximal and interior forearm. No underlying is no fractureThere is soft along the dorsal aspect of the ion was listed as "Soft tissue described. Clinical mended. Osteopenia and see."  If the clinical record revealed mentation of notification of the regarding the mass/injury of Resident # 12's forearm.  Let in hindsight she should have to the State Agency as an irigin and should have ation of the Responsible Party.  Let ay debriefing, the facility	F	157			
	Administrator and E informed of the find	Director of Nursing were ings.					

No further information was provided.

# DEPARTMENT OF HEALTH AND HUM/ SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	(X3) DATE SURVEY COMPLETED		
		495369	B. WING		06/22/2017	
	PROVIDER OR SUPPLIER	ER AT PATRIOTS COLONY	60	REET ADDRESS, CITY, STATE, ZIP CODE 100 PATRIOTS COLONY DRIVE ILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 167	(g)(10) The reside (i) Examine the reof the facility cond	I) RIGHT TO SURVEY OILY ACCESSIBLE Int has the right to- esults of the most recent survey ucted by Federal or State or plan of correction in effect with lity; and	F 167 F 167		7/24/17	
	and family member residents, the result the facility.  (ii) Have reports we certifications, and respecting the facility years, and any plants.	readily accessible to residents, ers and legal representatives of alts of the most recent survey of ith respect to any surveys, complaint investigations made altity during the 3 preceding n of correction in effect with lity, available for any individual quest; and				
	areas of the facility accessible to the processible	all not make available identifying complainants or residents. ENT is not met as evidenced ation, staff interview and facility view, the facility staff failed to and have readily accessible for availability of survey reports.		1. A sign was posted June 22, 201 the nurse is station by the Clinical Manager with notification that a note containing the last three years of state survey results is located in the front of the facility.	ebook ate	

#### DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		495369	B. WING			06/2	<b>22/20</b> 17
	PROVIDER OR SUPPLIER  NVALESCENT CENTE	ER AT PATRIOTS COLONY		60	TREET ADDRESS, CITY, STATE, ZIP CODE 000 PATRIOTS COLONY DRIVE VILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	[X5) COMPLETION DATE
F 225	tour of the facility we unit maintained closurit which lead to the Within the front entroof survey result represent residents hower the nursing unit of we be found.  On 6/22/17 at 12:35 conducted with the Practical Nurse-B (If the posting of survestated, "The resider admission." When in the admission parknow.  On 6/22/17 at 2:30 the nursing station where the survey result on 6/22/17 at 5:45 conducted with the When asked about stated, "The survey I don't know what has 483.12(a)(3)(4)(c)(1) ALLEGATIONS/IND 483.12(a) The facility (3) Not employ or of who-  (i) Have been found	O a.m. a general observation was conducted. The nursing sed doors at the end of the he entrance of the building. It is a created the last three years forts was available to visitors ever, there was no notice on where the survey reports could be p.m. an interview was Nursing Supervisor, Licensed LPN-B). When asked where ey results notice was, she and family are told on asked if the information was acket she stated she did not p.m., a sign was observed by water fountain indicating esults could be found.  p.m. an interview was Director of Nursing (Admin-B). The survey report notice, she are results (notice) was there but the appened to it; it's there now." 1)-(4) INVESTIGATE/REPORT DIVIDUALS		167	2. All residents are at risk for not he knowledge of location of last 3 year surveys. The notice will remain post the nurse is station and in the lobbidirecting residents to the last 3 year surveys. Residents will be informed Activities Director of location of the results through resident council and visits by July 24, 2017.  3. Nursing Staff will be re-educate availability of the survey results by the Clinical Educator by July 24, 2017.  4. The Administrator/Designee will the presence of the notification of the survey results posting twice weekly weeks then weekly for 8 weeks and monthly. The results of the audits we reported quarterly at the QA meeting evaluation of compliance and ongomenitoring for continuous improven analysis after the implementation.	rs of sted at y rs of d by survey d 1:1 ed on the for 4 d then vill be ng for ing ment	7/24/17

## DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		E CONSTRUCTION		TE SURVEY MPLETED
		405200	B WIND				
		495369	B. WING			06	<u>6/22/2017</u>
	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		60	TREET ADDRESS, CITY, STATE, ZIP CODE 000 PATRIOTS COLONY DRIVE VILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFE DEFICIENCY)	DBE	(X5) COMPLETION OATE
F 225	nurse aide registry exploitation, mistrea misappropriation of (iii) Have a disciplin or her professional body as a result of exploitation, mistrea misappropriation of (4) Report to the St licensing authorities actions by a court of which would indicate nurse aide or other (c) In response to a exploitation, or mist (1) Ensure that all a abuse, neglect, expincluding injuries of misappropriation of reported immediate after the allegation cause the allegation serious bodily injury the events that cause abuse and do not rethe administrator of	ing entered into the State concerning abuse, neglect, atment of residents or their property; or ary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property.  ate nurse aide registry or any knowledge it has of flaw against an employee, e unfitness for service as a		2225	JEFICIENCY)		
	adult protective ser- for jurisdiction in lor	vices where state law provides ng-term care facilities) in ate law through established					

#### DEPARTMENT OF HEALTH AND HUM, SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		495369	B. WING		06	/22/2017
NAME OF F	PROVIDER OR SUPPLIER		· <del></del>	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE COM	NVALESCENT CENTE	R AT PATRIOTS COLONY	ŀ	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5] COMPLETION OATE
F 225	Continued From pa	ge 13	F 22	5		
	(2) Have evidence thoroughly investigated	that all alleged violations are ated.		·		
	(3) Prevent further exploitation, or mist investigation is in p					
	administrator or his representative and with State law, including Agency, within 5 wo if the alleged violatic corrective action methics REQUIREMENT by:  Based on staff intereview, and clinical failed for 2 resident residents in the surreport injuries of un Agency; and failed	to other officials in accordance uding to the State Survey orking days of the incident, and on is verified appropriate		1. A full body assessment was completed on resident #1 on June 2017 and resident #12 on June No unknown injuries including a bruising and or masses were n D was removed from the sched 24, 2017 due to failure of licens	une 21, e 22, 2017. any oted. LPN dule May	:
	investigate and repensive bruise of unknown.  2. For Resident # 1 report to the State A forearm as an injury.  3. The facility staff.	Agency an injury to the right y of unknown origin.  failed to ensure one "Licensed PN) employee, was licensed to m quality of care.		2. All residents are at risk for injuries of unknown origin not be investigated or reported timely current residents with injuries s 6/23/17 will be audited by DON for appropriate notifications to appropriate. All residents with be immediately investigated by DON/designee with considerati to report to the appropriate stat agencies. DON/designee will wourses is licenses for current stated to the Va. Department of Health Fiby July 24, 2017.	being to OLC. All starting l/designee OLC as injuries will ion of need te //alidate all atus thru	

#### DEPARTMENT OF HEALTH AND HUM/ SERVICES

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RE & MEDICA\_ SERVICES			OMB NO	<u>). 0938-0391</u>
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
495369	B. WING		06	6/22/2017
R	•	STREET ADDRESS, CITY, STATE,	ZIP CODE	
TER AT PATRIOTS COLONY				
ICY MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
vas admitted to the facility on diagnoses of, but not limited to, ase, dementia, hypertension,  Minimum Data Set (MDS) was a ment with an Assessment (ARD) of 5/16/17. The MDS ed Resident #1 with severement; no behavior symptoms; we assistance from staff for bed as, ambulation, dressing, toileting, then the control of the diagram of the symptoms. He did not so when spoken to but mumbled a dom.  We and revealed a nurse's note and revealed a nurse's note or right hip area. There on of the bruise in the note.		3. Licensed nurses an receive re-education by Nursing/designee on im required for reporting/ir injuries of unknown origing prompt compliance and The Interdisciplinary Teach the Interdisciplinary Tea	ad CNAI's will the Director of amediate action avestigation of gin to ensure I timely reporting, am will review the ang meeting to f bruises of buse Investigation d Procedure will be QA nurse with the sure understanding rting requirements A new process for oplicant work sure exam will be affing coordinator verifications will Department of will review all known origin to d reporting is nee will audit new	
4/6/17 at 10:45 p.m. The d: the seed sliding out of wheelchair e to the floorno apparent this time"		expirations twice month licensing requirements unknown origin will be r meeting by Administrate evaluation of compliand monitoring for continuo	nly. All audits for and all injuries of reported at the QA or/designee for ce and ongoing us improvement	
THE TOTAL STATE OF THE STATE OF	495369  ER  ITER AT PATRIOTS COLONY  STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  page 14  was admitted to the facility on diagnoses of, but not limited to, ease, dementia, hypertension,  Minimum Data Set (MDS) was a ment with an Assessment (ARD) of 5/16/17. The MDS ed Resident #1 with severe ment; no behavior symptoms; we assistance from staff for bed s, ambulation, dressing, toileting, bendent on staff for bathing; and not of bowel and bladder.  40 a.m., Resident #1 was neelchair in his room. He did not s when spoken to but mumbled a dom.  55 a.m. Resident #1's clinical wed and revealed a nurse's note with the service on right hip area. Of fall on 04/06/2017." There on of the bruise in the note.  Evealed Resident #1 did have a 14/6/17 at 10:45 p.m. The did:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495369  B. WING  TER AT PATRIOTS COLONY  STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  Page 14  Vas admitted to the facility on diagnoses of, but not limited to, ease, dementia, hypertension,  Minimum Data Set (MDS) was a ment with an Assessment (ARD) of 5/16/17. The MDS ed Resident #1 with severe ment; no behavior symptoms; ve assistance from staff for bed so, ambulation, dressing, toileting, pendent on staff for bathing; and not of bowel and bladder.  40 a.m., Resident #1 was neelchair in his room. He did not so when spoken to but mumbled a dom.  55 a.m. Resident #1's clinical wed and revealed a nurse's note in the staff or of the bruise in the note.  Evealed Resident #1 did have a part of the bruise in the note.  Evealed Resident #1 did have a part of the bruise in the note.  Evealed Resident #1 did have a part of the bruise in the note.  Evealed Resident #1 did have a part of the bruise in the note.  Evealed Resident #1 did have a part of the bruise in the note.  Evealed Resident #1 did have a part of the bruise in the note.  Evealed Resident #1 did have a part of the bruise in the note.  Evealed Resident #1 did have a part of the bruise in the note.  Evealed Resident #1 did have a part of the bruise in the note.  Evealed Resident #1 did have a part of the bruise in the note.  Evealed Resident #1 did have a part of the bruise in the note.  Evealed Resident #1 did have a part of the bruise in the note.  Evealed Resident #1 did have a part of the bruise in the note.  Evealed Resident #1 did have a part of the bruise in the note.  Evealed Resident #1 did have a part of the bruise in the note.	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495369  B. WING  STREET ADDRESS, CITY, STATE, 6000 PATRIOTS COLONY DRIV WILLIAMSBURG, VA. 23188  STREET ADDRESS, CITY, STATE, 6000 PATRIOTS COLONY DRIV WILLIAMSBURG, VA. 23188  STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  PAGE IN CEACH CORRECTIVE ACTOR CROSS-REFERENCED TO DEFICIEN  Deficien  PREFIX TAG  TAG  STREET ADDRESS, CITY, STATE, 6000 PATRIOTS COLONY DRIV WILLIAMSBURG, VA. 23188  PROVIDER'S PLAN OF CROSS-REFERENCED TO DEFICIEN  TAG  PREFIX TAG  PREFIX TAG  CROSS-REFERENCED TO DEFICIEN  3. Licensed nurses are receive re-education by Nursing/designee on im required for reporting/ling injuries of unknown origin required for reporting/ling injuries of unknown origin required for reporting/ling injuries of unknown origin. The Atland reporting Policy and reviewed by corporate of Leadership team to ensure and adherence on reports of injuries of unknown origin and the proving policy and reviewed by corporate of Leadership team to ensure and adherence on reports of injuries of unknown origin intialed and tracked states and date of licen initialed and tracked states by July 24, 2017. Final be through the Virginia Health Professions.  STATEET ADDRESS, CITY. STATE, 6000 PATRIOTS COLONY DRIV WILLIAMSBURG, VA 23188  3. Licensed nurses are receive re-education by Nursing/designee on im require drop report of preports of injuries of unknown origin. The Atland and reporting Policy and reviewed by corporate of Leadership team to ensure and adherence on report of preports of injuries of unknown origin will be intend	(X3) PACODERSUPPLERICLIA A BUILDING (X3) MALTIPLE CONSTRUCTION (X3) DA CO CO CO MALTIPLE CONSTRUCTION (X3) DA CO

bruise investigation was requested.

Review of facility policy titled "Abuse Prevention

# DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495369	B. WING			06/	22/2017
	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		60	TREET ADDRESS, CITY, STATE, ZIP CODE 000 PATRIOTS COLONY DRIVE VILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	"4) Investigation Designated staff wili investigate all allega abuse b) The organization trends and patterns skin tears, bruising unusual occurrence 6) Reporting a) The organization ensure that all alleg neglect, exploitation injuries of unknown of resident property but not later than 2 made c) The organization alleged violations in including injuries of administrator or his facility"  On 6/22/17 at 5:20 #1's right hip was di Admin-B stated, "I of for the bruise to the not notified by the n until you found it." I would've done if she	with a last date of review of the following:  Ill immediately review and ations or observations of a will conduct analysis for a related to incidents (i.e. falls, or injury of unknown origin, es, reportable incidents, etc.)  I will maintain systems to ged violations involving abuse, or mistreatment, including source and misappropriation or, are reported immediately, hours after the allegation is a will immediately report all evolving neglect, abuse, unknown sourceto the or her designee of the p.m. the bruise to Resident iscussed with Admin-B. do not have an investigation or right hip." She stated "I was aurse and did not know about it when asked what she e was notified of the bruise, would've absolutely reported	F 2	225			
		2, the facility staff failed to nknown origin to the State					: : :

#### DEPARTMENT OF HEALTH AND HUM/ SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

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CENTER	45 FUR MEDICARE	& MEDICAL SERVICES			`	<u> </u>	. <del>0938-039</del> 1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY MPLETED
		495369	B. WING			06	/22/2017
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
TUE 001	DAL FOOENT OFNE	TO AT DATES OF SAN	[	6000	PATRIOTS COLONY DRIVE		
THE CON	NVALESCENT CENTE	R AT PATRIOTS COLONY		WIL	LIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	Resident # 12, an 8 admitted to the faci diagnoses of, but n Arthritis, Alzheimer Hypertension, Hypore Reflux Disease, Ostoperessive Disease. The most recent M quarterly assessment Reference Date (Alcoded Resident # 1 for Mental Status) of cognitive impairment in need of extensive person assistance in Resident # 12 was assistance of one sand total assistance	lity on 3/27/2013 with the ot limited to, Rheumatoid is Disease, Dysphagia, othyroidism, Gastroesophageal steoporosis, Anxiety, Major e and Psychosis.  Inimum Data Set (MDS) was a ent with an Assessment RD) of 3/9/2017. The MDS 2 with a BIMS (Brief Interview of 8/15 indicating severent; the resident was coded as e to total help with two staff in activities of daily living. coded as requiring extensive staff person for bed mobility e of two staff persons for coded as always incontinent	F 2	25			
	6/22/17. Review of 3/9/2017 at 7:00 AM during the early mo (Certified Nursing Amass on rt (right) for know how she acquipain to the mass. Malmost encapsulate resident's armband and caused it to be color, measuring 6 the upper mass and mass. Rcare [com	al record was conducted on the Nurses notes dated of revealed documentation that rning rounds, the CNA assistant) "discovered large prearm. Resident does not uired this mass and denied any mass is palpable and hard, and. When discovered, was in the middle of the mass dented. mass is bruised in cm x 10 cm [centimeters] on d 4 cm x 7 cm at the lower munication form] has been					

notified. Will continue to monitor."

There was no more documentation in the Nurses

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			(	OMB NO	<u>). 0938-0391</u>
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION		TE SURVEY MPLETEO
		495369	B. WING			06	6/22/2017
	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		6000	ET ADDRESS, CITY, STATE, ZIP COOE PATRIOTS COLONY DRIVE LIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO OEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 225	on 6/22/2017 at 3:3 conducted with the who stated she was Resident # 12's arm mass when she ins after further inspect looked like an injury with where Resider if it was leaning aga resident was being did not report the ininjury of unknown obe explained since with the exact locat arm could have pre turning and repositi informed Resident # 12's datold her how she the stated she wanted it knew about the mas because it looked rethe daughter to be a she did not docume with the Responsible to provide copies of Notes and any other mass/injury on Res	ass during the rest of the	F 2	225	UEFICIENCY)		
	copy of the Progres Practitioner on 3/9/2 Review of the Phys revealed document	25 PM, the DON presented a s Note written by the Nurse 2017. Icians Progress Notes ation on 3/9/2017 of a visit by her who wrote "patient seen"					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		E SURVEY MPLETED
		495369	B. WING			06	22/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TUE 001	WALESCENT OF NE	TO AT DATDIOTS COLONY	1	6	0000 PATRIOTS COLONY DRIVE		
THE CO	NVALESCENT CENTE	R AT PATRIOTS COLONY		٧	VILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION OATE
F 225	swelling extending patient has dement history. She denies left arm around whit to anterior surface. has not fallen and r X-ray was ordered.  Review of the X-ray revealed document swelling/prominence mid aspect of the aforeign body. There tissue calcification wrist." The impress swelling or mass as evaluation is recome degenerative disease Review of the Facil Management Policy "Reporting" reveales "will maintain system violations involving mistreatment, inclusioner and misappare reported immediately and the alleg that cause the allegent to an enterior surface and misappare reported immediately that cause the allegent to an enterior surface and misappare reported immediately that cause the allegent to an enterior surface and misappare reported immediately that cause the allegent to an enterior surface.	matoma on right forearm with up to elbow. Unclear etiology, ia and is unable to provide a pain, smiles and waves her ich has large purple hematoma. Nurse reports that patient no other incidents known." An arreport dated 3/10/2017 ation of "soft tissue e overlying the proximal and interior forearm. No underlying is no fractureThere is soft along the dorsal aspect of the ion was listed as "Soft tissue is described. Clinical imended. Osteopenia and se."  ity Abuse Prevention and y, Revision date 11/2016 under id statements that the facility ms to ensure that all alleged abuse, neglect, exploitation or ding injuries of unknown ropriation of resident property diately, but not later than 2 gation is made, if the events gation involve abuse or result		225	<u>'</u>		
	if the events that ca involve abuse and of injury, to the admin her designee, and to State Survey Agency services where state	ury, or not later than 24 hours ause the allegation do not do not result in serious bodily istrator of the facility, or his or to other officials (including the by and adult protective law provides for jurisdiction acilities) in accordance with					

State law through established procedures."

#### DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495369	B. WING			06	/22/2017
	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		6	TREET ADDRESS, CITY, STATE, ZIP CODE 0000 PATRIOTS COLONY DRIVE VILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 19	F2	225	1		
	reported the mass injury of unknown of documented notification.  During the end of diadministrator and Dinformed of the find No further information.  3. The facility staff of Practical Nurse" (Lipractice, and performance injury).						
	prohibition screenin (LPN D) was found graduate. LPN D w state board examin practice as a "Licen deadline for Licensu LPN D did not comp	ecord review for abuse ag of employees, one LPN, to have been hired as a new was required to have taken the ation to receive licensure to used Practical Nurse". The large for LPN D was 5-25-17. Collete the examination forked on in the facility					
	upon request, and i LPN D worked for 1	d LPN D's time clock history t revealed that on 5-29-17 2 hours as a nurse, and on ked as a nurse for 12.5 hours.					
	Management" was	n "Abuse Prevention and reviewed, and revealed under is procedure/Requirements"					

# DEPARTMENT OF HEALTH AND HUM 3ERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		495369	B. WING _		06	6/22/2017
	PROVIDER OR SUPPLIER	ER AT PATRIOTS COLONY		STREET ADDRESS, CITY, STATE, ZIP CODE 6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	Continued From p	age 20	F 22	5		:
	under sections "b, check and license from every state resections 1819 (e) act that the facility information on the certification agency will be contacted, licensure or certific determine if the postanding with the research of the Administrator of a made aware of the information was as facility.  483.12(b)(1)-(3), 4DEVELOP/IMPLM POLICIES  483.12 (b) The facility must written policies and (1) Prohibit and prexploitation of resi resident property,  (2) Establish polici investigate any sur (3) Include training §483.95,  483.95 (c) Abuse, neglect	and i", Multi state registry verification will be checked egistry established under (2) (A) or 1919 (e) (2) (A) of the believes will include individual. State licensure and ies, and applicable registries, prior to hire, to validate current cation requirements and to otential employee is in good registry.  end of day debrief at 5:00 p.m., and Director of Nursing were a findings. No further valiable to be presented by the 183.95(c)(1)-(3) IENT ABUSE/NEGLECT, ETC	F 22			7/24/17

#### DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	<u>RS FOR MEDICARE</u>	: & MEDICAID SERVICES			OMB NO	<u>). 0938-039</u> 1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	TE SURVEY MPLETED
		495369	B. WING_		06	6/22/2017
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP		
THE CO	NVALESCENT CENTE	R AT PATRIO⊺S COLONY		6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188		
	CHAMADVETA	TEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CO	DEPECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION OATE
F 226	requirements in § 4	83.12, facilities must also	F 22	26		:
	provide training to t educates staff on-	heir staff that at a minimum				
		constitute abuse, neglect, isappropriation of resident h at § 483.12.				
		or reporting incidents of abuse, n, or the misappropriation of				
	prevention.	anagement and resident abuse				
	Based on staff inte review, and clinical failed to operationa residents (Resident	rview, facility documentation record review, the facility staff lize the abuse policies for 2 t #1 and Resident #12) of 16 vey sample, and one		1. A full body assessmen completed on resident #1 c 2017 and resident #12 on No unknown injuries included bruising and or masses were D was removed from the s 24, 2017 due to failure of the second complete was removed.	on June 21, June 22, 2017. ding any ere noted. LPN chedule May	
	<ol> <li>For Resident #1, the facility staff failed to operationalize the abuse policy related to reporting and investigating injuries of unknown origin.</li> <li>For Resident # 12, the facility staff failed to operationalize the Abuse policies relating to reporting injuries of unknown origin to the State Agency.</li> </ol>			All residents are at rish injuries of unknown origin investigated or reported tin current residents with injurial contents.	k for potential not being nely to OLC. Al	
				June 23, 2017 will be audit DON/designee for appropr notifications to OLC as appresidents with injuries will investigated by DON/designees.	ted by riate propriate. All be immediately	
		failed to ensure their policy to irsing licensure was		consideration of need to re appropriate state agencies DON/designee will validate licenses for current status	eport to the s. e all nursest	
	The findings include	ed:		Department of Health Prof	essions by	

June 24, 2017.

#### DEPARTMENT OF HEALTH AND HUM/ CERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAÌU SERVICES			(	OMB N	IO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	TIPLE CONSTRUC ING			OATE SURVEY COMPLETED
		495369	B. WING				06/22/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADOR	RESS, CITY, STATE, ZII		
THE COI	NVALESCENT CENTE	R AT PATRIOTS COLONY			TS COLONY DRIVE BURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	ROVIDER'S PLAN OF C CH CORRECTIVE ACTI S-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 226	2/15/17 with the dia Parkinson's Diseas and anemia.  The most recent Mi quarterly assessme Reference Date (Alcoded Resident #1 impairment; no behextensive assistant transfers, ambulation hygiene; dependent always incontinent of the control of the	admitted to the facility on agnoses of, but not limited to, e. dementia, hypertension,  finimum Data Set (MDS) was a sent with an Assessment RD) of 5/16/17. The MDS with severe cognitive avior symptoms; required be from staff for bed mobility, on, dressing, toileting, and to on staff for bathing; and of bowel and bladder.  a.m., Resident #1 was elichair in his room. He did not when spoken to but mumbled a m.  a.m. Resident #1's clinical d and revealed a nurse's note of p.m. which read: a lise on right hip area. If all on 04/06/2017." There of the bruise in the note.  aled Resident #1 did have a 6/17 at 10:45 p.m. The lessed sliding out of wheelchair of the floorno apparent is time"	F 2	3. Licer receive reverse required injuries of prompt of The Intel 24 hour reassist in unknown and reported and adher by date of tracking status are initialed as by July 2 be through Health P  4. Admire reports of assure in complete applicant expiration licensing unknown meeting evaluation monitorii	ensed nurses and re-education by the designee on immal for reporting/involution of unknown original compliance and tierdisciplinary Tear report at morning identification of the origin. The Abustorting Policy and I depended by corporate Quality 24, 2017. A expiration of appind date of licensular and tracked staff 24, 2017. Final very and the Virginia Dependent of the Virginia Dependent of the Virginia Dependent of the Virginia of unknowestigation and red. DON/Designeest report for pendions twice monthly grequirements are norigin will be report for compliance in ground the continuous after the implements after th	he Director of nediate action restigation of not ensure imely reporting m will review the greeting to bruises of ise Investigation Procedure will A nurse with the re understanding requirement new process folicant work ure exam will be fing coordinator erifications will be partment of will review all nown origin to reporting is ee will audit nown origin to reported at the Questignee for and ongoing is improvement	n be e ng nts or e f

Review of facility policy titled "Abuse Prevention

# DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495369	B. WING		06	6/22/2017
	PROVIDER OR SUPPLIE	ER AT PATRIOTS COLONY		STREET ADDRESS, CITY, STATE, ZIF 6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188	· · · · · · · · · · · · · · · · · · ·	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION OATE
F 226	and Management "11/2016" includer "Policy Statement developing and opprocedures for sciprotection of resididentification, inveating and procedures for sciprotection of resididentification, inveating appropriation of "4) Investigation Designated staff vinvestigate all alleabuse b) The organization trends and pattern skin tears, bruisin unusual occurrent (6) Reporting (a) The organization ensure that all alleneglect, exploitation injuries of unknown of resident proper but not later than made c) The organization alleged violations including injuries of administrator or heacility"  On 6/22/17 at 5:21 #1's right hip was Admin-B stated "I the bruise to the rotified by the nur	" with a last date of review of d the following:The facility is committed to perationalizing policies and reening and training employees, lents and for the prevention, estigation, and reporting of istreatment, and of property"		226		

#### DEPARTMENT OF HEALTH AND HUM ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			<u>'</u>	<u>)MB NC</u>	<u>). 0938-0391                                    </u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495369	B. WING			06	<b>3/22/20</b> 17	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE CON	VALESCENT CENTE	R AT PATRIOTS COLONY			000 PATRIOTS COLONY DRIVE VILLIAMSBURG, VA 23188			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	IX5) COMPLETION DATE	
F 226	Continued From pa	ge 24	F 2	226	1			
		e was notified of the bruise, ould've absolutely reported						
	implement their abu	12, the facility staff failed to use policy concerning the by of unknown origin to the						
	admitted to the faci diagnoses of, but no Arthritis, Alzheimer' Hypertension, Hyper	Tyear old female, was lity on 3/27/2013 with the ot limited to, Rheumatoid s Disease, Dysphagia, othyroidism, Gastroesophageal teoporosis, Anxiety, Major e and Psychosis.						
	quarterly assessme Reference Date (Al coded Resident # 1	inimum Data Set (MDS) was a ent with an Assessment RD) of 3/9/2017. The MDS 2 with a BIMS (Brief Interview of 8/15 indicating severe						
	in need of extensive person assistance i Resident # 12 was assistance of one s and total assistance	nt; the resident was coded as e to total help with two staff n activities of daily living. coded as requiring extensive taff person for bed mobility e of two staff persons for coded as always incontinent er.						
	6/22/17. Review of 3/9/2017 at 7:00 AM during the early mo (Certified Nursing Amass on rt (right) for	al record was conducted on the Nurses notes dated A revealed documentation that rning rounds, the CNA assistant) "discovered large brearm. Resident does not aired this mass and denied any					:	

pain to the mass. Mass is palpable and hard,

#### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	<u>RS FOR MEDICARE</u>	: & MEDICAID SERVICES		Ϋ	<u>OMB NO.</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		E SURVEY IPLETED
		495369	B. WING		06/	22/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE CON	NVALESCENT CENTE	ER AT PATRIOTS COLONY		6000 PATRIOTS COLONY DRIVE		
THE CON	TVALESCENT CENTE			WILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	_ '	LD BE	(X5) COMPLETION DATE
F 000	0-1					
F 226	Continued From pa	=	F 2	<sup>2</sup> 26		
		ed. When discovered,				
		was in the middle of the mass				
		dented. mass is bruised in				
		cm x 10 cm on the upper				•
		cm at the lower mass. Roare				
		rm) has been filled out, visors have been notified. Will				1
	continue to monitor					:
		e documentation in the Nurses				1
		ass during the rest of the				ı
	month of March 20					
		30 PM, an interview was				
		Director of Nursing (DON)	:			
		s made aware of the area on	:			
		n and that it looked like a spected it. The DON stated	i			
		tion, she thought the area	:			
		y because it was consistent	:			
		nt # 12's arm would be located	:			
		ainst the side rail when the	:			
		turned. The DON stated she				
		njury to the State Agency as an	!			
		origin because the injury could	1			1
	be explained since	it appeared to be consistent				
	with the exact locat	ion of where the resident's				1
		essed on the side rail during	:			
		oning. The DON stated she				:
		# 12's Responsible Party				•
		nughter) about the mass and				i
		ought it happened. The DON				
		to "make sure the daughter				1
		ss before she came in to visit				
		eally ugly" and she "didn't want				ŧ
		alarmed." The DON stated				:
		ent the conversation she had le Party. The DON was asked				
		f the Physicians Progress				
	to brovine cobies or	ine r nysicians r rogress				

Notes and any other information regarding the

#### DEPARTMENT OF HEALTH AND HUMAN RVICES CENTERS FOR MEDICARE & MEDICAID RVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID LRVICES		\	0	<u>MB NO.</u>	<u>0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING			E SURVEY PLETED
		495369	B. WING	i		06/	22/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	<sup>2</sup> CODE		
THE CO	NVALESCENT CENTE	R AT PATRIOTS COLONY		6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188			
				<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD HE APPROPI	BE	(X5) COMPLETION OATE
F 226	Continued From pa	ge 26	. F:	226			
	mass/injury on Res	ident # 12's arm since the readily access the system.					
	copy of the Progres Practitioner on 3/9/2 Review of the Phys revealed document the Nurse Practition today for due to her swelling extending patient has dement history. She denies left arm around whito anterior surface. has not fallen and r X-ray was ordered.	25 PM, the DON presented a se Note written by the Nurse 2017. icians Progress Notes ation on 3/9/2017 of a visit by ner who wrote "patient seen matoma on right forearm with up to elbow. Unclear etiology, ia and is unable to provide a pain, smiles and waves her ch has large purple hematoma Nurse reports that patient no other incidents known." An					
	revealed document swelling/prominenc mid aspect of the a foreign body. There tissue calcification a wrist." The impress swelling or mass as	ation of "soft tissue e overlying the proximal and interior forearm. No underlying is no fractureThere is soft along the dorsal aspect of the ion was listed as "Soft tissue is described. Clinical mended. Osteopenia and					
	Management Policy "Reporting" reveale "will maintain system violations involving mistreatment, inclusiource and misapplare reported immediate.	ity Abuse Prevention and y, Revision date 11/2016 under d statements that the facility ms to ensure that all alleged abuse, neglect, exploitation or ding injuries of unknown ropriation of resident property diately, but not later than 2 gation is made, if the events					

that cause the allegation involve abuse or result

#### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

	0===========	0/4) BBB #BB #BB #BB #BB #BB	() (0) 1 41 11	~	E AGNIGNE LANGUI	1000 500	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION		'E SURVEY MPLETED
		495369	B. WING			06	/22/2017
	PROVIDER OR SUPPLIER	ER AT PATRIOTS COLONY		60	TREET ADDRESS, CITY, STATE, ZIP CODE 000 PATRIOTS COLONY DRIVE VILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION OATE
F 226	if the events that cae involve abuse and injury, to the adminher designee, and the State Survey Agency services where statin long-term care fastate law through of the DON stated the reported the massinjury of unknown of documented notific.  During the end of deadministrator and functional formed of the find to the State Agency.  No further information of the function of the state and function of the state and function of the state and functions.  Juring employee reprohibition screening (LPN D) was found graduate. LPN D was found graduate.	ury, or not later than 24 hours ause the allegation do not do not result in serious bodily istrator of the facility, or his or to other officials (including the cy and adult protective te law provides for jurisdiction acilities) in accordance with established procedures."  at in hindsight she should have to the State Agency as an origin and should have ation of the Responsible Party.  Tay debriefing, the facility Director of Nursing were lings that no report was made of the state of the control of the state of the facility described by the facility of	F 2	226			
	deadline for Licens	nsed Practical Nurse". The ure for LPN D was 5-25-17. plete the examination orked on in the facility					:

#### DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

OF M. F.	O I OK MEDIOAKE	G MILDIOAID OLIVIOLO	_			ONI CINE	<u>. บออบ-บอฮ เ</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495369	B. WING			06	/22/2017
	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		6000	ET ADDRESS, CITY, STATE, ZIP CODE PATRIOTS COLONY DRIVE LIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION OATE
F 226	upon request, and it	ge 28 d LPN D's time clock history it revealed that on 5-29-17 I2 hours as a nurse, and on ked as a nurse for 12.5 hours.	F	226			
	Management" was the heading "Specifunder sections "b, a check and license of the form every state respections 1819 (e) (2 act that the facility be information on the incertification agencies will be contacted, policensure or certification.	ndividual. State licensure and es, and applicable registries, rior to hire, to validate current ation requirements and to ential employee is in good					
	the Administrator ar made aware of the information was ava facility.	end of day debrief at 5:00 p.m., and Director of Nursing were findings. No further ailable to be presented by the RVICES PROVIDED MEET STANDARDS	F	281			7/24/17
	(b)(3) Comprehens	ive Care Plans					: : :
		led or arranged by the facility, omprehensive care plan,	!				
	This REQUIREMEN by:	al standards of quality.  NT is not met as evidenced  rview, facility documentation		,	1. Residents #3 and #10⊩s resp	onsible	

#### DEPARTMENT OF HEALTH AND HUMAN( **RVICES**

PRINTED: 07/17/2017 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID S⊏RVICES			O	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
		495369	B. WING			06/3	22/2017
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 001.	
				6	000 PATRIOTS COLONY DRIVE		
THE CO	NVALESCENT CENTE	R AT PATRIOTS COLONY		V	VILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	[X5) COMPLETION OATE
F 281	review and clinical refailed to follow the puality for medication Residents (Resident sample of 16 resident 1. For Resident #3, ensure 3 medication ordered by a physical 2. For Resident #10 ensure 1 medication ordered by a physical 3. For Resident #5,	record review, the facility staff professional standards of on administration, for three ats #3, #10 and #5) in a survey ents.  the facility staff failed to as were administered as ian.  the facility staff failed to a was administered as ian the facility staff failed to ent the need for PRN (as	F 2	281	parties and providers were notified 3, 2017 by clinical manager of the medications. There were no advergeactions from the missed medical Resident #5 order was clarified Jun 2017 for continuous oxygen clinical manager. Responsible representation notified June 21, 2017.  2. All residents within the facility a risk for medication omissions and oxygen orders. DON /designee will complete will complete a 100% audicurrent medications to ensure they available and have been given and 100% audit on residents with oxygen sure all residents with oxygen have	missed se se se sion. ne 21, l tive was are at unclear l dit of are l a en to	
	The findings include				correct orders.		
	1-19-17. Diagnoses Benign Prostatic Hi infections, vascular failure, atrial fibrillat Resident #3's most	admitted to the facility on sincluded: ypertrophy, urinary tract dementia, congestive heart ion, and urine retention.  recent MDS (minimum data ssessment reference date) of			3. The licensed nurses will receive re-education by July 24, 2017 by the DON/designee regarding the 6 right medication administration and the for managing unavailable medication and the residents regarding medical symptonecessary for print oxygen.	ne nts of process ons. or	
	4-27-17 was coded Resident #3 was co cognitive impairmer his own daily life de coded as needing e one to two staff mer daily living, and was	as a quarterly assessment. ded as having severe nt and was not able to make cisions. Resident #3 was also xtensive to total assistance of mbers to perform activities of			4. The DON/designee will audit 4 residents MARI s weekly for 4 weethen 2 weekly for 8 weeks to ensuraccuracy of medication. Will audit oxygen orders for 4 weeks and the weekly for 8 weeks. The results of audits will be reported monthly at t meeting for evaluation of accuracy	eks and e 4 en 2 the he QA	

Review of Resident #3's physician's orders, eMAR (electronic medication administration

record), Nursing progress notes, and the facility

monitoring for continuous improvement

analysis after the implementation.

## DEPARTMENT OF HEALTH AND HUMAN ( ?VICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	: & MEDICAID SERVICES			``	<u> </u>	<u>). 0938-0391                                    </u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-1</sup> A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495369	B. WING			06	/22/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE COM	WALESCENT CENTE	R AT PATRIOTS COLONY		60	00 PATRIOTS COLONY DRIVE		
111L 001	WALLOOLNI OLNIL			W	ILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION OATE
F 281	printed MAR with n	otes, revealed that the	F 2	281			
	medications, on the	dministered the following e following days. There were sed by staff in the clinical					
		sions other than "unavailable"					:
	milligrams to be given for the omiss MAR notes, as, "wa med not in stat box second note stated"	rinary tract infection) 200 ren two times daily for 3 days. s omitted, and the reason ion was documented in the aiting on pharmacy delivery; " (additional drug box), and a "Not administered". No ment this omission.					
	(milligrams) three ti (8:00 a.m. to 10:00 (urinary retention) 0 (8:00 a.m. to 10:00 omitted and no reas	gestive heart failure) 20 mg mes weekly in the morning a.m.), and Tamsulosin 0.4 mg daily in the morning a.m.). Both medications were son was given as to why. sing notes for this day.					
	revealed that becau	of Resident #3's clinical record use of the Resident's cognitive evidence that he ever refused	:				
	omission was not a nurse responsible f unknown, as no sig	ible for the 5-5-17 medication vailable during survey. The for the 5-26-17 omissions, was nature existed in the record ere were no nursing notes on					
		ress notes, and nursing e reviewed in their entirety for					

May, and June of 2017. There was no indication

#### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CLIVIL	19 LOU MIEDICANE	Q MEDICAL SERVICES		<u> </u>	Oiv	<u>IID NO. 0936-0391</u>		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		495369	B. WING			06/22/2017		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE			
THE COL	JVALESCENT CENTE	ED AT DATRICTS COLONY		6000 PATRIOTS COLONY DRIV	E			
THE COL	NVALESCENI CENTE	R AT PATRIOTS COLONY		WILLIAMSBURG, VA 23188				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD I	BE COMPLÉTION		
F 281	ever made aware the omissions occurred pyridium was disconschedule, meaning the order was never dose of pyridium continued the end of the course option was also not resident #3's care administer medica.  On 6-21-17 at 2:30 (DON) and Administrated they would be DON delivered a conformation of the course option was also not resident which is the stated that the medical administered, and the administered, and the administered, and the she stated administered that the medical resident planned, so that the she stated at the she stated are stated at the she stated are some proper time, prescription of the proper time, prescription of the staff involved with the staff involved	e party, nor the physician was nat these medication  I. As no one was notified, the ntinued on the original one dose was missed, and r fully completed. The omitted ould have been administered at se of treatment, however, this instituted.  plan was reviewed, and stated tions as ordered".  p.m., the Director of Nursing strator were interviewed, and book into the discrepancy. The pay of the E-MAR, physician dinursing progress notes for a nursing standard.	F 2	81				
	"Fundamentals of N	lursing, 7th Edition, Mosby's/						

Potter-Perry, p. 705: Professional standards,

# DEPARTMENT OF HEALTH AND HUMAN FRVICES CENTERS FOR MEDICARE & MEDICAID VICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495369	B. WING			06	6/22/2017	
	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		6000	EET ADDRESS, CITY, STATE, ZIP CODE  PATRIOTS COLONY DRIVE  LIAMSBURG, VA 23188			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<b>&lt;</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION OATE	
F 281	Nursing Scope and of (2004), apply to to administration. To follow the six rights medication errors can inconsistency in medication adminis	an Nurses Association's Standards of Nursing Practice the activity of medication prevent medication errors, of medications. Many an be linked, in some way, to adhering to the six rights of tration. The six rights of tration include the following: edication se ent ute	F2	81				
	were informed of the medications were a for Resident #3. The that the physician a not notified of the odebriefings on 6-21	and DON (director of nursing) to failure of the staff to ensure administered on 2 occasions ney were also made aware and the Responsible party were missions, at the end of day -17, and 6-22-17. No further ovided by the facility.						
		), the facility staff failed to n was administered as cian.						
		admitted to the facility on included; Fractured left leg, ression.	!					

Resident #10's most recent MDS (minimum data

#### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

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	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUI A. BUILO	TIPLE CO		(X3) OATE SURVEY COMPLETEO		
		495369	B. WING		· .	0	6/22/2017	
	PROVIOER OR SUPPLIER	R AT PATRIOTS COLONY		6000	ET AOORESS, CITY, STATE, ZIP COOE PATRIOTS COLONY DRIVE LIAMSBURG, VA 23188			
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F 281	Continued From pa	ge 33	F:	281				
	3-29-17 was coded assessment. Resid moderate cognitive was also coded as assistance of one s	assessment reference date) of as a significant change full dent #10 was coded as having impairment. Resident #10 needing extensive to total taff member to perform ing, and was a hospice						
	eMAR (electronic marecord), Nursing proprinted MAR with no Resident was not a medication, on the notes documented	t #10's physician's orders, nedication administration ogress notes, and the facility otes, revealed that the dministered the following following days. There were no by staff in the clinical record ther than "unavailable" on notes;						
	be given every day 10:00 a.m.). The mather reason given for documented in the on 5-5-17, and simple administered (other	nicrograms subcutaneously to in the morning (8:00 a.m. to nedication was omitted, and r the omission was MAR notes, as, "Not available"						
	omission LPN E sta event. The nurse w 6-6-17 omission wa	ible for the 5-5-17 medication ated she had no memory of the who was responsible for the as not available during survey. Sing notes describing either						
		ress notes, and nursing e reviewed in their entirety for					: :	

May, and June of 2017. There was no indication

#### DEPARTMENT OF HEALTH AND HUMAN RVICES CENTERS FOR MEDICARE & MEDICAID CANCES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

OFILE	TO TOTA WILD TO TITLE	C MEDIO/ND CLINIOLO			OWD NO	. 0000-000 1	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		STREET ADDRESS, CITY, STATE, ZIP COD 6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188	Ξ		
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F 281	•	party, nor the physician was nat these medication	F	281			
		e plan was reviewed, and nedications as ordered".					
	(DON) and Adminis stated they would be DON delivered a co- progress notes, and May and June 2017 stated that the med administered, and to administration of or- given at a different	p.m., the Director of Nursing trator were interviewed, and look into the discrepancy. The lopy of the E-MAR, physician dinursing progress notes for Y. When interviewed the DON ications could have been the doctor could be called to ok the time per day meds to be time than what was originally by would not be missed, then at it is."					
	provided the facility the medication is be proper time, prescri route. Resolve any medication with the staff involved with the	sing (DON) and Administrator policy which stated to verify eing administered at the bed dose, and by the correct concerns about the provider, prescriber, and/or ne patient's care. The DON is their nursing standard.					
	"Fundamentals of N Potter-Perry, p. 705 such as the Americ Nursing Scope and of (2004), apply to tadministration. To	ig standards for the edication is provided by fursing, 7th Edition, Mosby's/ : Professional standards, an Nurses Association's Standards of Nursing Practice he activity of medication prevent medication errors, of medications.					

medication errors can be linked, in some way, to

#### DEPARTMENT OF HEALTH AND HUMAN TVICES CENTERS FOR MEDICARE & MEDICAID LIKVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l · · ·	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495369	B. WING	<u> </u>	06	/22/2017	
•••	PROVIDER OR SUPPLIER  VALESCENT CENTE	R AT PATRIOTS COLONY		STREET ADDRESS, CITY, STATE, ZIP CODE 6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		ULD BE	(X5) COMPLETION DATE	
F 281	medication adminismedication adminismedication adminismedication adminismedication adminismedication adminismedication adminismedication administrator awere informed of the medications were afor Resident #10. That the physician anot notified of the odebriefings on 6-21	adhering to the six rights of adhering to the six rights of stration. The six rights of stration include the following: edication se ent sute	F	281			
	facility on 3/4/10 and the diagnoses of, by (Chronic Obstructive chronic bronchitis, at The most recent Mian annual assessming Reference Date (All coded Resident #5 extensive assistance transfers, dressing staff for toileting and oxygen use.	s originally admitted to the d readmitted on 4/18/16 with ut not limited to, COPD e Pulmonary Disease), anxiety and dementia.  Inimum Data Set (MDS) was sent with and Assessment RD) of 5/4/17. The MDS with intact cognition; required be from staff for bed mobility, and hygiene; dependent on d bathing; and coded for					
		p.m., Resident #5 was ed, head of bed up, alert and				·	

answered questions when spoken to. Oxygen 2

## DEPARTMENT OF HEALTH AND HUMAN RVICES CENTERS FOR MEDICARE & MEDICAID RVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

	TO TOTA WILDIONIAL	G WILDIO/ND CLIVIOLO	,		<u> </u>	IAID 146	7. 0330-033 I
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495369	B. WING			06	/22/2017
	PROVIDER OR SUPPLIER  NVALESCENT CENTE	R AT PATRIOTS COLONY		600	REET ADDRESS, CITY, STATE, ZIP CODE 00 PATRIOTS COLONY DRIVE LLIAMSBURG, VA 23188		
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F 281	use. When asked Resident #5 denied On 6/21/17 at 9:05 observed lying in be stated she wanted was in use at 2 lpm Resident #5's clinic 6/21/17 at 10:05 a.r current physician of (oxygen) 2 L/min (2 cannula PRN (as ne documentation in the rationale of the oxygen) on 6/21/17 at 1:30 conducted with the Practical Nurse-C (the rationale for Re LPN-C reviewed the was to be used PR into that."  On 6/21/17 at 2:10 observed in bed, re oxygen on at 2 lpm asked if she wears Resident #5 stated she uses the oxyge it."  On 6/21/17 at 3:10 conducted with LPN Nursing present. L should've been characteristics.	Ipm) via nasal cannula was in how her breathing was doing, any respiratory problems.  a.m., Resident #5 was ed, head of bed up, alert and to be left alone today. Oxygen via nasal cannula.  al record was reviewed on m. The review revealed reders which included "02 liters per minute) per nasal eeded)." There was no ne nurse's notes for the	F 2	81			

Administrator and Director of Nursing were

#### PRINTED: 07/17/2017 DEPARTMENT OF HEALTH AND HUM/ SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICA SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495369 B. WING 06/22/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6000 PATRIOTS COLONY DRIVE THE CONVALESCENT CENTER AT PATRIOTS COLONY WILLIAMSBURG, VA 23188 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 281 Continued From page 37 F 281 informed of the oxygen use without documented assessments or rationale for the as needed use. The oxygen policy was requested. Guidance given by Fundamentals of Nursing, Potter Perry by Mosby, Eighth Edition, page 873 included: "...Assessment...2. Assess patient's respiratory status...and lung sounds...5. Review patient's medical record for medical order for oxygen, noting delivery method, flow rate, and duration of oxygen therapy. Rationale Ensures safe and accurate oxygen administration. Safe oxygen delivery includes the six rights of mediation administration." Page 305 read: Nurses follow health care providers' orders unless they believe the orders are in error or harm patients. Therefore you need to assess all orders; if you find one to be erroneous or harmful, further clarification from the health care provider is necessary. Page 584 read: To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to these rights: 1. The right medication 2. The right dose

- 3. The right patient
- 4. The right route
- 5. The right time
- 6. The right documentation

On 6/22/17 at 6:10 p.m. the Administrator stated "We don't have an oxygen policy, we follow physician orders." The facility professional reference source used was Mosby. No further information was provided by the facility staff.

F 309 483.24, 483.25(k)(I) PROVIDE CARE/SERVICES

F 309

7/24/17

## DEPARTMENT OF HEALTH AND HUMAN RVICES CENTERS FOR MEDICARE & MEDICAID RVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		495369	B. WING _		0,	6/22/2017	
	PROVIDER OR SUPPLIEI	RER AT PATRIOTS COLONY		STREET ADDRESS, CITY, STATE, ZIP 6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188			
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		/ELL BEING life fundamental principle that	F 30	9			
	residents. Each r facility must provid services to attain practicable physic well-being, consis	and services provided to facility esident must receive and the de the necessary care and or maintain the highest cal, mental, and psychosocial tent with the resident's seessment and plan of care.					
,	applies to all treat facility residents. I assessment of a that residents rec- accordance with p practice, the comp	a fundamental principle that ment and care provided to Based on the comprehensive resident, the facility must ensure eive treatment and care in professional standards of prehensive person-centered e residents' choices, including					
	provided to reside consistent with prothe comprehensive	nent. ensure that pain management is ents who require such services, ofessional standards of practice, re person-centered care plan, goals and preferences.					
	residents who req services, consiste of practice, the co care plan, and the preferences. This REQUIREME	acility must ensure that uire dialysis receive such ant with professional standards imprehensive person-centered e residents' goals and					
	by: Based on staff in	terview, facility documentation		1. Resident # 1 and #6 p	hysician orders	8	

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	L.		(	FORM APPROVED OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
<u> </u>	495369	B. WING		06/22/2017
NAME OF PROVIDER OR SUPPLIER  THE CONVALESCENT CENTE	R AT PATRIOTS COLONY		STREET ADDRESS, CITY, STATE, ZIP CODE 6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188	
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE COMPLETION
failed to maintain the being for 3 (Reside residents in the sure 1. For Resident #1 ensure non-pharma attempted prior to a medications, Seroo 2. For Resident #5	record review, the facility staff ne highest practicable well nts #1, #5 and #6) of 16 vey sample.  , the facility staff failed to acological approaches were administering the antipsychotic		were clarified on June 22, 2017 manager. Resident # 5 physicial were clarified on July 10, 2017 b manager. The Providers orders updated to allow documentation non-pharmacological approache administering pain, anti-anxiety, anti-psychotic medications.  2. All residents are at risk for administration of prn pain, antial antipsychotic medications prior te	n orders by clinical were of es prior to and

3. For Resident #6, the facility staff failed to ensure non-pharmacological approaches were attempted prior to administering the antipsychotic medication. Haldol and antianxiety medication. Ativan.

attempted prior to administering the pain medications, Tramadol and Acetaminophen.

The findings included:

1. Resident #1 was admitted to the facility on 2/15/17 with the diagnoses of, but not limited to, Parkinson's Disease, dementia, hypertension, and anemia.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 5/16/17. The MDS coded Resident #1 with severe cognitive impairment; no behavior symptoms; required extensive assistance from staff for bed mobility, transfers, ambulation, dressing, toileting, and hygiene; dependent on staff for bathing; and always incontinent of bowel and bladder.

On 6/21/17 at 8:40 a.m., Resident #1 was

residents with PRN orders for pain, antianxiety and antipsychotic medications with clarification orders written as needed to prompt the nurse to provide and document non-pharmacological interventions. 3. Licensed nurses will receive re-education by the DON/designee by July 24, 2017 for order entry of medications

non-pharmacological interventions The

DON/designee will audit all current

- requiring non-pharmacological interventions and requirement to intervene and document all non-pharmacological interventions prior to administration of prn medications.
- 4. The DON/Designee will audit PRN medications documentation for non-pharmacological interventions prior to administration and that orders are entered with reminder to provide and document non-pharmacological interventions. These audits will be completed on 4 residents for 4 weeks, 2 residents weekly for 8 weeks and then 5 residents monthly

## DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING   COMPLETE    495369   B. WING   06/22/20  NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE    6000 PATRIOTS COLONY DRIVE	<u>OLIVILI</u>	10 I OIL MILDICAIL	& MEDICAL SERVICES				<u>uivib ivu.</u>	<u>. 0938-0391</u>	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  6000 PATRIOTS COLONY DRIVE						CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
THE CONVALESCENT CENTER AT PATRIOTS COLONY			495369	B. WING		<del></del>	06/	<b>22/20</b> 17	
THE CONVALESCENT CENTER AT PATRIOTS COLONY	NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE			
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WILLIAMSBURG, VA 23188	THE COL	WALESCENT CENTE			WI	LLIAMSBURG, VA 23188			
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION OATE	
F 309 Continued From page 40 observed in a wheelchair in his room with his wife present. He did not answer questions when spoken to but mumbled a few words at random.  On 6/22/17 at 9:55 a.m. Resident #1's clinical record was reviewed. The review revealed a physician's order for Seroquel 25 mg (milligrams) as needed two times daily starting 2/15/17 for agitation. The as needed Seroquel was documented as administered without non-pharmacological approaches on 2/10/17 at 4:27 p.m., 2/26/17 at 9:26 a.m., 2/28/17 at 3:22 p.m., and 3/2/17. The Seroquel was discontinued on 3/3/17 and reordered on 3/4/17 for "unspecified dementia with behavioral disturbance." It was administered on 3/4/17 at 10:00 p.m., 3/10/17 at 12:45 a.m., 3/15/17 at 7:41 p.m., and 3/3/1/17 at 17:57 p.m. On 3/28/17 the Seroquel was administered without documented attempted non-pharmacological approaches on 4/1/17 at 11:39 a.m., 4/1/17 at 9:30 p.m., 4/1/17 at 4:44 p.m., 4/8/17 at 6:05 p.m., 4/1/17 at 6:05 p.m., 4/1/17 at 4:44 p.m., and 4/13/17 at 11:30 a.m., 4/1/17 at 6:05 p.m., 4/1	F 309	observed in a whee present. He did no spoken to but mum  On 6/22/17 at 9:55 record was reviewe physician's order fo as needed two time agitation. The as n documented as adrianon-pharmacologic 4:27 p.m., 2/26/17 ap.m., and 3/2/17. Ton 3/3/17 and reord "unspecified demer disturbance." It was 10:00 p.m., 3/10/17 p.m., and 3/31/17 a Seroquel order was mouth) daily prn semay repeat in 30 m Seroquel was admi attempted non-pharmacologic administration of Seroquel administration of Seroquel order was mouth) the seroquel was admi attempted non-pharmacologic administration of Seroquel administration of Seroquel administration of Seroquel of the failt non-pharmacologic informed of the failt non-pharmacologic informed of the failt non-pharmacologic.	elchair in his room with his wife t answer questions when abled a few words at random.  a.m. Resident #1's clinical and. The review revealed a per Seroquel 25 mg (milligrams) as daily starting 2/15/17 for eeded Seroquel was ministered without and approaches on 2/10/17 at at 9:26 a.m., 2/28/17 at 3:22. The Seroquel was discontinued dered on 3/4/17 for at a tax with behavioral and with behavioral and and and at 12:45 a.m., 3/15/17 at 7:41 at 1:57 p.m. On 3/28/17 the changed to "1 (25 mg) po (by vere distress/aggression and in if not effective" The inistered without documented remacological approaches on and in if not effective" The inistered without documented remacological approaches on and in it not effective" The inistered without documented remacological approaches on and in it not effective The inistered without documented remacological approaches on and in it not effective The inistered without documented remacological approaches on and in it not effective The inistered without documented remacological approaches on and in it not effective The inistered without documented remacological approaches on and in it not effective The inistered without documented remacological approaches on and in it not effective The initial and it is not effective The initi	F 3		the QA meeting by Director of Nursing/designee for evaluation compliance and ongoing monitor continuous improvement analysis	of ing for		

medication administration records for

## DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

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				VV	/ILLIAMSBURG, VA 23188		
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F 309	Continued From pa	nge 41	F;	309			
	February-April 201 plan were requeste	7, physician orders and care d.					
	was informed of the non-pharmacologic administration of State facility realized worked on the communes to attempt a non-pharmacologic information was proceed as a constant of the diagnoses of, by (Chronic Obstructive chronic bronchitis, of the most recent M an annual assessme Reference Date (Al coded Resident #5 extensive assistant transfers, dressing	ral interventions prior to the eroquel. Admin-B explained it was an issue and they puter program to direct the and document ral approaches. No further ovided by the facility staff.  I was originally admitted to the addreadmitted on 4/18/16 with out not limited to, COPD re Pulmonary Disease), anxiety and dementia.  Inimum Data Set (MDS) was been with and Assessment RD) of 5/4/17. The MDS with intact cognition; required the from staff for bed mobility, and hygiene; dependent on distance.					
	On 6/21/17 at 10:09	5 a.m. Resident #5's clinical dd The review revealed 2016					:
	twice a day as need was documented a 11:50 and 9/13/16 a The nurse did not c	nilligrams) 1 tablet by mouth ded for pain. The Tramadol s administered on 9/12/16 at at 10:40 for "Pain to back." locument the description of or al interventions attempted	•				

prior to administering the pain medication. She

## DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

<u> </u>	COT OIL HILDIONICE	WINDOWNE CERTICES				7111D 110	. 0000 0001	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495369	B. WING			06/	22/2017	
	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		60	TREET ADDRESS, CITY, STATE, ZIP CODE 000 PATRIOTS COLONY DRIVE VILLIAMSBURG, VA 23188	-	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION OATE	
F 309	And,  Acetaminophen 32: as needed every fo Acetaminophen wa administered on 12 documentation of lonon-pharmacologic prior to the adminis She did however do Resident #5's care reviewed and include "Resident has exprepain/discomfort rela Arthritis-Osteoarthr  The approaches challing and assintensity, quality and Encourage and assintensity, quality and Encourage resident interventions are not Administer medicate physician; Assist the resident manner that is most other devices as not Apply heat or cold a requested by reside physician; Apply gentle massatolerated by or requested by or requested of the physician of t	from the result as "effective."  5 mg tablet (650 mg=2 tablets) ur hours for pain. The s documented as /25/16 at 9:36 p.m. without ocation or description of, nor cal interventions attempted tration of the pain medication. Ocument the result as "Relief."  1 plan dated from 5/24/16 was ded: 1 essed/demonstrated ated to: -Rheumatoid itis"  1 eck included, but were not sist resident to identify d location of pain; to tell nurse when pain of being effective; cion as prescribed by the as needed to position in a t comfortable; use pillows or ent and/or ordered by age or range of motion as rested by resident; may re-focus resident such as no, etc.  1 plicy titled "Pain Assessment"		309				
		with a "Last Revision Date" of	:					

## DEPARTMENT OF HEALTH AND HUM, SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495369	B. WING	i		06/	22/2017
	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		6	TREET ADDRESS, CITY, STATE, ZIP CODE 5000 PATRIOTS COLONY DRIVE VILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION OATE
F 309	highest practicable prevent or manage the facility:  a) Recognizes who pain and identifies obe anticipated; b) Evaluates the exand c) Manages or prevesident's goals, the and plan of care, and plan of care, and plan of care, and practice." The polymer of practice. The polymer of practice assessment will sig C. Resident's expresservation of symplemonstrative of pafrequently.  a. When a resipain/discomfort, trebe provided per phycomprehensive care b. The medical of the resident's pain provided, and effect treatment/intervention on 6/21/17 at 3:10 conducted with the When asked about approaches prior to medication, Adminanon-pharmacological pain and the following provided and proaches prior to medication, Adminanon-pharmacological pain and the facility of the provided provided and the facility of the facilit	e following:  attain or maintain his/her level of well-being and to pain, to the extent possible, en the resident is experiencing circumstances when pain can  kisting pain and the cause(s); vents pain, consistent with the e comprehensive assessment and current clinical standards colicy also included: d nurse completing the n/date the assessment form. ession of pain/discomfort and ptoms that may be ain will be monitored  dent expresses atment and/or intervention will ysician order and/or the e plan. I record will include description in, treatment or interventions tiveness of the on"  p.m. an interview was Director of Nursing (Admin-B). non-pharmacological	F	309			

notes."

## DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495369	B. WING			06/	/22/2017	
	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		600	REET ADDRESS, CITY, STATE, ZIP CODE 00 PATRIOTS COLONY DRIVE LLIAMSBURG, VA 23188		_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	IX5) COMPLETION DATE	
F 309	6/24/16 with the dia dementia, psychosi encephalopathy, and The most recent MI assessment with ar coded Resident #6 impairment; no psyc for wandering; requirem staff for all act	s admitted to the facility on agnoses of, but not limited to, is, depression, metabolic ad chronic pain.	F3	809				
	observed sleeping i	p.m. Resident #6 was in bed, fall mat <b>s</b> and bed alarm vas in a recliner chair next to	:					
		p.m. Resident #6's clinical d. The review revealed nich included:						
	every four hours standaloperidol was dis- instructions include read: "1 po (by mo	) 1 mg tablet oral as needed arting 2/15/17. The order for continued 4/27/17. The d with the physician's order uth) every four hours as distress or aggression that ed. And,						
	rectally every 2 hou	) 1mg PO , sublingual or irs as needed for restlessness, ir seizures. Tablet may be ved if needed.	:					
		2017 Medication ord (MAR) revealed the Haldol on 4/2/17 at 8:04 a.m. with						

## DEPARTMENT OF HEALTH AND HUM/ SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

CENTER	49 FOR MEDICARE	A MEDICAIL SERVICES				OIND IN	<del>J. 0936-0391</del>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		ATE SURVEY OMPLETED
		495369	B. WING			00	6/22/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		<del>.</del>
THE CO	NVALESCENT CENTE	R AT PATRIOTS COLONY			00 PATRIOTS COLONY DRIVE LLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	Review of the nurse a.m. revealed the form nurses station. The sustained no injurite on 4/2/17 at 10:28 arrival increase aging witness fall with no am with effectiness the moment voices. There were no doct interventions prior to the May Lorazepam was ad (10:12 p.m.) with "Form There were no nurse of administration of Resident #6's care." Resident is at risk of psychoactive me (as needed). The increase plan were: "Administer medical Observe and report tardive dyskinesia; Assess for other cardisturbances prior to "Behavioral Symptom physical behavioral symptom physical sym	Behavior Decreased." es notes for 4/2/17 at 7:30 collowing documentation: wheel chair while sitting at the fall was witnessed, resident its. Nurses note documented a.m. read "Resident upon tation to get up unassisted, injuries Haldol given at 804 (sic). resident lying down at no complaints at the moment. In the administration of Haldol.  2017 MAR revealed the ministered on 5/24/17 at 22:12 Results" listed as "Relief." sees notes at or around the time the Ativan.  plan included: for side effects related to use dication: antipsychotics PRN moactive medications are manage following is agitation that can not be terventions included in the					
	directed." Intervent						

## DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAL JERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495369	B. WING			06	6/22/2017
	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		60	REET ADDRESS, CITY, STATE, ZIP CODE . 000 PATRIOTS COLONY DRIVE FILLIAMSBURG, VA 23188	, 00	ILLIZVII
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 309	precipitating factors Attempt to redirect. Speak to resident in On 6/21/17 at 4:30 Director of Nursing and surveyor requencement of Nursing and State	n as ordered; behavior (time of day, so, specific staff or situation); Allow time to calm down. In a calm voice."  p.m. the Administrator and were informed of the findings ested information on all approaches for the PRN istered.  a.m., The Clinical Manager, sy "Could not find any actions." A copy of the facility macological and psychoactive is requested and received. The rocedure titled "Psychoactive havior Monitoring" included the facility of life and function of ring approaches to meeting incident the strongh individualized, approaches to reduce potentially ful behaviors and promote abilities and quality of life. It is effective when they are used dress significant, specific, or psychiatic causes, or new rioral symptoms. All ding medications, need to be acy, risks, benefits and harm"		609			

will be ordered with medication and indication for

## DEPARTMENT OF HEALTH AND HUM/ SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3	(X3) DATE SURVEY COMPLETED		
		495369	B. WING_			06/22/2017		
	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		STREET ADDRESS, CITY, STATE, ZI 6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIAT			
F 309	Continued From pa	ge 47	F 30	9				
	interventions.	pted before the prn						
	(Admin-B) explainer issue and they work to direct the nurses non-pharmacologic information was pro-	p.m. The Director of Nursing d the facility realized it was an ked on the computer program to attempt and document al approaches. No further ovided by the facility staff.  I)-(3) FREE OF ACCIDENT VISION/DEVICES	F 32	3		7/24/17		
	(d) Accidents. The facility must en	sure that -						
		vironment remains as free rds as is possible; and						
	` '	eceives adequate supervision ices to prevent accidents.		•				
	appropriate alternat bed rail. If a bed or must ensure correc	e facility must attempt to use ives prior to installing a side or side rail is used, the facility t installation, use, and I rails, including but not limited nents.						
	(1) Assess the residence from bed rails prior	dent for risk of entrapment to installation.						
		and benefits of bed rails with dent representative and obtain rior to installation.						

## DEPARTMENT OF HEALTH AND HUM/ SERVICES

PRINTED: 07/17/2017

	RS FOR MEDICARE	& MEDICA SERVICES		(		. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY APLETED
		495369	B. WING		06/	<b>22/201</b> 7
	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		STREET ADDRESS, CITY, STATE, ZIP CO 6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR  X (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 48	F 3	23		
	appropriate for the This REQUIREMENT by: Based on observate facility staff failed to environment as evicential to the control of the control	bed's dimensions are resident's size and weight. It is not met as evidenced ion and staff interview, the ensure a hazard free denced by 1: An emergency locked by resident lift devices		The lift devices were impressed from the emergency June 22, 2017 by LPN C. Rewheelchair arm was replace.	cy door on esident #1	
		sident #1's wheelchair arm		<ul><li>2017 by Therapy Director.</li><li>2. All residents are at risk f</li></ul>		
	Manager, Licensed 6/20/17 at approxim devices were obser emergency exit doo the lifts were partial door. LPN-C move	r of the facility with Unit Practical Nurse-C (LPN-C) on lately 3:15 p.m., 4 resident lift lift ved in the out cove near the r closest to room 127. 2 of ly blocking the emergency exit d both lifts to the opposite out lading to the area and out		environmental hazards. The was immediately removed a wheelchair arm was replace were immediately checked fobjects in front of fire doors were noted. A 100% audit woon all wheelchair arms to en by Administrator /designee of 2017.	lift device nd the d. All doors or other and none as performed sure no tears	
	Coves were a "T" shape).  On 6/20/17 at 3:40 p.m. an interview was conducted with LPN-C. When asked about the doors near room 127, LPN-C explained the "Back door is an emergency exit and will alarm if door is pushed." When asked where the lifts are normally stored, LPN-C stated "Usually on the other side of the hall (the other out cove area)." She stated "We need to keep that area clear so we can get out or someone can get in."  On 6/21/17 at 3:45 p.m., no emergency exit doors were observed to be blocked. At 4:50 p.m., the Director of Nursing and Administrator were informed of the findings.			<ol> <li>The facility staff will rece education by the Administrat regarding maintaining an entis hazard free of not having a door blocked by a resident libe educated by Administrato process for reporting tears in wheelchair arm rest cushion 2017.</li> <li>The emergency doors where they are hazard free 5 times weeks then twice weekly for then weekly. All wheelchairs inspected for torn armrests seed, 2017 following the wheel</li> </ol>	tor/designee vironment that an emergency ft. Staff will or/designee on a the by July 24, will be audited be to ensure weekly for 4 8 weeks and is will be starting July	

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICA SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CEIVIE	(2 LOK MEDICAKE	A MEDICA - SEKVICES			<u>.</u>		MB NO.	<u> </u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l · ·	IPLE CONSTRU				E SURVEY PLETED
		495369	B. WING_				06/2	22/2017
NAME OF F	ROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE, ZIP C	ODE		
THE COL	NALESCENT CENTE	D AT DATRICTS COLONY		6000 PATRIC	OTS COLONY DRIVE			
THE CON	IVALESCENT CENTE	ER AT PATRIOTS COLONY		WILLIAMS	BURG, VA 23188			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF COR ACH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION OATE
F 323	Continued From pa	nge 40	F 32	7			ļ	
1 020	•	_	ГЭД		المائد والمصاد والخائد وال	-44 -46-		į ;
		a.m. during general acility with the Director of			le with needs provide		erapy	
		), Admin-D was asked if			r for immediate repai ement of wheelchair.		culte of	
		hould be blocked; he replied			lits will be reported m			
	"Absolutely not."	loana de dicentea, ne replica		QA mee	eting for evaluation of going for monitoring	of comp	liance	
	No further informati staff.	ion was provided by the facility		improve	ement analysis after entation.		;he	
	2/15/17 with the dia	s admitted to the facility on agnoses of, but not limited to, e, dementia, hypertension,						
	quarterly assessme Reference Date (AF coded Resident #1 impairment; no beh extensive assistand transfers, ambulation hygiene; dependent	inimum Data Set (MDS) was a cent with an Assessment RD) of 5/16/17. The MDS with severe cognitive navior symptoms; required be from staff for bed mobility, on, dressing, toileting, and ton staff for bathing; and of bowel and bladder.						
	observed in a whee arm rest cushion wa multiple spots along did not answer ques mumbled a few wor wife was present up interview was condu wheelchair arm, Re had a different whee	a.m., Resident #1 was elchair in his room. The right as torn and peeled off in g the arm rest. Resident #1 stions when spoken to but rds at random. Resident #1's oon observation and a family ucted. When asked about the esident #1's wife stated "He elchair when we first got did not have any visible gs on his arms.						
	On 6/21/17 at 2:05	p.m. Resident #1 was	:				,	

observed in the wheelchair in his room with his

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		495369	B. WING_		06	5/22/2017
	PROVIDER OR SUPPLIER	ER AT PATRIOTS COLONY		STREET ADDRESS, CITY, STATE, ZIP CODE 6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 50	F 32	3		
	resident's wife state lunch and I think the	aff member present. The ed "We just got back from ey're going to walk him again." n rest remained torn.				
	The Administrator a informed of the torr	and Director of Nursing were n arm rest.				;
F 328 SS≕D	conducted with the When asked about stated "We have a be rolled in." She so "Could've been and no documented skin a.m., Resident #1 win the hallway with a rest had no tears or information was produced.	a.m. an interview was Director of Nursing (Admin-B). checking equipment, Admin-B wheelchair washer that it can stated the wheelchair arm oversight." Resident #1 had n issues on his arms. At 11:35 was observed in his wheelchair a staff member. The right arm r peeled areas. No further ovided by facility staff. b)(h)(i)(j) TREATMENT/CARE EDS	F 32	8		7/24/17
		ensure that residents receive nd care to maintain mobility th, the facility must:				
	with professional st	e and treatment, in accordance candards of practice, including ations from the resident's and				
	appointments with a	sist the resident in making a qualified person, and portation to and from such				
		erostomy, or ileostomy care. Isure that residents who				

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICA. SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

<u> </u>	TO I OIT WILDIONITE	C WILDIO! "- OFICE				IVID IV	<u>. 0000-009 l</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		re survey MPLETED
		495369	B. WING			06	/22/2017
	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		60	REET ADDRESS, CITY, STATE, ZIP CODE 00 PATRIOTS COLONY DRIVE ILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION OATE
F 328	services, receive su professional standa comprehensive per the resident's goals  (g)(5) A resident who receives the approption of the appropriation of the a	ureterostomy, or ileostomy uch care consistent with ards of practice, the son-centered care plan, and and preferences.  To is fed by enteral means oriate treatment and services lications of enteral feeding afted to aspiration pneumonia, dehydration, metabolic masal-pharyngeal ulcers.  S. Parenteral fluids must be stent with professional ce and in accordance with the comprehensive are plan, and the resident's	F:	3328			
	professional standa comprehensive per	•					
	resident who has a and assistance, cor standards of practic person-centered ca and preferences, to prosthetic device.	e facility must ensure that a prosthesis is provided care nsistent with professional ce, the comprehensive are plan, the residents' goals wear and be able to use the					

by:

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICA, SERVICES

CENTER	19 LOK MEDICAKE	& MEDICAID SEKVICES			` <u> </u>	<u>IMB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILE		E CONSTRUCTION		E SURVEY PLETED
		495369	B. WING	·		06/:	22/2017
NAME OF E	PROVIDER OR SUPPLIER		1	s	TREET ADDRESS, CITY, STATE, ZIP CODE	<del></del> -	
					000 PATRIOTS COLONY DRIVE		
THE CO	NVALESCENT CENTE	R AT PATRIOTS COLONY			VILLIAMSBURG, VA 23188		
	CUMMADVCTA	TEMENT OF DEFICIENCIES				<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 328	Continued From pa	ge 52		328	'		
. 020	•			J20		: ماليا	:
		tion, resident interview, staff all record review, the facility			<ol> <li>Resident #5 order was clarified</li> <li>21, 2017 for continuous oxygen by</li> </ol>		
		e oxygen use was clarified for	1		manager. Responsible representa		!
		of 16 residents in the survey			notified June 21, 2017.	ive was	
	sample.	or to residents in the survey			·		! : :
	Decident #5 had av	venn in ven anatinvevalv			2. All residents within the facility		
		ygen in use continuously ey however, the physician's			risk for unclear oxygen orders. DO		:
	order was for PRN	•	! !		/designee will complete a 100% au		•
	Older Was for I TIN	(as needed) use.			residents with oxygen to ensure at residents with oxygen have the co		
	The findings include	ed:	orders.			rect	
	on 3/4/10 and read diagnoses of, but n	iginally admitted to the facility mitted on 4/18/16 with the ot limited to, COPD (Chronic hary Disease), chronic and dementia.			<ol> <li>The Licensed nurses will receive-education by the Director of Nursing/designee regarding medic symptom necessary for prn oxyget by July 24, 2107.</li> </ol>	al	
	an annual assessm Reference Date (All coded Resident #5 extensive assistance transfers, dressing staff for toileting and oxygen use.  On 6/20/17 at 3:35 observed lying in be answered questions liters per minute (2 use. When asked leaders.)	nimum Data Set (MDS) was ent with and Assessment RD) of 5/4/17. The MDS with intact cognition; required to from staff for bed mobility, and hygiene; dependent on dibathing; and coded for p.m., Resident #5 was ed, head of bed up, alert and is when spoken to. Oxygen 2 lpm) via nasal cannula was in now her breathing was doing, any respiratory problems.			4. The DON/ designee will complexygen order audits weekly for 4 wand 2 audits per week for 8 weeks monthly. The results of the audits reported monthly at the QA meetine evaluation of compliance and ongo monitoring for continuous improve analysis after the implementation. DON/designee responsible.	reeks then 2 will be g for ping for	
	observed lying in be	a.m., Resident #5 was ed, head of bed up, alert and o be left alone today. Oxygen via nasal cannula.				i :	

### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICA SERVICES			<u> </u>	<u>OMB NO</u>	<u>D. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		ATE SURVEY OMPLETED
		495369	B. WING	·		0	6/22/2017
NAME OF	PROVIDER OR SUPPLIER			Ţ,	STREET ADDRESS, CITY, STATE, ZIP CODE		<u></u>
THE COI	NVALESCENT CENTE	R AT PATRIOTS COLONY			6000 PATRIOTS COLONY DRIVE		
<del></del>	· ·				WILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 328	Continued From pa	ge 53	: : F:	328			
		al record was reviewed on		J_ (			:
	6/21/17 at 10:05 a.r	m. The review revealed	į i				: :
		ders which included "02	!				
		liters per minute) per nasal eeded)." The was no	<u> </u>				
		ne nurse's notes for the			•		
	rationale of the oxy	gen use.	<b>i</b> !				
	On 6/21/17 at 1:30	p.m. an interview was	:				
		Unit Manager, Licensed	 				
		LPN-C). When asked about	:				
		sident #5's oxygen use, e physician's orders, noted it					
		N and stated she "Will look	:				
	On 6/21/17 at 2:10	p.m. Resident #5 was					
	observed in bed, re	ading a newspaper, with the					
		via nasal cannula. When					
		the oxygen all the time, "Yes I do." When asked why					: !
		n she stated "Because I need					
	it."						1
	On 6/21/17 at 3:10	p.m. an interview was					1
		I-C with the Director of					
		PN-C stated the "Order					:
		nged from PRN to continuous					
		ath." At 4:35 p.m. the Director of Nursing were					:
		gen use without documented	!				
		onale for the as needed use.					* * *
	The oxygen policy v	vas requested.					:
	On 6/22/17 at 6:10	p.m. the Administrator stated	!				
	"We don't have an o	oxygen policy, we follow					
	physician orders."	The facility professional					

reference source used was Mosby. No further information was provided by the facility staff.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARE & SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION		TE SURVEY MPLETED
		495369	B. WING			06	/22/2017
	PROVIDER OR SUPPLIER	ER AT PATRIOTS COLONY		6000	EET ADDRESS, CITY, STATE, ZIP CODE PATRIOTS COLONY DRIVE LIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<b>X</b>	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	IX5) COMPLETION DATE
	483.45(d)(e)(1)-(2) FROM UNNECES	) DRUG REGIMEN IS FREE SARY DRUGS	F 3	29			7/24/17
	Each resident's dr	ssary Drugs-General. ug regimen must be free from s. An unnecessary drug is any	÷				
	(1) In excessive do therapy); or	ose (including duplicate drug					
	(2) For excessive	duration; or					
	(3) Without adequa	ate monitoring; or					
	(4) Without adequa	ate indications for its use; or					
	. ,	e of adverse consequences dose should be reduced or					
		ons of the reasons stated in through (5) of this section.					
		ropic Drugs. ehensive assessment of a y must ensure that	!				
	drugs are not given medication is nece	have not used psychotropic in these drugs unless the essary to treat a specific osed and documented in the					
	gradual dose redu	use psychotropic drugs receive ctions, and behavioral ss clinically contraindicated, in					

## DEPARTMENT OF HEALTH AND HUM/ SERVICES CENTERS FOR MEDICARE & MEDICA. SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICA. SERVICES			(	OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION		E SURVEY APLETED
		495369	B. WING			06/	/22/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CO	WALESCENT SENTE	D AT DATDICTO COL CAN		6	000 PATRIOTS COLONY DRIVE		
THE CO	NVALESCENI CENTE	R AT PATRIOTS COLONY		V	VILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION OATE
F 329	Continued From pa	ge 55	F 3	29	!		
	· ·	NT is not met as evidenced		20			
	by:						
		rview, facility documentation			1. Resident #1 and #6 orders		
		record review, the facility staff			clarified on June 22, 2017 by cl		
		Residents #1, #5 and #6) of 16			manager. Resident # 5 orders v		
	unnecessary medic	vey sample were free from			clarified on July 10, 2017 by clir manager. The Providers orders		1
	urinecessary medic	ations.			updated to allow documentation		
	1. For Resident #1	, the facility staff failed to			non-pharmacological approach		
		cological interventions were			administering pain, anti-anxiety		
	attempted prior to a medications, Seroq	dministering the antipsychotic uel and Haldol.			anti-psychotic medications.		
					2. All residents are at risk for		
		, the facility staff failed to			administration of unnecessary		
		cological interventions were			medications. The DON/designe		
		dministering the pain adol and Acetaminophen.	1		audit all current residents with F for pain, antianxiety and antipsy		i.
	medications, traine	ador and Acetaminophen.	•		medications with clarification or		
	3. For Resident #6	, the facility staff failed to			written as needed to prompt the		
		cological interventions were			provide and document		
		dministering the antipsychotic and antianxiety medication,			non-pharmacological intervention	ins.	
	Ativan.	,			3. Licensed nurses will receive	<b>.</b>	 
					re-education by the DON/design		
	The findings include	ed:			24, 2017 of unnecessary medic		İ
	4 Desident#4	- 4 - 10 - 4 t - 11 - 6 - 110			administration. Education will in		
		admitted to the facility on			order entry and documentation		
		gnoses of, but not limited to, e, dementia, hypertension,			non-pharm logical interventions appropriate.	as	
	The most recent Mi	nimum Data Set (MDS) was a			4. The DON/Designee will aud	lit PRN	; !
		nt with an Assessment			medications documentation for		
	Reference Date (AF	RD) of 5/16/17. The MDS			non-pharmacological intervention	ons prior to	
		with severe cognitive			administration and that orders a		
		avior symptoms; required			with reminder to provide and do		
	extensive assistance	e from staff for hed mobility			non-pharmacological intervention	ine	

transfers, ambulation, dressing, toileting, and

hygiene; dependent on staff for bathing; and

These audits will be completed on 4

residents for 4 weeks, 2 residents weekly

## DEPARTMENT OF HEALTH AND HUMA'' SERVICES CENTERS FOR MEDICARE & MEDICA. SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	42 FOR MEDICARE	& MEDICA. SERVICES				IVID NO.	<u>0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		495369	B. WING_			06/2	<b>22/201</b> 7
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				600	00 PATRIOTS COLONY DRIVE		
THE CO	NVALESCENT CENTE	R AT PATRIOTS COLONY		W	ILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	IX5) COMPLETION DATE
F 329	Continued From pa	ae 56	F 32	20			
1 020	-	<del>-</del>	F 32	29		44.5	
	always incontinent	of bowel and bladder.			for 8 weeks and then 5 residents m		
		<b>5</b>	İ		for 3 months. All audits will be repo	rted at	
		a.m., Resident #1 was			the QA meeting by Director of	Ì	
		Ichair in his room with his wife			Nursing/designee for evaluation of		
		t answer questions when			compliance and ongoing monitoring		
	spoken to but mum	bled a few words at random.			continuous improvement analysis a implementation.	after the	
	On 6/22/17 at 9:55	a.m. Resident #1's clinical			implementation.		
		d. The review revealed a				: 	
		r Seroquel 25 mg (milligrams)				į	
		s daily starting 2/15/17 for				ļ	
		eeded Seroquel was				!	
	documented as adr	•					
		al approaches on 2/10/17 at				:	
		at 9:26 a.m., 2/28/17 at 3:22				;	
		he Seroquel was discontinued				:	
	on 3/3/17 and reord						
	"unspecified demer						
		s administered on 3/4/17 at					
		at 12:45 a.m., 3/15/17 at 7:41	 				
		t 1:57 p.m. On 3/28/17 the				i	
		changed to "1 (25 mg) po (by	i			!	
		vere distress/aggression and					
		in if not effective" The				İ	
		nistered without documented				ļ	
		macological approaches on				!	
		., 4/1/17 at 9:30 p.m., 4/7/17				!	
		at 6:05 p.m., 4/11/17 at 6:33				į	
	p.m., and 4/13/17 a						
	Nh	and desired for the section				!	
		reviewed for the above				!	
		ation dates. There were no				ļ	
	documented attemp					ļ	
		al interventions prior to the				! :	
	administration of Se	eroquel.					
	0 0/00/47 -4 4:00					!	
		p.m. the Unit Manager,					
	FICELISED LINGUIGH	Nurse-C (LPN-C) was				į.	

informed of the failure to attempt

### DEPARTMENT OF HEALTH AND HUM? SERVICES CENTERS FOR MEDICARE & MEDICA. SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO 0938-0391

CLIVIL	10 I OK MILDICAKE	A MILDIOA. SLINVICES			<u> </u>	VID NO.	<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING		(X3) DATE COMF	SURVEY
		495369	B. WING	)		06/2	2/2017
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZI			
THE CO	NVALESCENT CENTE	R AT PATRIOTS COLONY		6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	•	ION SHOULD HE APPROPR	BE	IX5) COMPLETION OATE
F 329	administration of Somedication administration administration administration administration administration of Some administration of Some administration of Some administration of Some administration of Some administration administration administration of Some administration o	al approaches prior to the eroquel. Resident #1's stration records for 7, physician orders and care d.  p.m. The Director of Nursing e failure to attempt al interventions prior to the eroquel. Admin-B explained it was an issue and they puter program to direct the	F	329			
	an annual assessm Reference Date (Al coded Resident #5 extensive assistance transfers, dressing staff for toileting an coded for not havin On 6/21/17 at 10:08 record was reviewe physician orders wh	5 a.m. Resident #5's clinical d The review revealed 2016 nich included:					
		ded for pain. The Tramadol sadministered on 9/12/16 at					

11:50 and 9/13/16 at 10:40 for "Pain to back."

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		E SURVEY MPLETED
		495369	B. WING	i		06	/22/2017
	PROVIDER OR SUPPLIER  NVALESCENT CENTE	ER AT PATRIOTS COLONY		600	REET ADDRESS, CITY, STATE, ZIP CODE 00 PATRIOTS COLONY DRIVE LLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION OATE
F 329	The nurse did not d non-pharmacologic prior to administerir	age 58 document the description of or cal interventions attempted ng the pain medication. She nent the result as "effective."	F:	329			
	as needed every for Acetaminophen wa administered on 12 documentation of lo non-pharmacologic prior to the adminis	5 mg tablet (650 mg=2 tablets) our hours for pain. The as documented as 2/25/16 at 9:36 p.m. without ocation or description of, nor cal interventions attempted stration of the pain medication. ocument the result as "Relief."					
	reviewed and include "Resident has expression."	essed/demonstrated ated to: -Rheumatoid	:				
	limited to: Encourage and ass intensity, quality and Encourage resident interventions are no Administer medicat physician; Assist the resident a manner that is mos other devices as ne Apply heat or cold a requested by reside physician; Apply gentle massa tolerated by or reque	t to tell nurse when pain of being effective tion as prescribed by the as needed to position in a st comfortable; use pillows or eeded; applications as tolerated by or ent and/or ordered by					

music, conversation, etc.

## DEPARTMENT OF HEALTH AND HUMA\*\* SERVICES CENTERS FOR MEDICARE & MEDICAL JERVICES

A. BUILDING  A. BUILDING  A. BUILDING  A. BUILDING  O6/22/201  NAME OF PROVIDER OR SUPPLIER  THE CONVALESCENT CENTER AT PATRIOTS COLONY   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  A. BUILDING  O6/22/201  STREET ADDRESS, CITY, STATE, ZIP CODE  6000 PATRIOTS COLONY DRIVE  WILLIAMSBURG, VA 23188	CENTER	RS FOR MEDICARE	& MEDICAL SERVICES			. O	MB NO. 0938-039
NAME OF PROVIDER OR SUPPLIER  THE CONVALESCENT CENTER AT PATRIOTS COLONY    SUMMARY STATEMENT OF DEFICIENCIES   FREERIX   FROM							(X3) DATE SURVEY COMPLETED
THE CONVALESCENT CENTER AT PATRIOTS COLONY  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 329  Continued From page 59  Review of facility policy titled "Pain Assessment" originated 4/09 and with a "Last Revision Date" of 4/27/17 included the following: "Purpose: To help a resident attain or maintain his/her highest practicable level of well-being and to prevent or manage pain, to the extent possible, the facility: a) Recognizes when the resident is experiencing pain and identifies circumstances when pain can be anticipated; b) Evaluates the existing pain and the cause(s); and c) Manages or prevents pain, consistent with the resident's goals, the comprehensive assessment and plan of care, and current clinical standards of practice." The policy also included:  "i. The licensed nurse completing the assessment will sign/date the assessment form. C. Resident's expression of pain/discomfort and observation of symptoms that may be			495369	B. WING			06/22/2017
X4   ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDERS PLAN OF CORRECTION SHOULD BE REFUX   TAG   TAG   COMPAL TAG   PREFIX   TAG   PROVIDERS PLAN OF CORRECTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   PROVIDERS PLAN OF CORRECTION SHOULD BE COMPAL TAG   CROSS-REFERENCED TO THE APPROPRIATE   DEFICIENCY)    F 329   Continued From page 59   F 329    Review of facility policy titled "Pain Assessment" originated 4/09 and with a "Last Revision Date" of 4/27/171 included the following: "Purpose: To help a resident attain or maintain his/her highest practicable level of well-being and to prevent or manage pain, to the extent possible, the facility: a) Recognizes when the resident is experiencing pain and identifies circumstances when pain can be anticipated; b) Evaluates the existing pain and the cause(s); and c) Manages or prevents pain, consistent with the resident's goals, the comprehensive assessment and plan of care, and current clinical standards of practice." The policy also included:  "ii. The licensed nurse completing the assessment will sign/date the assessment form. C. Resident's expression of pain/discomfort and observation of symptoms that may be	NAME OF F	PROVIDER OR SUPPLIER		Ī	STREET ADDRESS, C	ITY, STATE, ZIP CODE	
Summary Statement of Deficiencies   ID   PROVIDER'S PLAN OF CORRECTION   SHOULD BE   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   CROSS-REFERENCE TO THE APPROPRIATE   DAY	THE CON	NVALESCENT CENTE	R AT PATRIOTS COLONY				
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 329  Continued From page 59  Review of facility policy titled "Pain Assessment" originated 4/09 and with a "Last Revision Date" of 4/27/17 included the following: "Purpose: To help a resident attain or maintain his/her highest practicable level of well-being and to prevent or manage pain, to the extent possible, the facility: a) Recognizes when the resident is experiencing pain and identifies circumstances when pain can be anticipated; b) Evaluates the existing pain and the cause(s); and c) Manages or prevents pain, consistent with the resident's goals, the comprehensive assessment and plan of care, and current clinical standards of practice." The policy also included:  "i. The licensed nurse completing the assessment will sign/date the assessment form. C. Resident's expression of pain/discomfort and observation of symptoms that may be	2541.17	CUMMANDV CTA	TEMENT OF DEFICIENCIES				
Review of facility policy titled "Pain Assessment" originated 4/09 and with a "Last Revision Date" of 4/27/17 included the following: "Purpose:  To help a resident attain or maintain his/her highest practicable level of well-being and to prevent or manage pain, to the extent possible, the facility:  a) Recognizes when the resident is experiencing pain and identifies circumstances when pain can be anticipated; b) Evaluates the existing pain and the cause(s); and c) Manages or prevents pain, consistent with the resident's goals, the comprehensive assessment and plan of care, and current clinical standards of practice." The policy also included:  "i. The licensed nurse completing the assessment will sign/date the assessment form. C. Resident's expression of pain/discomfort and observation of symptoms that may be	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH COR	RECTIVE ACTION SHOULD RENCED TO THE APPROPE	BE COMPLETION
originated 4/09 and with a "Last Revision Date" of 4/27/17 included the following: "Purpose:  To help a resident attain or maintain his/her highest practicable level of well-being and to prevent or manage pain, to the extent possible, the facility:  a) Recognizes when the resident is experiencing pain and identifies circumstances when pain can be anticipated; b) Evaluates the existing pain and the cause(s); and c) Manages or prevents pain, consistent with the resident's goals, the comprehensive assessment and plan of care, and current clinical standards of practice." The policy also included:  "i. The licensed nurse completing the assessment will sign/date the assessment form. C. Resident's expression of pain/discomfort and observation of symptoms that may be	F 329	Continued From pa	ge 59	F 3	29		
frequently.  a. When a resident expresses pain/discomfort, treatment and/or intervention will be provided per physician order and/or the comprehensive care plan.  b. The medical record will include description of the resident's pain, treatment or interventions provided, and effectiveness of the treatment/intervention"  On 6/21/17 at 3:10 p.m. an interview was conducted with the Director of Nursing (Admin-B). When asked about non-pharmacological approaches prior to administering pain medication, Admin-B stated "(Nurses) should try		originated 4/09 and 4/27/17 included the "Purpose: To help a resident a highest practicable prevent or manage the facility:  a) Recognizes whe pain and identifies to be anticipated; b) Evaluates the exand c) Manages or preventing goals, the and plan of care, are of practice." The position of symptom of the provided per phycomprehensive care b. The medical of the resident's pai provided, and effect treatment/interventing to help a sked about approaches prior to	with a "Last Revision Date" of e following:  attain or maintain his/her level of well-being and to pain, to the extent possible, on the resident is experiencing circumstances when pain can existing pain and the cause(s); wents pain, consistent with the excomprehensive assessment and current clinical standards olicy also included:  If nurse completing the in/date the assessment form, ession of pain/discomfort and potoms that may be ain will be monitored  If wents and/or intervention will visician order and/or the eplan.  If record will include description in, treatment or interventions tiveness of the on"  p.m. an interview was Director of Nursing (Admin-B), non-pharmacological administering pain				

## DEPARTMENT OF HEALTH AND HUMA\*\* SERVICES CENTERS FOR MEDICARE & MEDICAL JERVICES

CENTER	42 LOK MEDICAKE	& MEDICAL JERVICES				<u> </u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		TE SURVEY MPLETED
		495369	B. WING			06	/22/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE COL	NALESCENT CENTE	D AT DATRIOTS COLONY		600	00 PATRIOTS COLONY DRIVE		
THE CON	WALESCENT CENTE	R AT PATRIOTS COLONY		W	ILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION OATE
F 329	Continued From pa	ae 60	F 3	20			
. 5-5	· ·	ical approach before giving a	: 1 3	23			1
		uld've been documented in the	: :				:
	6/24/16 with the dia	s admitted to the facility on gnoses of, but not limited to, s, depression, metabolic d chronic pain.					
	coded Resident #6 impairment; no psyd for wandering; requ from staff for all act	OS was a quarterly ARD of 3/28/17. The MDS with severe cognitive chotic behaviors but did code ired extensive assistance ivities of daily living except as dependent on staff for.					
	observed sleeping i	p.m. Resident #6 was n bed, fall mats and bed alarm as in a recliner chair next to					
		p.m. Resident #6's clinical d. The review revealed nich included:					
	every four hours state haloperidol was discinstructions included read: "1 po (by most	1 mg tablet oral as needed arting 2/15/17. The order for continued 4/27/17. The d with the physician's order with) every four hours as distress or aggression that d. And,					
	rectally every 2 hou	1mg PO, sublingual or rs as needed for restlessness, r seizures. Tablet may be red if needed.					

### DEPARTMENT OF HEALTH AND HUMAN PERVICES CENTERS FOR MEDICARE & MEDICAL FRANCES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTERO	FUR MEDICARE	& MEDICAL JERVICES				OMB M	<u>J. 0938-0391</u>
STATEMENT OF O	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION		ATE SURVEY OMPLETED
		495369	B. WING			0,	6/22/2017
NAME OF PRO	OVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		-
THE CONV	ALESCENT CENTE	R AT PATRIOTS COLONY			PATRIOTS COLONY DRIVE IAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUCH CORRECTIVE ACTION SHOUCH CROSS-REFERENCED TO THE APPOPULATION OF THE APPOPULATION	OULD BE	(X5) COMPLETION OATE
RAW"RainsoawathTin RL(To R "Fo(sb) rec:"/Ota	ras administered of Results" listed as "leview of the nurse .m. revealed the formurses station. The ustained no injurie in 4/2/17 at 10:28 arrival increase agitatiness fall with no im with effectiness here were no document voices there were no document voices and review of the May 20 orazepam was adialo:12 p.m.) with "Fore were no nurse fadministration of desident #6's care Resident #6's ca	2017 Medication ord (MAR) revealed the Haldol on 4/2/17 at 8:04 a.m. with Behavior Decreased." es notes for 4/2/17 at 7:30 ollowing documentation: wheel chair while sitting at e fall was witnessed, resident es. Nurses note documented a.m. read "Resident upon tation to get up unassisted, injuries Haldol given at 804 (sic). resident lying down at no complaints at the moment. umented non-pharmacological to the administration of Haldol.  2017 MAR revealed the ministered on 5/24/17 at 22:12 Results" listed as "Relief." ese notes at or around the time the Ativan.  plan included:  for side effects related to use dication: antipsychotics PRN noactive medications are manage following s_agitation that can not be terventions included in the		329			

"Behavioral Symptoms: (resident name) has

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAN SERVICES

CENTER	RS FOR MEDICARE	& MEDICAL SERVICES				<u>MB NO.</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		495369	B. WING		····	06/	22/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		' '
THE CON	IVAL FECENT CENTE	D AT DATRICTS COLONY		60	00 PATRIOTS COLONY DRIVE		
INE COR	NVALESCEN! CENTE	R AT PATRIOTS COLONY		W	ILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	others-agitation, att directed." Intervent "Provide medication Monitor pattern of be precipitating factors. Attempt to redirect. Speak to resident in On 6/21/17 at 4:30 Director of Nursing and surveyor requenon-pharmacologic medications adminion On 6/22/17 at 8:35 Admin-G stated the non-pharm intervent policy on non-pharm medication use was facility policy and provided medication and Bel following:  "Purpose: To optimize the quaresidents by improve the health, psychos needs of all resident person-centered ap distressing or harm	symptoms directed at empting to hit staff, not easily cions included: as ordered; ehavior (time of day, s, specific staff or situation); Allow time to calm down. a calm voice."  p.m. the Administrator and were informed of the findings sted information on al approaches for the PRN	F 3	329	JENGINOT)		
	Medications may be appropriately to add underlying medical or worsening behave interventions, include	e effective when they are used dress significant, specific, or psychiatic causes, or new vioral symptoms. All ling medications, need to be cy, risks, benefits and harm"					

#### PRINTED: 07/17/2017 DEPARTMENT OF HEALTH AND HUMP\* SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICA, **JERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495369 B. WING 06/22/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6000 PATRIOTS COLONY DRIVE THE CONVALESCENT CENTER AT PATRIOTS COLONY WILLIAMSBURG, VA 23188 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ΙD JX5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 329 Continued From page 63 F 329 "Psychoacive Medication Monitoring A. All routine and prn psychoactive medications will be ordered with medication and indication for use and physical monitor of non-pharmacological interventions. a. Administering nurse will complete in the MAR the note of non-pharmacological interventions attempted before the prn medication is given ... " On 6/22/17 at 5:20 p.m. The Director of Nursing (Admin-B) explained the facility realized it was an issue and they worked on the computer program to direct the nurses to attempt and document non-pharmacological approaches. No further information was provided by the facility staff. F 371 483.60(i)(1)-(3) FOOD PROCURE. F 371 7/24/17 SS=D STORE/PREPARE/SERVE - SANITARY

service safety.

authorities.

(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local

(i) This may include food items obtained directly from local producers, subject to applicable State

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.

(iii) This provision does not preclude residents from consuming foods not procured by the facility.

(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food

and local laws or regulations.

## DEPARTMENT OF HEALTH AND HUMP\* SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICA, JERVICES			OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495369	B. WING		06/	/22/2017
	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		STREET ADDRESS, CITY, STATE, ZIP 6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION OATE
F 371	Continued From pa	ge 64	F 3	71		
	foods brought to re visitors to ensure so handling, and const. This REQUIREMED by:  Based on observat facility staff failed to infection control project machine.  The facility staff failed to infection control project machine.  The facility staff fail in the kitchen main the back flow of wath the back flow of wath the back flow of wath the back flow of wath the back flow of wath the back flow of wath the back flow of wath the back flow of wath the back flow from the back flow flow flow flow flow flow flow flow	is not met as evidenced tion and staff interview, the maintain an effective ogram concerning the kitchen ed to ensure the ice machine stained an air gap to prevent ste water.		<ol> <li>The pipe leading from machine in dietary was cor 20, 2017 by the Maintenanto ensure the required air gregulation.</li> <li>All residents are at risk failure to maintain the air gice machines. All ice machines are at risk failure to maintain the air gice machines. All ice machines are at risk failure to maintain the air gale added for appropriate at 22, 2017 by the Maintenant 3. Checking of the air gale added to the daily task list staff. The Dietary Staff were by the Food Service Direct maintaining the proper air regulation on June 23, 2014. The Food Service Direct will audit the daily task lists the air gap between the drafloor drain twice weekly for weekly for 8 weeks and the results of the audits will be quarterly at the QA meeting of compliance and ongoing continuous improvement a implementation.</li> </ol>	rrected on June nce Technician gap per k for facility gap on dietary chines were air gap on June nce Technician.  In has been for the dietary re in-serviced for on gap per 17.  Sector/designee and visualize ain pipe and 4 weeks, then en monthly. The exported g for evaluation g monitoring for	

gap of at least twice the diameter of the pipe. He

# DEPARTMENT OF HEALTH AND HUM? SERVICES CENTERS FOR MEDICARE & MEDICA SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
		495369	B. WING		06	/ <b>22/20</b> 17	
	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		STREET ADDRESS, CITY, STATE, ZIP CODE 6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	JX5) COMPLETION DATE	
F 371	kitchen and the pipe by a construction el remind the employe maintained.	ge 65 as under construction in the es could have been bumped mployee. He stated he would ees that the air gap must be and Director of Nursing were	F 3	71			
	notified of the issue The Administrator s Director had correct air gap should be m No further informati	on 6/22/2017 at 2:45 p.m. tated the Maintenance ted the problem and that an naintained.	F 3	72		7/24/17	
	This REQUIREMENt by: Based on observatifacility staff failed to enclosed and proper manner.  The doors on the cand contained discassmelling debris was large dumpster closs. Findings included:  On 6/20/2017 at 2:3 of the facility dumps building near the kit were two dumpsters.	arbage and refuse properly. NT is not met as evidenced ion and staff interview, the assure that garbage was arly disposed in a sanitary ardboard dumpster were open arded food items and foul a noted on the ground near the se to the building.  35 p.m., a tour was conducted ater area outside of the chen of the building. There is observed in the area. The dumpster was observed to		<ol> <li>The doors to the smaller docardboard were immediately cleaned the area by the large dumpster pressure washed during the surger June 20, 2017.</li> <li>All residents are at risk who dumpster areas not being sanited dumpster doors not closed at a The larger dumpster for garbager eplaced due to leakage cause seals with a new dumpster on 2017.</li> <li>The dietary staff will receive re-education by the Food Servity July 24, 2017 on keeping the area clean and doors closed at</li> </ol>	osed and was rvey on en the eary with ill times. ge was d by bad June 23, e ce Director e dumpster		

## DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

CENTER	KS FOR MEDICARE	E & MEDICAL SERVICES			\	<u> </u>	<u>. 0938-039</u> 1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		E SURVEY IPLETED
		495369	B. WING			06/	22/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
TUE 001		TO AT DATIDATE OOL ONLY		600	00 PATRIOTS COLONY DRIVE		İ
IHE CON	IVALESCENT CENTE	ER AT PATRIOTS COLONY		W	ILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 3 <b>7</b> 2	cardboard boxes as an empty aluminum tea and other food is a larger dumpster of with foul smelling do Services (Admin F) on the ground was surveyor asked if the and food. The Direct that the large dump on a routine basis as of the dumpster whistated the dumpster.	age 66 pen. The dumpster was full of s well as food items including in can of soup, bottle of iced items. The paved area around used by the kitchen was filled lebris. The Director of Dining stated around that the debris the result of rain water. The ne foul smelling debris was oil ctor of Dining Services stated oster was emptied by a truck and that liquids might run out nen it was turned over. Admin For doors should be kept closed e no debris outside of the	F3	F72	with this task being added to the I Daily cleaning schedule.  4. The Food Service Director/de will audit the dumpster area twice for 4 weeks, then weekly for 8 we then monthly. The results of the a be reported quarterly at the QA m for evaluation of compliance and monitoring for continuous improve analysis after the implementation.	signee weekly eks and udits will eeting ongoing ement	
	Director of Nursing findings. The Admir and it has been clear No further informati 483.45(a)(b)(1) PHACCURATE PROC (a) Procedures. A find pharmaceutical servithat assure the accordispensing, and admirately and pharmacist who (1) Provides consultation of the pharmacist who (1) Provides consultation of the pharmacist who	ion was provided. ARMACEUTICAL SVC - CEDURES, RPH  facility must provide vices (including procedures curate acquiring, receiving, ministering of all drugs and t the needs of each resident.  tation. The facility must be services of a licensed	F 4	25			<b>7</b> /24/17
		acy services in the facility;					:

		AND HUM/ SERVICES			(	FORM	07/17/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUC	TION		E SURVEY IPLETED
		495369	B. WING			06/	22/2017
	PROVIDER OR SUPPLIER	R AT PATRIOTS COLONY		6000 PATRIOT	ESS, CITY, STATE, ZIP CO 'S COLONY DRIVE URG, VA 23188	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X EACI	OVIDER'S PLAN OF CORF H CORRECTIVE ACTION S -REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE
F 425	by: Based on staff intereview, and clinical failed to ensure that for administration for and #10) in a survers. For Resident #3, for the treatment of unavailable for administration for the treatment of unavailable for administration.	rview, facility documentation record review, the facility staff t medications were available or two residents (Residents #3 y sample of 16 residents.  Pyridium, a medication used urinary tract infections, was ninistration on 5-5-17.  O, Forteo, a medication used osteoporosis, was unavailable in 5-5-17.	. F4	1. Resident and provided and provided and provided and and and and and and and and and an	dent #3 and resident iders were notified or clinical manager of ton omission that occurs on adverse reaction ons.  The sidents in the facility of medication available on omissions. DON/ a a 100% audit of curs on list to the medication the medicart.	on July 10, the curred on May from missed  y are at risk bility and designee will rrent tions being	1

1. Resident #3, was admitted to the facility on 1-19-17. Diagnoses included; Benign Prostatic Hypertrophy, urinary tract infections, vascular dementia, congestive heart failure, atrial fibrillation, and urine retention.

Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4-27-17 was coded as a quarterly assessment. Resident #3 was coded as having severe cognitive impairment and was not able to make his own daily life decisions. Resident #3 was also coded as needing extensive to total assistance of one to two staff members to perform activities of daily living, and was a hospice patient.

Review of Resident #3's physician orders, eMAR (electronic medication administration record), Nursing progress notes, and the facility printed MAR with notes, revealed that the Resident was not administered the following medication, on the

- re-education on July 24, 2017 by the DON/designee regarding the process for managing unavailable medications to prevent medication omissions.
- 4. The DON/designee will audit charts for medication administration record for accuracy and medication availability on 4 residents per week for 4 weeks, 2 residents per week for 8 weeks and then 5 residents monthly. The results of the audits will be reported monthly at the QA meeting for evaluation of compliance and ongoing for monitoring for continuous improvement analysis after implementation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAL JERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495369	B. WING			06/	<b>22/20</b> 17	
	PROVIDER OR SUPPLIER	ER AT PATRIOTS COLONY		6000	EET ADDRESS, CITY, STATE, ZIP CODE 0 PATRIOTS COLONY DRIVE LIAMSBURG, VA 23188			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 425	by staff in the clini other than "unava MAR notes;"  5-5-17 Pyridium (unilligrams to be gother medication work given for the omis MAR notes, as, "uned not in stat bo "Not administered this omission.  A thorough review revealed that becalevel there was not medications.  The nurse responsions omission was not The physician proprogress notes work May, and June of that the responsible ever made aware occurred. As no owas discontinued meaning one dose was never fully copyridium could have end of the course option was also not	ere were no notes documented cal record for the omissions ilable" for the pyridium in the urinary tract infection) 200 iven two times daily for 3 days, as omitted, and the reason sion was documented in the vaiting on pharmacy delivery; x", and a second note stated". No nursing notes document of Resident #3's clinical record ause of the Resident's cognitive revidence that he ever refused evidence that he ever refused sible for the 5-5-17 medication available during survey.  In gress notes, and nursing ere reviewed in their entirety for 2017. There was no indication le party, nor the physician was that this medication omission on the original schedule, et was missed, and the order expleted. The omitted dose of the been administered at the of treatment, however, this of instituted.	F4	25	CETICIENCY)			
		e plan was reviewed, and stated ations as ordered".						
	On 6-21-17 at 2:30	p.m., the Director of Nursing						

## DEPARTMENT OF HEALTH AND HUM/ SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	13 FUR WIEDICARE	A MEDICAN SERVICES				<u> </u>	<u>). 0938-0391</u>
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED
		495369	B. WING			06	6/22/2017
NAME OF F	PROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	<u>·</u>	
THE COL	ANAL ESCENT CENTS	TO AT DATRIOTS COLONY	J	600	00 PATRIOTS COLONY DRIVE		
IME CO	WALESCENT CENTE	ER AT PATRIOTS COLONY	J	W	ILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 425	stated they would lot DON delivered a coprogress notes, and May and June 2017 stated that the med administered, and the administration of or given at a different planned, so that the she stated "it is what the Director of Nurprovided the facility the medication is be proper time, prescriptore. Resolve any medication with the staff involved with the staff involved with the medications were a they were also may and the Responsible omission, at the endorse.	strator were interviewed, and ook into the discrepancy. The opy of the E-MAR, physician d nursing progress notes for 7. When interviewed the DON dication could have been the doctor could be called to ok ne time per day meds to be time than what was originally ey would not be missed, then at it is."  rsing (DON) and Administrator of policy which stated to verify eing administered at the ribed dose, and by the correct of concerns about the exprovider, prescriber, and/or the patient's care.  and DON (director of nursing) he failure of the staff to ensure available for Resident #3. In the physician le party were not notified of the id of day debriefings on 17. No further information was		125			
	9-1-15. Diagnoses dementia, and depr						
	Resident #3's most	t recent MDS (minimum data					

set) with an ARD (assessment reference date) of

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		E CONSTRUCTION		E SURVEY IPLETED
		495369	B. WING			06	/22/2017
	PROVIDER OR SUPPLIER  NVALESCENT CENTE	R AT PATRIOTS COLONY		60	TREET ADDRESS, CITY, STATE, ZIP CODE  000 PATRIOTS COLONY DRIVE  //ILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	:	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION OATE
F 425	assessment. Resid moderate cognitive was also coded as assistance of one s	ge 70 as a significant change full dent #10 was coded as having impairment. Resident #10 needing extensive to total taff member to perform ing, and was a hospice	F 4	25	•		
	eMAR (electronic m record), Nursing pro- printed MAR with no Resident was not a medication, on the notes documented	#10's physician's orders, nedication administration ogress notes, and the facility otes, revealed that the dministered the following following day. There were no by staff in the clinical record ner than "unavailable" on notes;					
	micrograms subcut day in the morning medication was on	etion (Osteoporosis) 20 aneously to be given every (8:00 a.m. to 10:00 a.m.). The nitted, and the reason given for ocumented in the MAR notes, on 5-5-17.					
	omission LPN E sta	ble for the 5-5-17 medication ated she had no memory of the no nursing notes describing					
	progress notes wer May, and June of 2 that the responsible	ress notes, and nursing e reviewed in their entirety for 017. There was no indication e party, nor the physician was nat these medication					
	Resident #10's care	e plan was reviewed, and					

stated "administer medications as ordered".

#### PRINTED: 07/17/2017 DEPARTMENT OF HEALTH AND HUMA!" RERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICA ERVICES د OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495369 B. WING 06/22/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6000 PATRIOTS COLONY DRIVE THE CONVALESCENT CENTER AT PATRIOTS COLONY WILLIAMSBURG, VA 23188 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D (X5) COMPLETION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 425 Continued From page 71 F 425 On 6-21-17 at 2:30 p.m., the Director of Nursing (DON) and Administrator were interviewed, and stated they would look into the discrepancy. The DON delivered a copy of the E-MAR, physician progress notes, and nursing progress notes for May and June 2017. When interviewed the DON stated that the medication could have been administered, and the doctor could be called to ok administration of one time per day meds to be given at a different time than what was originally planned, so that they would not be missed, then she stated "it is what it is." The Director of Nursing (DON) and Administrator provided the facility policy which stated to verify the medication is being administered at the proper time, prescribed dose, and by the correct route. Resolve any concerns about the medication with the provider, prescriber, and/or staff involved with the patient's care. The administrator and DON (director of nursing) were informed of the failure of the staff to ensure medication was available for Resident #10. They were also made aware that the physician and the Responsible party were not notified of the omissions, at the end of day debriefings on 6-21-17, and 6-22-17. No further information was provided by the facility. F 441 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, F 441 7/24/17

SS=F PREVENT SPREAD, LINENS

(a) Infection prevention and control program.

a minimum, the following elements:

The facility must establish an infection prevention and control program (IPCP) that must include, at

#### PRINTED: 07/17/2017 DEPARTMENT OF HEALTH AND HUM? SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICA, SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495369 B. WING 06/22/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6000 PATRIOTS COLONY DRIVE THE CONVALESCENT CENTER AT PATRIOTS COLONY WILLIAMSBURG, VA 23188 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ΙD (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION OATE **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 441 Continued From page 72 F 441 (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 §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (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:

involved, and

circumstances.

(A) The type and duration of the isolation,

depending upon the infectious agent or organism

(B) A requirement that the isolation should be the least restrictive possible for the resident under the

(v) The circumstances under which the facility

## DEPARTMENT OF HEALTH AND HUMA REVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER  NVALESCENT CENTE	R AT PATRIOTS COLONY		STREET ADDRESS, CITY, STATE, ZIP COD 6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION OATE
F 441	disease or infected contact with resider contact will transmit (vi) The hand hygie by staff involved in (4) A system for recunder the facility's lactions taken by the (e) Linens. Person process, and transprocess, and transprocess, and transprocess of infection.  (f) Annual review. Tannual review of its program, as necess	byees with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact.  Fording incidents identified PCP and the corrective efacility.  The must handle, store, port linens so as to prevent the IPCP and update their	F	441		
	Based on observate facility staff failed to infection control proof. The facility staff faile in the kitchen, and to care halls, maintain back flow of waster. The findings include On 6/20/2017 at 2:: kitchen was conduct (Admin F) and chef machine in the kitch presence of the Din	ed to ensure the ice machines he one serving the Long Term ed an air gap to prevent the water.		<ol> <li>The pipe leading from the machine in dietary was correct Maintenance Technician on Ju to ensure the required air gap regulation. The pipe leading from machine by the nurse! is statio corrected on June 22, 2017 the Maintenance Technician to ensure required air gap per regulation the pipe and the floor drain.</li> <li>All residents are at risk for maintain the air gap on all ice in All ice machines were inspected appropriate air gap on June 22 the Maintenance Technician.</li> </ol>	ed the ne 20, 2017 per om the ice n was esure the between failure to machines.	

was under construction. The surveyors and

3. Checking of the air gap has been

PRINTED: 07/17/2017

	:NT OF HEALTH FOR MEDICARE	1	SERVICES					APPROVED 0938-0391
STATEMENT OF AND PLAN OF CO	DEFICIENCIES	(X1) PROVIDER	VSUPPLIER/CLIA ATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		E CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		4	95369	B. WING			06	/22/2017
NAME OF PRD	VIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CONVA	L ESCENT SENTE	D AT DATING	TO COLONY	1	6	000 PATRIOTS COLONY DRIVE		
THE CONVA	LESCENT CENTE	K AI PAIRIU	15 COLONY		٧	VILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFI) TAG		PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 441 Co	ontinued From pa	ge 74		F 4	141	1		
Accobs The information of the in	min F had to ent serve the pipes a ere were two pip diameter; one pip her rested approx ain. There was n p, between the e ain. The air gap tering back into t ck flow from the rector (Admin F) p in place. He st ide the drain and	er the construent drain for the seach approper was inside kimately an interest of space, known of the pipe prevents was the ice maching ated the pipe of that there should have a could not have an aying on top the known as the pipe and and Director of the could have and the pipe and and Director of the could have and the pipe and the could have and the pipe and the could have and the pipe and the could have and the pipe and the could have a could have a could have a could have a could have a could have and a could have a	the ice machine.  oximately an inch the drain and the ch above the wn as the air e and the floor te water from ne pipe should cur. The Dining nere was no air s should not be nould be an air r of the pipe. He struction in the e been bumped stated he would ir gap must be ce machine that oss from the th two nurses A and LPN B air gap. The of the drain. he air gap, the floor drain.  f Nursing were			added to the daily task list for the staff. The Dietary Staff were inby the Food Service Director of maintaining the proper air gap regulation on June 23, 2017. M Staff were inserviced by the D Facilities on June 23, 2017 for the proper air gap per regulation Maintenance staff will audit the nourishment room ice machine daily following the updated task.  4. The Food Service Director will audit the daily task check of visualize the air gap between the pipe and floor drain on the kitch machine twice weekly for 4 weekly for 8 weeks and then m Director of Facilities / Designed the daily task list and visualize between the drain pipe and floot the nourishment room ice machine twice weekly for 4 weeks, then weekly for 4 weeks, then weekly for 4 weeks, then monthly. The resulting for evaluation of continuous and ongoing monitoring for continuous months.	serviced n per daintenance draintenance drai	

No further information was provided.

air gap should be maintained.

F 514 483.70(i)(1)(5) RES SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIB

The Administrator stated the Maintenance Director had corrected the problem and that an

F 514

7/24/17

		AND HUMA RERVICES			FOR	D: 07/17/2017 MAPPROVED D: 0938-0391
STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DA	TE SURVEY MPLETED
		495369	B. WING _		06	5/22/2017
	VIDER OR SUPPLIER	R AT PATRIOTS COLONY		STREET ADDRESS, CITY, STATE, ZIP C 6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULD BE	(X5) COMPLETION DATE
F 514 C	ontinued From pa	ge 75	F 51	14		
(1 st m	andards and prac	vith accepted professional tices, the facility must cords on each resident that				
(i)	Complete;					
(ii	) Accurately docu	mented;				
(iii	i) Readily accessi	ble; and				
(iv	v) Systematically o	organized				
(5	) The medical rec	ord must contain-				
(i)	Sufficient informa	ation to identify the resident;				
(ii	) A record of the re	esident's assessments;				
•	i) The comprehen ovided;	sive plan of care and services				
ar	nd resident review	ny preadmission screening evaluations and ducted by the State;		·		 
	) Physician's, nurs ofessional's progr	se's, and other licensed ess notes; and				
(v	i) Laboratory, radi	ology and other diagnostic				

by:

services reports as required under §483.50. This REQUIREMENT is not met as evidenced

Based on staff interview, facility documentation

failed to ensure a complete and accurate clinical

review, and clinical record review, the facility staff

1. Residents # 7 and # 9 Food allergies

were reviewed and corrected on June 22,

2017 by clinical manager in the electronic

## DEPARTMENT OF HEALTH AND HUM, SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICA: SERVICES				<u>MB NO.</u>	<u> 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495369	B. WING	;		06/	<b>22/201</b> 7
NAME OF F	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE	,	
				6	5000 PATRIOTS COLONY DRIVE		
THE CO	NVALESCENT CENTE	R AT PATRIOTS COLONY		V	WILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION OATE
F 514	Continued From pa	ge 76		514	1 1		
	•	ents (Residents #7 and #9) in	' '	017	medical record as well as the paper	or.	
	the survey sample				thinned record. The dietary depart		
	the survey sample of to residents.				was notified clinical manager of the		
	1. The facility staff documented Resident #7's				clarification orders June 22, 2017		
	food allergy in Resident #9's clinical record.				corrected the diet slips. Provider a		
	Resident #7 was th	e spouse of Resident #9.			Responsible Representative notific		
	<u> </u>				error June 22, 2017 by clinical mai		
	2. The facility staff documented Resident #9's food allergy in Resident #7's clinical record.				The residents had no allergic reac	tions.	
	tood allergy in Resi	dent #/'s clinical record.			2 All registers admitted with lead	مالام	I
	The Findings included:				<ol><li>All residents admitted with look sound a-like names could potentia</li></ol>		i
	The Findings includ	eu.			affected by an order entry error wh		!
	1. Resident #7 was	admitted to the facility on			orders could be transposed. All cu		i I
		#7's diagnoses included, high			residentsi food allergies will be re		į
	cholesterol, neurog	enic disease, dementia,			by DON/designee by July 24, 2017	. Any	!
	anxiety, and transie	nt ischemic attack (TIA).			discrepancies found will be immed corrected.	iately	
	The Minimum Data	Set, which was an admission					İ
		n an Assessment Reference			<ol><li>The Licensed nurses will recei</li></ol>		i I
		-17, coded Resident #7 being			education by the DON/designee or		1
		and be understood by others,			entry and verification of all nursing		
		coded as having a Brief	1		including allergies. A second nurse		
		Status score of 14, out of a indicating no cognitive	:		review prior to activation of orders.  Nutrition Services Communication		1
	impairment.	indicating no cognitive			will be reviewed and signed by two		 
	impairmont.		:		prior to submission to dietary by Ju		1
	2. Resident #9 was	admitted to the facility on	•		2017.	··· <b>,</b> — ··,	i 
	4-22-17, and was th	ne spouse of Resident #7.	:				:
		oses included, acute toxic			<ol><li>DON/Designee will audit all</li></ol>		
		gh cholesterol, congestive	1		admissions at morning meeting for	•	
	heart failure, pneumonia, hypertension, lumbar			accuracy of allergies and nutrition			
		eficiency, dementia and			services communication form. Res		! !
	depression.		!		admission audits will be reported a QA meeting by the DON/designee		!
	The Minimum Data	Set, which was an admission			evaluation of compliance and ongo		1 ! !
		n an Assessment Reference	1		monitoring for continuous improve		t :
		7, coded Resident #9 being	1		analysis after the implementation.		

(ARD) date of 5-5-17, coded Resident #9 being able to understand and be understood by others, in addition, she was coded as having a Brief

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 07/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	49 LOK MEDICAKE	& MICHICA' > SEKAICES				MR NO	<u>. 0938-0391</u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495369	B. WING			06/	/22/2017
NAME OF F	PROVIDER OR SUPPLIER		_	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
THE COM	MAI ESCENT CENTE	R AT PATRIOTS COLONY		6001	0 PATRIOTS COLONY DRIVE		l
IIIL OO	TVALESCENT CLITT	KAI FAIRIO IS COLONI		WIL	LLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	Continued From pa	iae 77	F 5	14			
	Interview for Mental	I Status score of 14, out of a indicating no cognitive		/ <b>1</b> −r			
	The following is a re records, as the food	eview of both Resident's d allergies for these two changed in error by the facility					
	#7's clinical record, Services Communion the clinical chart as attention, along with Resident's recent he	ew was conducted of Resident revealing a signed "Nutrition cation Form" sticking up out of it was "flagged" to garner two documents from the ospitalization. The document and read, "Food allergies					
	Record, and hospita	the Medication Administration al admission records were all ent #7, and stated "No known					
	Nurse (LPN) C, and and could not answer flagged for attention	sician, Licensed Practical d LPN B, were all interviewed er why the documents were a, and the clinical chart was on k, instead of in the chart rack, n number.					
	Resident #7's care pstated "no allergies"	plan was reviewed, and also ".					
	The Director of Nurs	end of day debrief at 5:00 p.m. sing (DON), and the asked to clarify this matter.					

On 6-21-17 at 10:00 a.m., Resident #9's clinical record was reviewed. This Resident's record

	TMENT OF HEALTH	AND HUM SERVICES		(	FOR	D: 07/17/2017 M APPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495369	B. WING			6/22/2017
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE CO	NVALESCENT CENTE	R AT PATRIOTS COLONY		6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5  COMPLETION DATE
F 514	of her clinical recommost recent "Nutritic Form". The form recommost recent "Nutritic Form". The form recommost recent at 11:00 two Resident's form and that Resident #7 had Residents were sponsored were aware however, other staff.  On 6-21-17, and 6-2 debriefs, the DON a aware of the inaccur.	ge 78 dent Had a fish allergy on all ds, with the exception of her on Services Communication ead, "No Food allergies".  D. a.m. the DON stated that the is had been mixed up by staff, 19 actually had the fish allergy in allergies. The two cuses, and resided in the ON went on to say that dining e of Resident #9's fish allergy, if could have been confused.  22-17 at the end of day and Administrator were made rate clinical records of 19. The facility provided no	F 5	14		

	OF MEDICARE & MEDICARD SE	BROWER #	Transpire designation of the second	A FORM				
STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY				
			A. BUILDING:	COMPLETE:				
		495369	B. WING	6/22/2017				
NAME OF PR	OVIDER OR SUPPLIER		S, CITY, STATE, ZIP CODE					
THE CON	VALESCENT CENTER AT PATRIOTS COL	6000 PATRIOT WILLIAMSBU	CS COLONY DRIVE JRG, VA					
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN	ENCIES						
F 278	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED							
	(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.							
	(h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.							
	(i) Certification (1) A registered nurse must sign and certify that the assessment is completed.							
	(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.							
	(j) Penalty for Falsification (I) Under Medicare and Medicaid, an individual who willfully and knowingly-							
	(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or							
	(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.							
	(2) Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced by:							
	Based on family interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure an accurate Minimum Data Set (MDS) assessment for one (Resident #1) of 16 residents in the survey sample.							
•	Resident #1's initial and quarterly MDS assessments, Section A1800 "Entered From," listed he entered from an "Acute Hospital" however, he was admitted directly from home.							
	The findings included:							
	Resident #1 was admitted to the facility on 2/15/17 with the diagnoses of, but not limited to, Parkinson's Disease, dementia, hypertension, and anemia.							
	The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 5/16/17. The MDS coded Resident #1 with severe cognitive impairment; no behavior symptoms; required extensive assistance from staff for bed mobility, transfers, ambulation, dressing, toileting, and hygiene; dependent on staff for bathing; and always incontinent of bowel and bladder.							

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents