STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare standard survey was conducted 6-20-17 through 6-22-17. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code Survey/Report will follow.

The census in this 60 certified bed facility was 50 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents #1 through #12 and #16) and 3 closed record reviews (Residents #13 through #15).

F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		7/24/17

(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/17/2017

STATEMENT OF DEFICIENCIES AND PLAN DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to notify the physician and Responsible party (RP) of medication omissions for one Resident (Residents #3) and failed to report to the state agency (Office of Licensure and Certification) and the RP of an injury of unknown origin for one Resident (Resident #12) in the survey sample of 16 residents. 1. For Resident #3, the facility staff failed to notify the physician, and RP, of medication omissions.	F 157	1. Resident #12 s family RP and the provider were notified of the injury of unknown origin by director of nursing on March 9, 2017. Resident #3 s and resident #10 s responsible representative and the provider were notified of the medication omissions that occurred by clinical manager on July 3, 2017. 2. All residents are at risk of failure to notify responsible representative and providers of medication administration	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2	F 157		

2. For Resident # 12, the facility staff failed to report an injury of unknown origin to the State Agency.

The Findings included:

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's 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 medications, on the following days. There were no notes documented by staff in the clinical record for the omissions other than "unavailable" 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;

omissions and to notify OLC for injuries of unknown origin. All current residents will have MARs starting 6/23/2017 audited for omissions and appropriate notifications. All current residents with injuries starting 6/23/17 will be audited for appropriate notifications to OLC as appropriate.

3. The licensed nurses will receive re-education by July 24, 2017 by the DON/designee regarding the process for notification of responsible party and providers for omission of medication. All departments will be re-educated on the process for reporting injuries of unknown origin immediately to the Administrator/DON to assure compliance with timely reporting to the OLC.

4. The DON/ designee will audit 4 resident MARs and nurses notes weekly for 4 weeks and then 2 weekly for 8 weeks to ensure accuracy in documentation, notification to responsible parties and providers. Administrator/DON will review all reports of injuries of unknown origin to assure investigation and reporting is completed at morning meeting. All discrepancies for responsible party notification, provider notification and 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3	F 157		

med not in stat box", and a second note stated "Not administered". No nursing notes document this omission.

5-26-17 Lasix (congestive heart failure) 20 mg (milligrams) three times weekly in the morning (8:00 a.m. to 10:00 a.m.), and Tamsulosin (urinary retention) 0.4 mg daily in the morning (8:00 a.m. to 10:00 a.m.). Both medications were omitted and no reason was given as to why. There were no nursing notes for this day.

A thorough review of Resident #3's clinical record revealed that because of the Resident's cognitive level there was no evidence that he ever refused medications.

The nurse responsible for the 5-5-17 medication omission was not available during survey. The nurse responsible for the 5-26-17 omissions, was unknown, as no signature existed in the record for this date, and there were no nursing notes on this date.

The physician progress notes, and nursing progress notes were reviewed in their entirety for May, and June of 2017. There was no indication that the responsible party, nor the physician was ever made aware that these medication omissions occurred. As no one was notified, the pyridium was discontinued on the original schedule, meaning one dose was missed, and the order was never fully completed. The omitted dose of pyridium could have been administered at the end of the course of treatment, however, this option was also not instituted.

Resident #3's care plan was reviewed, and stated "administer medications as ordered".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 4	F 157		

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 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, dementia, and depression.

Resident #3's most recent MDS (minimum data

STATEMENT DF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY CDMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION OATE
F 157	Continued From page 5	F 157		

set) with an ARD (assessment reference date) of 3-29-17 was coded as a significant change full assessment. Resident #10 was coded as having moderate cognitive impairment. Resident #10 was also coded as needing extensive to total assistance of one staff member to perform activities of daily living, and was a hospice patient.

Review of Resident #10's physician's 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 following days. There were no notes documented by staff in the clinical record for the omissions other than "unavailable" on 5-5-17 in the MAR notes;

5-5-17 , and 6-6-17, Forteo injection (Osteoporosis) 20 micrograms subcutaneously to be given every day in the morning (8:00 a.m. to 10:00 a.m.). The medication was omitted, and the reason given for the omission was documented in the MAR notes, as, "Not available" on 5-5-17, and simply on 6-6-17, "Not administered (other/enter administration note)". No nursing notes document either omission.

The nurse responsible for the 5-5-17 medication omission LPN E stated she had no memory of the event. The nurse who was responsible for the 6-6-17 omission was not available during survey. There were no nursing notes describing either omission.

The physician progress notes, and nursing progress notes were reviewed in their entirety for May, and June of 2017. There was no indication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 6	F 157		

that the responsible party, nor the physician was ever made aware that these medication omissions occurred.

Resident #10's care plan was reviewed, and stated "administer medications as ordered".

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 notification of the physician, and RP that medications were omitted on 2 occasions for Resident #10, at the end of day debriefings on 6-21-17, and 6-22-17. No further information was provided by the facility.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 7	F 157		

report an injury of unknown origin to the State Agency.

Resident # 12, an 87 year old female, was admitted to the facility on 3/27/2013 with the diagnoses of, but not limited to, Rheumatoid Arthritis, Alzheimer's Disease, Dysphagia, Hypertension, Hypothyroidism, Gastroesophageal Reflux Disease, Osteoporosis, Anxiety, Major Depressive Disease and Psychosis.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 3/9/2017. The MDS coded Resident # 12 with a BIMS (Brief Interview for Mental Status) of 8/15 indicating severe cognitive impairment; the resident was coded as in need of extensive to total help with two staff person assistance in activities of daily living. Resident # 12 was coded as requiring extensive assistance of one staff person for bed mobility and total assistance of two staff persons for transfers. She was coded as always incontinent of bowel and bladder.

Review of the clinical record was conducted on 6/22/17. Review of the Nurses notes dated 3/9/2017 at 7:00 AM revealed documentation that during the early morning rounds, the CNA (Certified Nursing Assistant) "discovered large mass on rt (right) forearm. Resident does not know how she acquired this mass and denied any pain to the mass. Mass is palpable and hard, almost encapsulated. When discovered, resident's armband was in the middle of the mass and caused it to be dented. mass is bruised in color, measuring 6 cm x 10 cm on the upper mass and 4 cm x 7 cm at the lower mass. Rcare (communication form) has been filled out,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 8	F 157		

provider and supervisors have been notified. Will continue to monitor."
There was no more documentation in the Nurses Notes about the mass during the rest of the month of March 2017.

On 6/22/2017 at 3:30 PM, an interview was conducted with the Director of Nursing (DON) who stated she was made aware of the area on Resident # 12's arm and that it looked like a mass when she inspected it. The DON stated after further inspection, she thought the area looked like an injury because it was consistent with where Resident # 12's arm would be located if it was leaning against the side rail when the resident was being turned. The DON stated she did not report the injury to the State Agency as an injury of unknown origin because the injury could be explained since it appeared to be consistent with the exact location of where the resident's arm could have pressed on the side rail during turning and repositioning. The DON stated she informed Resident # 12's Responsible Party (Resident # 12's daughter) about the mass and told her how she thought it happened. The DON stated she wanted to "make sure the daughter knew about the mass before she came in to visit because it looked really ugly" and she "didn't want the daughter to be alarmed." The DON stated she did not document the conversation she had with the Responsible Party. The DON was asked to provide copies of the Physicians Progress Notes and any other information regarding the mass/injury on Resident # 12's arm since the surveyor could not readily access the system.

On 6/22/2017 at 4:05 PM, the DON presented a copy of the Progress Note written by the Nurse Practitioner on 3/9/2017.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 9	F 157		

Review of the Physicians Progress Notes revealed documentation on 3/9/2017 of a visit by the Nurse Practitioner who wrote "patient seen today due to hematoma on right forearm with swelling extending up to elbow. Unclear etiology, patient has dementia and is unable to provide history. She denies pain, smiles and waves her left arm around which has large purple hematoma to anterior surface. Nurse reports that patient has not fallen and no other incidents known." An X-ray was ordered.

Review of the X-ray report dated 3/10/2017 revealed documentation of "soft tissue swelling/prominence overlying the proximal and mid aspect of the anterior forearm. No underlying foreign body. There is no fracture.....There is soft tissue calcification along the dorsal aspect of the wrist." The impression was listed as "Soft tissue swelling or mass as described. Clinical evaluation is recommended. Osteopenia and degenerative disease."

Thorough review of the clinical record revealed there was no documentation of notification of the Responsible Party regarding the mass/injury of unknown origin on Resident # 12's forearm.

The DON stated that in hindsight she should have reported the mass to the State Agency as an injury of unknown origin and should have documented notification of the Responsible Party.

During the end of day debriefing, the facility Administrator and Director of Nursing were informed of the findings.

No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167 SS=C	Continued From page 10 483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility staff failed to prominently post and have readily accessible for the residents, the availability of survey reports. The findings included:	F 167	1. A sign was posted June 22, 2017 at the nurse's station by the Clinical Manager with notification that a notebook containing the last three years of state survey results is located in the front lobby of the facility.	7/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167	Continued From page 11 On 6/22/17 at 11:00 a.m. a general observation tour of the facility was conducted. The nursing unit maintained closed doors at the end of the unit which lead to the entrance of the building. Within the front entrance area the last three years of survey result reports was available to visitors and residents however, there was no notice on the nursing unit of where the survey reports could be found. On 6/22/17 at 12:35 p.m. an interview was conducted with the Nursing Supervisor, Licensed Practical Nurse-B (LPN-B). When asked where the posting of survey results notice was, she stated, "The resident and family are told on admission." When asked if the information was in the admission packet she stated she did not know. On 6/22/17 at 2:30 p.m., a sign was observed by the nursing station water fountain indicating where the survey results could be found. On 6/22/17 at 5:45 p.m. an interview was conducted with the Director of Nursing (Admin-B). When asked about the survey report notice, she stated, "The survey results (notice) was there but I don't know what happened to it; it's there now."	F 167	2. All residents are at risk for not having knowledge of location of last 3 years of surveys. The notice will remain posted at the nurse's station and in the lobby directing residents to the last 3 years of surveys. Residents will be informed by Activities Director of location of the survey results through resident council and 1:1 visits by July 24, 2017. 3. Nursing Staff will be re-educated on availability of the survey results by the Clinical Educator by July 24, 2017. 4. The Administrator/Designee will audit the presence of the notification of the survey results posting twice weekly for 4 weeks then weekly for 8 weeks and then monthly. The results of the audits will be reported quarterly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.	
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or	F 225		7/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 12	F 225		

mistreatment by a court of law;

(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or

(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 13 (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed for 2 residents (Resident #1 and #12) of 16 residents in the survey sample to investigate and report injuries of unknown origin to the State Agency; and failed to ensure 1 Licensed Practical Nurse was qualified and licensed to practice. 1. For Resident #1, the facility staff failed to investigate and report to the State Agency, a right hip bruise of unknown origin. 2. For Resident # 12, the facility staff failed to report to the State Agency an injury to the right forearm as an injury of unknown origin. 3. The facility staff failed to ensure one "Licensed Practical Nurse" (LPN) employee, was licensed to practice and perform quality of care. The findings included:	F 225	1. A full body assessment was completed on resident #1 on June 21, 2017 and resident #12 on June 22, 2017. No unknown injuries including any bruising and or masses were noted. LPN D was removed from the schedule May 24, 2017 due to failure of licensure exam. 2. All residents are at risk for potential injuries of unknown origin not being investigated or reported timely to OLC. All current residents with injuries starting 6/23/17 will be audited by DON/designee for appropriate notifications to OLC as appropriate. All residents with injuries will be immediately investigated by DON/designee with consideration of need to report to the appropriate state agencies. DON/designee will validate all nurses' licenses for current status thru the Va. Department of Health Professions by July 24, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 14	F 225		

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 assessment 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 observed in a wheelchair in his room. 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 and revealed a nurse's note dated 4/9/17 at 4:37 p.m. which read:
"Resident has a bruise on right hip area. Possible results of fall on 04/06/2017." There was no description of the bruise in the note.

Further review revealed Resident #1 did have a witnessed fall on 4/6/17 at 10:45 p.m. The nurse's note read:
"Resident was witnessed sliding out of wheelchair and taking a knee to the floor...no apparent injuries visible at this time..."

On 6/22/17 at 10:55 a.m., the Director of Nursing (Admin-B) was informed of the finding and a bruise investigation was requested.

Review of facility policy titled "Abuse Prevention

3. Licensed nurses and CNAIs will receive re-education by the Director of Nursing/designee on immediate action required for reporting/investigation of injuries of unknown origin to ensure prompt compliance and timely reporting. The Interdisciplinary Team will review the 24 hour report at morning meeting to assist in identification of bruises of unknown origin. The Abuse Investigation and reporting Policy and Procedure will be reviewed by corporate QA nurse with the Leadership team to ensure understanding and adherence on reporting requirements by date July 24, 2017. A new process for tracking expiration of applicant work status and date of licensure exam will be initialed and tracked staffing coordinator by July 24, 2017. Final verifications will be through the Virginia Department of Health Professions.

4. Administrator/DON will review all reports of injuries of unknown origin to assure investigation and reporting is completed. DON/Designee will audit new applicant report for pending licensure expirations twice monthly. All audits for licensing requirements and all injuries of unknown origin will be reported at the QA meeting by Administrator/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 15	F 225		

and Management" with a last date of review of "11/2016" included the following:
"...4) Investigation
Designated staff will immediately review and investigate all allegations or observations of abuse...
b) The organization will conduct analysis for trends and patterns related to incidents (i.e. falls, skin tears, bruising or injury of unknown origin, unusual occurrences, reportable incidents, etc.)...
6) Reporting
a) The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made...
c) The organization will immediately report all alleged violations involving neglect, abuse, including injuries of unknown source...to the administrator or his or her designee of the facility..."

On 6/22/17 at 5:20 p.m. the bruise to Resident #1's right hip was discussed with Admin-B. Admin-B stated, "I do not have an investigation for the bruise to the right hip." She stated "I was not notified by the nurse and did not know about it until you found it." When asked what she would've done if she was notified of the bruise, Admin-B stated, "I would've absolutely reported and investigated it."

2. For Resident # 12, the facility staff failed to report an injury of unknown origin to the State Agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 16	F 225		

Resident # 12, an 87 year old female, was admitted to the facility on 3/27/2013 with the diagnoses of, but not limited to, Rheumatoid Arthritis, Alzheimer's Disease, Dysphagia, Hypertension, Hypothyroidism, Gastroesophageal Reflux Disease, Osteoporosis, Anxiety, Major Depressive Disease and Psychosis.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 3/9/2017. The MDS coded Resident # 12 with a BIMS (Brief Interview for Mental Status) of 8/15 indicating severe cognitive impairment; the resident was coded as in need of extensive to total help with two staff person assistance in activities of daily living. Resident # 12 was coded as requiring extensive assistance of one staff person for bed mobility and total assistance of two staff persons for transfers. She was coded as always incontinent of bowel and bladder.

Review of the clinical record was conducted on 6/22/17. Review of the Nurses notes dated 3/9/2017 at 7:00 AM revealed documentation that during the early morning rounds, the CNA (Certified Nursing Assistant) "discovered large mass on rt (right) forearm. Resident does not know how she acquired this mass and denied any pain to the mass. Mass is palpable and hard, almost encapsulated. When discovered, resident's armband was in the middle of the mass and caused it to be dented. mass is bruised in color, measuring 6 cm x 10 cm [centimeters] on the upper mass and 4 cm x 7 cm at the lower mass. Rcare [communication form] has been filled out, provider and supervisors have been notified. Will continue to monitor."
There was no more documentation in the Nurses

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COOE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 17	F 225		

Notes about the mass during the rest of the month of March 2017.

On 6/22/2017 at 3:30 PM, an interview was conducted with the Director of Nursing (DON) who stated she was made aware of the area on Resident # 12's arm and that it looked like a mass when she inspected it. The DON stated after further inspection, she thought the area looked like an injury because it was consistent with where Resident # 12's arm would be located if it was leaning against the side rail when the resident was being turned. The DON stated she did not report the injury to the State Agency as an injury of unknown origin because the injury could be explained since it appeared to be consistent with the exact location of where the resident's arm could have pressed on the side rail during turning and repositioning. The DON stated she informed Resident # 12's Responsible Party (Resident # 12's daughter) about the mass and told her how she thought it happened. The DON stated she wanted to "make sure the daughter knew about the mass before she came in to visit because it looked really ugly" and she "didn't want the daughter to be alarmed." The DON stated she did not document the conversation she had with the Responsible Party. The DON was asked to provide copies of the Physicians Progress Notes and any other information regarding the mass/injury on Resident # 12's arm since the surveyor could not readily access the system.

On 6/22/2017 at 4:05 PM, the DON presented a copy of the Progress Note written by the Nurse Practitioner on 3/9/2017.
Review of the Physicians Progress Notes revealed documentation on 3/9/2017 of a visit by the Nurse Practitioner who wrote "patient seen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 18	F 225		

today for due to hematoma on right forearm with swelling extending up to elbow. Unclear etiology, patient has dementia and is unable to provide history. She denies pain, smiles and waves her left arm around which has large purple hematoma to anterior surface. Nurse reports that patient has not fallen and no other incidents known." An X-ray was ordered.

Review of the X-ray report dated 3/10/2017 revealed documentation of "soft tissue swelling/prominence overlying the proximal and mid aspect of the anterior forearm. No underlying foreign body. There is no fracture.....There is soft tissue calcification along the dorsal aspect of the wrist." The impression was listed as "Soft tissue swelling or mass as described. Clinical evaluation is recommended. Osteopenia and degenerative disease."

Review of the Facility Abuse Prevention and Management Policy, Revision date 11/2016 under "Reporting" revealed statements that the facility "will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 19	F 225		

The DON stated that in hindsight she should have reported the mass to the State Agency as an injury of unknown origin and should have documented notification of the Responsible Party.

During the end of day debriefing, the facility Administrator and Director of Nursing were informed of the findings.

No further information was provided.

3. The facility staff failed to ensure one "Licensed Practical Nurse" (LPN) employee, was licensed to practice, and perform care as a LPN according to the Virginia Department of Health Professions requirements.

During employee record review for abuse prohibition screening of employees, one LPN, (LPN D) was found to have been hired as a new graduate. LPN D was required to have taken the state board examination to receive licensure to practice as a "Licensed Practical Nurse". The deadline for Licensure for LPN D was 5-25-17. LPN D did not complete the examination successfully, and worked on in the facility unlicensed.

The facility provided LPN D's time clock history upon request, and it revealed that on 5-29-17 LPN D worked for 12 hours as a nurse, and on 5-30-17 LPN D worked as a nurse for 12.5 hours.

The facility policy on "Abuse Prevention and Management" was reviewed, and revealed under the heading "Specific procedure/Requirements"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 20 under sections "b, and i", Multi state registry check and license verification will be checked from every state registry established under sections 1819 (e) (2) (A) or 1919 (e) (2) (A) of the act that the facility believes will include information on the individual. State licensure and certification agencies, and applicable registries, will be contacted, prior to hire, to validate current licensure or certification requirements and to determine if the potential employee is in good standing with the registry. On 6-22-17 at the end of day debrief at 5:00 p.m., the Administrator and Director of Nursing were made aware of the findings. No further information was available to be presented by the facility.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation	F 226		7/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION OATE
F 226	Continued From page 21 requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to operationalize the abuse policies for 2 residents (Resident #1 and Resident #12) of 16 residents in the survey sample, and one Employee. 1. For Resident #1, the facility staff failed to operationalize the abuse policy related to reporting and investigating injuries of unknown origin. 2. For Resident # 12, the facility staff failed to operationalize the Abuse policies relating to reporting injuries of unknown origin to the State Agency. 3. The facility staff failed to ensure their policy to check employee nursing licensure was implemented. The findings included:	F 226	1. A full body assessment was completed on resident #1 on June 21, 2017 and resident #12 on June 22, 2017. No unknown injuries including any bruising and or masses were noted. LPN D was removed from the schedule May 24, 2017 due to failure of licensure exam. 2. All residents are at risk for potential injuries of unknown origin not being investigated or reported timely to OLC. All current residents with injuries starting June 23, 2017 will be audited by DON/designee for appropriate notifications to OLC as appropriate. All residents with injuries will be immediately investigated by DON/designee with consideration of need to report to the appropriate state agencies. DON/designee will validate all nurses' licenses for current status thru the Va. Department of Health Professions by June 24, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 22	F 226		

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 observed in a wheelchair in his room. 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 and revealed a nurse's note dated 4/9/17 at 4:37 p.m. which read:
"Resident has a bruise on right hip area. Possible results of fall on 04/06/2017." There was no description of the bruise in the note.

Further review revealed Resident #1 did have a witnessed fall on 4/6/17 at 10:45 p.m. The nurse's note read:
"Resident was witnessed sliding out of wheelchair and taking a knee to the floor...no apparent injuries visible at this time..."

On 6/22/17 at 10:55 a.m., the Director of Nursing (Admin-B) was informed of the finding and a bruise investigation was requested.

Review of facility policy titled "Abuse Prevention

3. Licensed nurses and CNAs will receive re-education by the Director of Nursing/designee on immediate action required for reporting/investigation of injuries of unknown origin to ensure prompt compliance and timely reporting. The Interdisciplinary Team will review the 24 hour report at morning meeting to assist in identification of bruises of unknown origin. The Abuse Investigation and reporting Policy and Procedure will be reviewed by corporate QA nurse with the Leadership team to ensure understanding and adherence on reporting requirements by date July 24, 2017. A new process for tracking expiration of applicant work status and date of licensure exam will be initialed and tracked staffing coordinator by July 24, 2017. Final verifications will be through the Virginia Department of Health Professions.

4. Administrator/DON will review all reports of injuries of unknown origin to assure investigation and reporting is completed. DON/Designee will audit new applicant report for pending licensure expirations twice monthly. All audits for licensing requirements and all injuries of unknown origin will be reported at the QA meeting by Administrator/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION OATE
F 226	Continued From page 23	F 226		

and Management" with a last date of review of "11/2016" included the following:

"Policy Statement:...The facility is committed to developing and operationalizing policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property..."

"...4) Investigation
Designated staff will immediately review and investigate all allegations or observations of abuse...
b) The organization will conduct analysis for trends and patterns related to incidents (i.e. falls, skin tears, bruising or injury of unknown origin, unusual occurrences, reportable incidents, etc.)...
6) Reporting
a) The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made...
c) The organization will immediately report all alleged violations involving neglect, abuse, including injuries of unknown source...to the administrator or his or her designee of the facility..."

On 6/22/17 at 5:20 p.m. the bruise to Resident #1's right hip was discussed with Admin-B. Admin-B stated "I do not have an investigation for the bruise to the right hip." She stated "I was not notified by the nurse and did not know about it until you found it." When asked what she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 24	F 226		

would've done if she was notified of the bruise, Admin-B stated "I would've absolutely reported and investigated it."

2. For Resident # 12, the facility staff failed to implement their abuse policy concerning the reporting of an injury of unknown origin to the State Agency.

Resident # 12, an 87 year old female, was admitted to the facility on 3/27/2013 with the diagnoses of, but not limited to, Rheumatoid Arthritis, Alzheimer's Disease, Dysphagia, Hypertension, Hypothyroidism, Gastroesophageal Reflux Disease, Osteoporosis, Anxiety, Major Depressive Disease and Psychosis.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 3/9/2017. The MDS coded Resident # 12 with a BIMS (Brief Interview for Mental Status) of 8/15 indicating severe cognitive impairment; the resident was coded as in need of extensive to total help with two staff person assistance in activities of daily living. Resident # 12 was coded as requiring extensive assistance of one staff person for bed mobility and total assistance of two staff persons for transfers. She was coded as always incontinent of bowel and bladder.

Review of the clinical record was conducted on 6/22/17. Review of the Nurses notes dated 3/9/2017 at 7:00 AM revealed documentation that during the early morning rounds, the CNA (Certified Nursing Assistant) "discovered large mass on rt (right) forearm. Resident does not know how she acquired this mass and denied any pain to the mass. Mass is palpable and hard,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 25	F 226		

almost encapsulated. When discovered, resident's armband was in the middle of the mass and caused it to be dented. mass is bruised in color, measuring 6 cm x 10 cm on the upper mass and 4 cm x 7 cm at the lower mass. Rcare (communication form) has been filled out, provider and supervisors have been notified. Will continue to monitor."
There was no more documentation in the Nurses Notes about the mass during the rest of the month of March 2017.

On 6/22/2017 at 3:30 PM, an interview was conducted with the Director of Nursing (DON) who stated she was made aware of the area on Resident # 12's arm and that it looked like a mass when she inspected it. The DON stated after further inspection, she thought the area looked like an injury because it was consistent with where Resident # 12's arm would be located if it was leaning against the side rail when the resident was being turned. The DON stated she did not report the injury to the State Agency as an injury of unknown origin because the injury could be explained since it appeared to be consistent with the exact location of where the resident's arm could have pressed on the side rail during turning and repositioning. The DON stated she informed Resident # 12's Responsible Party (Resident # 12's daughter) about the mass and told her how she thought it happened. The DON stated she wanted to "make sure the daughter knew about the mass before she came in to visit because it looked really ugly" and she "didn't want the daughter to be alarmed." The DON stated she did not document the conversation she had with the Responsible Party. The DON was asked to provide copies of the Physicians Progress Notes and any other information regarding the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 26	F 226		

mass/injury on Resident # 12's arm since the surveyor could not readily access the system.

On 6/22/2017 at 4:05 PM, the DON presented a copy of the Progress Note written by the Nurse Practitioner on 3/9/2017.
Review of the Physicians Progress Notes revealed documentation on 3/9/2017 of a visit by the Nurse Practitioner who wrote "patient seen today for due to hematoma on right forearm with swelling extending up to elbow. Unclear etiology, patient has dementia and is unable to provide history. She denies pain, smiles and waves her left arm around which has large purple hematoma to anterior surface. Nurse reports that patient has not fallen and no other incidents known." An X-ray was ordered.

Review of the X-ray report dated 3/10/2017 revealed documentation of "soft tissue swelling/prominence overlying the proximal and mid aspect of the anterior forearm. No underlying foreign body. There is no fracture.....There is soft tissue calcification along the dorsal aspect of the wrist." The impression was listed as "Soft tissue swelling or mass as described. Clinical evaluation is recommended. Osteopenia and degenerative disease."

Review of the Facility Abuse Prevention and Management Policy, Revision date 11/2016 under "Reporting" revealed statements that the facility "will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION OATE
F 226	Continued From page 27	F 226		

in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures."

The DON stated that in hindsight she should have reported the mass to the State Agency as an injury of unknown origin and should have documented notification of the Responsible Party.

During the end of day debriefing, the facility Administrator and Director of Nursing were informed of the findings that no report was made to the State Agency.

No further information was provided.

3. The facility staff failed to ensure their policy to check employee nursing licensure was implemented.

During employee record review for abuse prohibition screening of employees, one LPN, (LPN D) was found to have been hired as a new graduate. LPN D was required to have taken the state board examination to receive licensure to practice as a "Licensed Practical Nurse". The deadline for Licensure for LPN D was 5-25-17. LPN D did not complete the examination successfully, and worked on in the facility unlicensed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 28 The facility provided LPN D's time clock history upon request, and it revealed that on 5-29-17 LPN D worked for 12 hours as a nurse, and on 5-30-17 LPN D worked as a nurse for 12.5 hours. The facility policy on "Abuse Prevention and Management" was reviewed, and revealed under the heading "Specific procedure/Requirements" under sections "b, and i", Multi state registry check and license verification will be checked from every state registry established under sections 1819 (e) (2) (A) or 1919 (e) (2) (A) of the act that the facility believes will include information on the individual. State licensure and certification agencies, and applicable registries, will be contacted, prior to hire, to validate current licensure or certification requirements and to determine if the potential employee is in good standing with the registry. On 6-22-17 at the end of day debrief at 5:00 p.m., the Administrator and Director of Nursing were made aware of the findings. No further information was available to be presented by the facility.	F 226		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation	F 281	1. Residents #3 and #10[illegible]s responsible	7/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 29	F 281		

review and clinical record review, the facility staff failed to follow the professional standards of quality for medication administration, for three Residents (Residents #3, #10 and #5) in a survey sample of 16 residents.

1. For Resident #3, the facility staff failed to ensure 3 medications were administered as ordered by a physician.

2. For Resident #10, the facility staff failed to ensure 1 medication was administered as ordered by a physician

3. For Resident #5, the facility staff failed to assess and document the need for PRN (as needed) oxygen use.

The findings included:

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's orders, eMAR (electronic medication administration record), Nursing progress notes, and the facility

parties and providers were notified on July 3, 2017 by clinical manager of the missed medications. There were no adverse reactions from the missed medication. Resident #5 order was clarified June 21, 2017 for continuous oxygen clinical manager. Responsible representative was notified June 21, 2017.

2. All residents within the facility are at risk for medication omissions and unclear oxygen orders. DON /designee will complete will complete a 100% audit of current medications to ensure they are available and have been given and a 100% audit on residents with oxygen to ensure all residents with oxygen have the correct orders.

3. The licensed nurses will receive re-education by July 24, 2017 by the DON/designee regarding the 6 rights of medication administration and the process for managing unavailable medications. Education will include instruction for residents regarding medical symptom necessary for prn oxygen.

4. The DON/designee will audit 4 residents MARs weekly for 4 weeks and then 2 weekly for 8 weeks to ensure accuracy of medication. Will audit 4 oxygen orders for 4 weeks and then 2 weekly for 8 weeks. The results of the audits will be reported monthly at the QA meeting for evaluation of accuracy for monitoring for continuous improvement analysis after the implementation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 30	F 281		

printed MAR with notes, revealed that the Resident was not administered the following medications, on the following days. There were no notes documented by staff in the clinical record for the omissions other than "unavailable" 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; med not in stat box" (additional drug box), and a second note stated "Not administered". No nursing notes document this omission.

5-26-17 Lasix (congestive heart failure) 20 mg (milligrams) three times weekly in the morning (8:00 a.m. to 10:00 a.m.), and Tamsulosin (urinary retention) 0.4 mg daily in the morning (8:00 a.m. to 10:00 a.m.). Both medications were omitted and no reason was given as to why. There were no nursing notes for this day.

A thorough review of Resident #3's clinical record revealed that because of the Resident's cognitive level there was no evidence that he ever refused medications.

The nurse responsible for the 5-5-17 medication omission was not available during survey. The nurse responsible for the 5-26-17 omissions, was unknown, as no signature existed in the record for this date, and there were no nursing notes on this date.

The physician progress notes, and nursing progress notes were reviewed in their entirety for May, and June of 2017. There was no indication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 31	F 281		

that the responsible party, nor the physician was ever made aware that these medication omissions occurred. As no one was notified, the pyridium was discontinued on the original schedule, meaning one dose was missed, and the order was never fully completed. The omitted dose of pyridium could have been administered at the end of the course of treatment, however, this option was also not instituted.

Resident #3's care plan was reviewed, and stated "administer medications as ordered".

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 DON stated "Mosby's" as their nursing standard.

Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Mosby's/ Potter-Perry, p. 705: Professional standards,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 32	F 281		

such as the American Nurses Association's Nursing Scope and Standards of Nursing Practice of (2004), apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:

1. The right medication
2. The right dose
3. The right client
4. The right route
5. The right time
6. The right documentation."

The administrator and DON (director of nursing) were informed of the failure of the staff to ensure medications were administered on 2 occasions for Resident #3. 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.

2. For Resident #10, the facility staff failed to ensure 1 medication was administered as ordered by a physician.

Resident #10, was admitted to the facility on 9-1-15. Diagnoses included; Fractured left leg, dementia, and depression.

Resident #10's most recent MDS (minimum data

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495369	A. BUILOING _____ B. WING _____	06/22/2017

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION OATE
F 281	Continued From page 33	F 281		

set) with an ARD (assessment reference date) of 3-29-17 was coded as a significant change full assessment. Resident #10 was coded as having moderate cognitive impairment. Resident #10 was also coded as needing extensive to total assistance of one staff member to perform activities of daily living, and was a hospice patient.

Review of Resident #10's physician's 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 following days. There were no notes documented by staff in the clinical record for the omissions other than "unavailable" on 5-5-17 in the MAR notes;

5-5-17 and 6-6-17, Forteo injection (Osteoporosis) 20 micrograms subcutaneously to be given every day in the morning (8:00 a.m. to 10:00 a.m.). The medication was omitted, and the reason given for the omission was documented in the MAR notes, as, "Not available" on 5-5-17, and simply on 6-6-17, "Not administered (other/enter administration note)". No nursing notes document either omission.

The nurse responsible for the 5-5-17 medication omission LPN E stated she had no memory of the event. The nurse who was responsible for the 6-6-17 omission was not available during survey. There were no nursing notes describing either omission.

The physician progress notes, and nursing progress notes were reviewed in their entirety for May, and June of 2017. There was no indication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 34	F 281		

that the responsible party, nor the physician was ever made aware that these medication omissions occurred.

Resident #10's care plan was reviewed, and stated "administer medications as ordered".

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 DON stated "Mosby's" as their nursing standard.

Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Mosby's/ Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing Scope and Standards of Nursing Practice of (2004), apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 35	F 281		

an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:

1. The right medication
2. The right dose
3. The right client
4. The right route
5. The right time
6. The right documentation."

The administrator and DON (director of nursing) were informed of the failure of the staff to ensure medications were administered on 2 occasions 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.

3. Resident #5 was originally admitted to the facility on 3/4/10 and readmitted on 4/18/16 with the diagnoses of, but not limited to, COPD (Chronic Obstructive Pulmonary Disease), chronic bronchitis, anxiety and dementia.

The most recent Minimum Data Set (MDS) was an annual assessment with and Assessment Reference Date (ARD) of 5/4/17. The MDS coded Resident #5 with intact cognition; required extensive assistance from staff for bed mobility, transfers, dressing and hygiene; dependent on staff for toileting and bathing; and coded for oxygen use.

On 6/20/17 at 3:35 p.m., Resident #5 was observed lying in bed, head of bed up, alert and answered questions when spoken to. Oxygen 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 36	F 281		

liters per minute (2 lpm) via nasal cannula was in use. When asked how her breathing was doing, Resident #5 denied any respiratory problems.

On 6/21/17 at 9:05 a.m., Resident #5 was observed lying in bed, head of bed up, alert and stated she wanted to be left alone today. Oxygen was in use at 2 lpm via nasal cannula.

Resident #5's clinical record was reviewed on 6/21/17 at 10:05 a.m. The review revealed current physician orders which included "02 (oxygen) 2 L/min (2 liters per minute) per nasal cannula PRN (as needed)." There was no documentation in the nurse's notes for the rationale of the oxygen use.

On 6/21/17 at 1:30 p.m. an interview was conducted with the Unit Manager, Licensed Practical Nurse-C (LPN-C). When asked about the rationale for Resident #5's oxygen use, LPN-C reviewed the physician's orders, noted it was to be used PRN and stated she "Will look into that."

On 6/21/17 at 2:10 p.m. Resident #5 was observed in bed, reading a newspaper, with the oxygen on at 2 lpm via nasal cannula. When asked if she wears the oxygen all the time, Resident #5 stated "Yes I do." When asked why she uses the oxygen she stated "Because I need it."

On 6/21/17 at 3:10 p.m. an interview was conducted with LPN-C with the Director of Nursing present. LPN-C stated the "Order should've been changed from PRN to continuous for shortness of breath." At 4:35 p.m. the Administrator and Director of Nursing were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 37 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 281		
F 309	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES	F 309		7/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=E	Continued From page 38 FOR HIGHEST WELL BEING	F 309		

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation

1. Resident # 1 and #6 physician orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 39	F 309		

review and clinical record review, the facility staff failed to maintain the highest practicable well being for 3 (Residents #1, #5 and #6) of 16 residents in the survey sample.

1. For Resident #1, the facility staff failed to ensure non-pharmacological approaches were attempted prior to administering the antipsychotic medications, Seroquel and Haldol.

2. For Resident #5, the facility staff failed to ensure non-pharmacological approaches were attempted prior to administering the pain medications, Tramadol and Acetaminophen.

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.

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

were clarified on June 22, 2017 by clinical manager. Resident # 5 physician orders were clarified on July 10, 2017 by clinical manager. The Providers orders were updated to allow documentation of non-pharmacological approaches prior to administering pain, anti-anxiety, and anti-psychotic medications.

2. All residents are at risk for administration of prn pain, antianxiety and antipsychotic medications prior to non-pharmacological interventions The DON/designee will audit all current 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 3/31/17 at 1:57 p.m. On 3/28/17 the Seroquel order was changed to "1 (25 mg) po (by mouth) daily prn severe distress/aggression and may repeat in 30 min if not effective..." 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., 4/7/17 at 4:44 p.m., 4/8/17 at 6:05 p.m., 4/11/17 at 6:33 p.m., and 4/13/17 at 11:11 a.m. Nurses notes were reviewed for the above Seroquel administration dates. There were no documented attempts to use non-pharmacological interventions prior to the administration of Seroquel. On 6/22/17 at 4:00 p.m. the Unit Manager, Licensed Practical Nurse-C (LPN-C) was informed of the failure to attempt non-pharmacological approaches prior to the administration of Seroquel. Resident #1's medication administration records for	F 309	for 3 months. All audits will be reported at the QA meeting by Director of Nursing/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 41	F 309		

February-April 2017, physician orders and care plan were requested.

On 6/22/17 at 5:20 p.m. The Director of Nursing was informed of the failure to attempt non-pharmacological interventions prior to the administration of Seroquel. 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.

2. . Resident #5 was originally admitted to the facility on 3/4/10 and readmitted on 4/18/16 with the diagnoses of, but not limited to, COPD (Chronic Obstructive Pulmonary Disease), chronic bronchitis, anxiety and dementia.

The most recent Minimum Data Set (MDS) was an annual assessment with and Assessment Reference Date (ARD) of 5/4/17. The MDS coded Resident #5 with intact cognition; required extensive assistance from staff for bed mobility, transfers, dressing and hygiene; dependent on staff for toileting and bathing. Resident #5 was coded for not having pain.

On 6/21/17 at 10:05 a.m. Resident #5's clinical record was reviewed The review revealed 2016 physician orders which included:

Tramadol 50 mg (milligrams) 1 tablet by mouth twice a day as needed for pain. The Tramadol was documented as administered on 9/12/16 at 11:50 and 9/13/16 at 10:40 for "Pain to back." The nurse did not document the description of or non-pharmacological interventions attempted prior to administering the pain medication. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 42	F 309		

did however document the result as "effective." And,

Acetaminophen 325 mg tablet (650 mg=2 tablets) as needed every four hours for pain. The Acetaminophen was documented as administered on 12/25/16 at 9:36 p.m. without documentation of location or description of, nor non-pharmacological interventions attempted prior to the administration of the pain medication. She did however document the result as "Relief."

Resident #5's care plan dated from 5/24/16 was reviewed and included:
"Resident has expressed/demonstrated pain/discomfort related to: -Rheumatoid Arthritis-Osteoarthritis"

The approaches check included, but were not limited to:
Encourage and assist resident to identify intensity, quality and location of pain;
Encourage resident to tell nurse when pain interventions are not being effective;
Administer medication as prescribed by the physician;
Assist the resident as needed to position in a manner that is most comfortable; use pillows or other devices as needed;
Apply heat or cold applications as tolerated by or requested by resident and/or ordered by physician;
Apply gentle massage or range of motion as tolerated by or requested by resident;
Offer activities that may re-focus resident such as music, conversation, etc.

Review of facility policy titled "Pain Assessment" originated 4/09 and with a "Last Revision Date" of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 43	F 309		

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 demonstrative of pain will be monitored 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 a non-pharmacological approach before giving a medication, (it) should've been documented in the notes."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 44	F 309		

3. Resident #6 was admitted to the facility on 6/24/16 with the diagnoses of, but not limited to, dementia, psychosis, depression, metabolic encephalopathy, and chronic pain.

The most recent MDS was a quarterly assessment with an ARD of 3/28/17. The MDS coded Resident #6 with severe cognitive impairment; no psychotic behaviors but did code for wandering; required extensive assistance from staff for all activities of daily living except bathing which he was dependent on staff for.

On 6/21/17 at 2:15 p.m. Resident #6 was observed sleeping in bed, fall mats and bed alarm in place. His wife was in a recliner chair next to the bed.

On 6/21/17 at 2:20 p.m. Resident #6's clinical record was reviewed. The review revealed physician orders which included:

Haloperidol (Haldol) 1 mg tablet oral as needed every four hours starting 2/15/17. The order for haloperidol was discontinued 4/27/17. The instructions included with the physician's order read: "1 po (by mouth) every four hours as needed for severe distress or aggression that cannot be redirected. And,

Lorazepam (Ativan) 1mg PO , sublingual or rectally every 2 hours as needed for restlessness, anxiety, dyspnea, or seizures. Tablet may be crushed and dissolved if needed.

Review of the April 2017 Medication Administration Record (MAR) revealed the Haldol was administered on 4/2/17 at 8:04 a.m. with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 45	F 309		

"Results" listed as "Behavior Decreased."
Review of the nurses notes for 4/2/17 at 7:30 a.m. revealed the following documentation: "Resident slid from wheel chair while sitting at nurses station. The fall was witnessed, resident sustained no injuries. Nurses note documented on 4/2/17 at 10:28 a.m. read "Resident upon arrival increase agitation to get up unassisted, witness fall with no injuries Haldol given at 804 am with effectiness (sic). resident lying down at the moment voices no complaints at the moment. There were no documented non-pharmacological interventions prior to the administration of Haldol.

Review of the May 2017 MAR revealed the Lorazepam was administered on 5/24/17 at 22:12 (10:12 p.m.) with "Results" listed as "Relief." There were no nurses notes at or around the time of administration of the Ativan.

Resident #6's care plan included:

"Resident is at risk for side effects related to use of psychoactive medication: antipsychotics PRN (as needed). Psychoactive medications are being used to treat/manage following behaviors/symptoms_agitation that can not be redirected." The interventions included in the care plan were:
"Administer medications as ordered;
Observe and report s/sx (signs/symptoms) of tardive dyskinesia;
Assess for other causes for mood/behavior disturbances prior to use of PRN medication.

"Behavioral Symptoms: (resident name) has physical behavioral symptoms directed at others-agitation, attempting to hit staff, not easily directed." Interventions included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 46	F 309		

"Provide medication as ordered;
Monitor pattern of behavior (time of day, precipitating factors, specific staff or situation)...; Attempt to redirect. Allow time to calm down. Speak to resident in a calm voice."

On 6/21/17 at 4:30 p.m. the Administrator and Director of Nursing were informed of the findings and surveyor requested information on non-pharmacological approaches for the PRN medications administered.

On 6/22/17 at 8:35 a.m., The Clinical Manager, Admin-G stated they "Could not find any non-pharm interventions." A copy of the facility policy on non-pharmacological and psychoactive medication use was requested and received. The facility policy and procedure titled "Psychoactive Medication and Behavior Monitoring" included the following:

"Purpose:
To optimize the quality of life and function of residents by improving approaches to meeting the health, psychosocial and behavioral health needs of all residents through individualized, person-centered approaches to reduce potentially distressing or harmful behaviors and promote improved functional abilities and quality of life. Medications may be effective when they are used appropriately to address significant, specific, underlying medical or psychiatic causes, or new or worsening behavioral symptoms. All interventions, including medications, need to be monitored for efficacy, risks, benefits and harm..."

"Psychoacive Medication Monitoring
A. All routine and prn psychoactive medications will be ordered with medication and indication for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 47 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 309		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 323		7/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 48	F 323		

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility staff failed to ensure a hazard free environment as evidenced by 1: An emergency door was partially blocked by resident lift devices and 2: Tears in Resident #1's wheelchair arm rest cushion.

The findings included:

1. During initial tour of the facility with Unit Manager, Licensed Practical Nurse-C (LPN-C) on 6/20/17 at approximately 3:15 p.m., 4 resident lift devices were observed in the out cove near the emergency exit door closest to room 127. 2 of the lifts were partially blocking the emergency exit door. LPN-C moved both lifts to the opposite out cove (the hallway leading to the area and out 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.

1. The lift devices were immediately removed from the emergency door on June 22, 2017 by LPN C. Resident #1 wheelchair arm was replaced on June 22, 2017 by Therapy Director.

2. All residents are at risk for environmental hazards. The lift device was immediately removed and the wheelchair arm was replaced. All doors were immediately checked for other objects in front of fire doors and none were noted. A 100% audit was performed on all wheelchair arms to ensure no tears by Administrator /designee on June 21, 2017.

3. The facility staff will receive re-education by the Administrator/designee regarding maintaining an environment that is hazard free of not having an emergency door blocked by a resident lift. Staff will be educated by Administrator/designee on process for reporting tears in the wheelchair arm rest cushion by July 24, 2017.

4. The emergency doors will be audited by the Administrator/designee to ensure they are hazard free 5 times weekly for 4 weeks then twice weekly for 8 weeks and then weekly. All wheelchairs will be inspected for torn armrests starting July 24, 2017 following the wheelchair cleaning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 49 On 6/22/17 at 11:00 a.m. during general observation of the facility with the Director of Facilities (Admin-D), Admin-D was asked if emergency exits should be blocked; he replied "Absolutely not." No further information was provided by the facility staff. 2. 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 observed in a wheelchair in his room. The right arm rest cushion was torn and peeled off in multiple spots along the arm rest. Resident #1 did not answer questions when spoken to but mumbled a few words at random. Resident #1's wife was present upon observation and a family interview was conducted. When asked about the wheelchair arm, Resident #1's wife stated "He had a different wheelchair when we first got here." Resident #1 did not have any visible wounds or dressings on his arms. On 6/21/17 at 2:05 p.m. Resident #1 was observed in the wheelchair in his room with his	F 323	schedule with needs provided to therapy director for immediate repair or replacement of wheelchair. 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 the implementation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 50 wife and a male staff member present. The resident's wife stated "We just got back from lunch and I think they're going to walk him again." The wheelchair arm rest remained torn. The Administrator and Director of Nursing were informed of the torn arm rest. On 6/22/17 at 8:55 a.m. an interview was conducted with the Director of Nursing (Admin-B). When asked about checking equipment, Admin-B stated "We have a wheelchair washer that it can be rolled in." She stated the wheelchair arm "Could've been an oversight." Resident #1 had no documented skin issues on his arms. At 11:35 a.m., Resident #1 was observed in his wheelchair in the hallway with a staff member. The right arm rest had no tears or peeled areas. No further information was provided by facility staff.	F 323		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who	F 328		7/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 51	F 328		

require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 52	F 328		

Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to ensure oxygen use was clarified for one (Resident #5) of 16 residents in the survey sample.

Resident #5 had oxygen in use continuously throughout the survey however, the physician's order was for PRN (as needed) use.

The findings included:

Resident #5 was originally admitted to the facility on 3/4/10 and readmitted on 4/18/16 with the diagnoses of, but not limited to, COPD (Chronic Obstructive Pulmonary Disease), chronic bronchitis, anxiety and dementia.

The most recent Minimum Data Set (MDS) was an annual assessment with and Assessment Reference Date (ARD) of 5/4/17. The MDS coded Resident #5 with intact cognition; required extensive assistance from staff for bed mobility, transfers, dressing and hygiene; dependent on staff for toileting and bathing; and coded for oxygen use.

On 6/20/17 at 3:35 p.m., Resident #5 was observed lying in bed, head of bed up, alert and answered questions when spoken to. Oxygen 2 liters per minute (2 lpm) via nasal cannula was in use. When asked how her breathing was doing, Resident #5 denied any respiratory problems.

On 6/21/17 at 9:05 a.m., Resident #5 was observed lying in bed, head of bed up, alert and stated she wanted to be left alone today. Oxygen was in use at 2 lpm via nasal cannula.

1. Resident #5 order was clarified July 21, 2017 for continuous oxygen by clinical manager. Responsible representative was notified June 21, 2017.

2. All residents within the facility are at risk for unclear oxygen orders. DON /designee will complete a 100% audit on residents with oxygen to ensure all residents with oxygen have the correct orders.

3. The Licensed nurses will receive re-education by the Director of Nursing/designee regarding medical symptom necessary for prn oxygen orders by July 24, 2107.

4. The DON/ designee will complete 4 oxygen order audits weekly for 4 weeks and 2 audits per week for 8 weeks then 2 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 the implementation. DON/designee responsible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 53	F 328		

Resident #5's clinical record was reviewed on 6/21/17 at 10:05 a.m. The review revealed current physician orders which included "02 (oxygen) 2 L/min (2 liters per minute) per nasal cannula PRN (as needed)." The was no documentation in the nurse's notes for the rationale of the oxygen use.

On 6/21/17 at 1:30 p.m. an interview was conducted with the Unit Manager, Licensed Practical Nurse-C (LPN-C). When asked about the rationale for Resident #5's oxygen use, LPN-C reviewed the physician's orders, noted it was to be used PRN and stated she "Will look into that."

On 6/21/17 at 2:10 p.m. Resident #5 was observed in bed, reading a newspaper, with the oxygen on at 2 lpm via nasal cannula. When asked if she wears the oxygen all the time, Resident #5 stated "Yes I do." When asked why she uses the oxygen she stated "Because I need it."

On 6/21/17 at 3:10 p.m. an interview was conducted with LPN-C with the Director of Nursing present. LPN-C stated the "Order should've been changed from PRN to continuous for shortness of breath." At 4:35 p.m. the Administrator and Director of Nursing were informed of the oxygen use without documented assessments or rationale for the as needed use. The oxygen policy was requested.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		7/24/17

483.45(d) Unnecessary Drugs-General.
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--

(1) In excessive dose (including duplicate drug therapy); or

(2) For excessive duration; or

(3) Without adequate monitoring; or

(4) Without adequate indications for its use; or

(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

483.45(e) Psychotropic Drugs.
Based on a comprehensive assessment of a resident, the facility must ensure that--

(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 55 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure 3 (Residents #1, #5 and #6) of 16 residents in the survey sample were free from unnecessary medications. 1. For Resident #1, the facility staff failed to ensure non-pharmacological interventions were attempted prior to administering the antipsychotic medications, Seroquel and Haldol. 2. For Resident #5, the facility staff failed to ensure non-pharmacological interventions were attempted prior to administering the pain medications, Tramadol and Acetaminophen. 3. For Resident #6, the facility staff failed to ensure non-pharmacological interventions were attempted prior to administering the antipsychotic medication, Haldol and antianxiety medication, Ativan. 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	F 329	1. Resident #1 and #6 orders were clarified on June 22, 2017 by clinical manager. Resident # 5 orders were clarified on July 10, 2017 by clinical manager. The Providers orders were updated to allow documentation of non-pharmacological approaches prior to administering pain, anti-anxiety, and anti-psychotic medications. 2. All residents are at risk for administration of unnecessary medications. The DON/designee will audit all current 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 of unnecessary medication administration. Education will include order entry and documentation of non-pharm logical interventions as appropriate. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 56	F 329		

always incontinent of bowel and bladder.

On 6/21/17 at 8:40 a.m., Resident #1 was 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 3/31/17 at 1:57 p.m. On 3/28/17 the Seroquel order was changed to "1 (25 mg) po (by mouth) daily prn severe distress/aggression and may repeat in 30 min if not effective..." 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., 4/7/17 at 4:44 p.m., 4/8/17 at 6:05 p.m., 4/11/17 at 6:33 p.m., and 4/13/17 at 11:11 a.m.

Nurses notes were reviewed for the above Seroquel administration dates. There were no documented attempts to use non-pharmacological interventions prior to the administration of Seroquel.

On 6/22/17 at 4:00 p.m. the Unit Manager, Licensed Practical Nurse-C (LPN-C) was informed of the failure to attempt

for 8 weeks and then 5 residents monthly for 3 months. All audits will be reported at the QA meeting by Director of Nursing/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 57	F 329		

non-pharmacological approaches prior to the administration of Seroquel. Resident #1's medication administration records for February-April 2017, physician orders and care plan were requested.

On 6/22/17 at 5:20 p.m. The Director of Nursing was informed of the failure to attempt non-pharmacological interventions prior to the administration of Seroquel. 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.

2. Resident #5 was originally admitted to the facility on 3/4/10 and readmitted on 4/18/16 with the diagnoses of, but not limited to, COPD (Chronic Obstructive Pulmonary Disease), chronic bronchitis, anxiety and dementia.

The most recent Minimum Data Set (MDS) was an annual assessment with an Assessment Reference Date (ARD) of 5/4/17. The MDS coded Resident #5 with intact cognition; required extensive assistance from staff for bed mobility, transfers, dressing and hygiene; dependent on staff for toileting and bathing. Resident #5 was coded for not having pain.

On 6/21/17 at 10:05 a.m. Resident #5's clinical record was reviewed The review revealed 2016 physician orders which included:

Tramadol 50 mg (milligrams) 1 tablet by mouth twice a day as needed for pain. The Tramadol was documented as administered on 9/12/16 at 11:50 and 9/13/16 at 10:40 for "Pain to back."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 58	F 329		

The nurse did not document the description of or non-pharmacological interventions attempted prior to administering the pain medication. She did however document the result as "effective." And,

Acetaminophen 325 mg tablet (650 mg=2 tablets) as needed every four hours for pain. The Acetaminophen was documented as administered on 12/25/16 at 9:36 p.m. without documentation of location or description of, nor non-pharmacological interventions attempted prior to the administration of the pain medication. She did however document the result as "Relief."

Resident #5's care plan dated from 5/24/16 was reviewed and included:
"Resident has expressed/demonstrated pain/discomfort related to: -Rheumatoid Arthritis-Osteoarthritis"

The approaches check included, but were not limited to:
Encourage and assist resident to identify intensity, quality and location of pain;
Encourage resident to tell nurse when pain interventions are not being effective;
Administer medication as prescribed by the physician;
Assist the resident as needed to position in a manner that is most comfortable; use pillows or other devices as needed;
Apply heat or cold applications as tolerated by or requested by resident and/or ordered by physician;
Apply gentle massage or range of motion as tolerated by or requested by resident;
Offer activities that may re-focus resident such as music, conversation, etc.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 59	F 329		

Review of facility policy titled "Pain Assessment" originated 4/09 and with a "Last Revision Date" of 4/27/17 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 demonstrative of pain will be monitored 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 60	F 329		

a non-pharmacological approach before giving a medication, (it) should've been documented in the notes."

3. Resident #6 was admitted to the facility on 6/24/16 with the diagnoses of, but not limited to, dementia, psychosis, depression, metabolic encephalopathy, and chronic pain.

The most recent MDS was a quarterly assessment with an ARD of 3/28/17. The MDS coded Resident #6 with severe cognitive impairment; no psychotic behaviors but did code for wandering; required extensive assistance from staff for all activities of daily living except bathing which he was dependent on staff for.

On 6/21/17 at 2:15 p.m. Resident #6 was observed sleeping in bed, fall mats and bed alarm in place. His wife was in a recliner chair next to the bed.

On 6/21/17 at 2:20 p.m. Resident #6's clinical record was reviewed. The review revealed physician orders which included:

Haloperidol (Haldol) 1 mg tablet oral as needed every four hours starting 2/15/17. The order for haloperidol was discontinued 4/27/17. The instructions included with the physician's order read: "1 po (by mouth) every four hours as needed for severe distress or aggression that cannot be redirected. And,

Lorazepam (Ativan) 1mg PO , sublingual or rectally every 2 hours as needed for restlessness, anxiety, dyspnea, or seizures. Tablet may be crushed and dissolved if needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 61	F 329		

Review of the April 2017 Medication Administration Record (MAR) revealed the Haldol was administered on 4/2/17 at 8:04 a.m. with "Results" listed as "Behavior Decreased." Review of the nurses notes for 4/2/17 at 7:30 a.m. revealed the following documentation: "Resident slid from wheel chair while sitting at nurses station. The fall was witnessed, resident sustained no injuries. Nurses note documented on 4/2/17 at 10:28 a.m. read "Resident upon arrival increase agitation to get up unassisted, witness fall with no injuries Haldol given at 804 am with effectiness (sic). resident lying down at the moment voices no complaints at the moment. There were no documented non-pharmacological interventions prior to the administration of Haldol.

Review of the May 2017 MAR revealed the Lorazepam was administered on 5/24/17 at 22:12 (10:12 p.m.) with "Results" listed as "Relief." There were no nurses notes at or around the time of administration of the Ativan.

Resident #6's care plan included:

"Resident is at risk for side effects related to use of psychoactive medication: antipsychotics PRN (as needed). Psychoactive medications are being used to treat/manage following behaviors/symptoms_agitation that can not be redirected." The interventions included in the care plan were:
"Administer medications as ordered;
Observe and report s/sx (signs/symptoms) of tardive dyskinesia;
Assess for other causes for mood/behavior disturbances prior to use of PRN medication.

"Behavioral Symptoms: (resident name) has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 62	F 329		

physical behavioral symptoms directed at others-agitation, attempting to hit staff, not easily directed." Interventions included: "Provide medication as ordered; Monitor pattern of behavior (time of day, precipitating factors, specific staff or situation)...; Attempt to redirect. Allow time to calm down. Speak to resident in a calm voice."

On 6/21/17 at 4:30 p.m. the Administrator and Director of Nursing were informed of the findings and surveyor requested information on non-pharmacological approaches for the PRN medications administered.

On 6/22/17 at 8:35 a.m., The Clinical Manager, Admin-G stated they "Could not find any non-pharm interventions." A copy of the facility policy on non-pharmacological and psychoactive medication use was requested and received. The facility policy and procedure titled "Psychoactive Medication and Behavior Monitoring" included the following:

"Purpose:
To optimize the quality of life and function of residents by improving approaches to meeting the health, psychosocial and behavioral health needs of all residents through individualized, person-centered approaches to reduce potentially distressing or harmful behaviors and promote improved functional abilities and quality of life. Medications may be effective when they are used appropriately to address significant, specific, underlying medical or psychiatic causes, or new or worsening behavioral symptoms. All interventions, including medications, need to be monitored for efficacy, risks, benefits and harm..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 63 "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 329		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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 service safety.	F 371		7/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 64 (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to maintain an effective infection control program concerning the kitchen ice machine. The facility staff failed to ensure the ice machine in the kitchen maintained an air gap to prevent the back flow of waste water. The findings included: On 6/20/2017 at 2:20 p.m., an initial tour of the kitchen was conducted with the Director of Dining (Admin F) and chef (Employee D). The ice machine in the kitchen was observed in the presence of the Dining Director. The ice machine was located along a wall adjacent to a room that was under construction. The surveyors and Admin F had to enter the construction area to observe the pipes and drain for the ice machine. There were two pipes each approximately an inch in diameter; one pipe was inside the drain and the other rested approximately an inch above the drain. There was no space, known as the air gap, between the end of the pipe and the floor drain. The air gap prevents waste water from entering back into the ice machine pipe should back flow from the floor drain occur. The Dining Director (Admin F) agreed that there was no air gap in place. He stated the pipes should not be inside the drain and that there should be an air gap of at least twice the diameter of the pipe. He	F 371	1. The pipe leading from the ice machine in dietary was corrected on June 20, 2017 by the Maintenance Technician to ensure the required air gap per regulation. 2. All residents are at risk for facility failure to maintain the air gap on dietary ice machines. All ice machines were inspected for appropriate air gap on June 22, 2017 by the Maintenance Technician. 3. Checking of the air gap has been added to the daily task list for the dietary staff. The Dietary Staff were in-serviced by the Food Service Director on maintaining the proper air gap per regulation on June 23, 2017. 4. The Food Service Director/designee will audit the daily task lists and visualize the air gap between the drain pipe and floor drain twice weekly for 4 weeks, then weekly for 8 weeks and then monthly. The results of the audits will be reported quarterly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 65 stated the facility was under construction in the kitchen and the pipes could have been bumped by a construction employee. He stated he would remind the employees that the air gap must be maintained. The Administrator and Director of Nursing were notified of the issue on 6/22/2017 at 2:45 p.m. The Administrator stated the Maintenance Director had corrected the problem and that an air gap should be maintained. No further information was provided.	F 371		
F 372 SS=F	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to assure that garbage was enclosed and properly disposed in a sanitary manner. The doors on the cardboard dumpster were open and contained discarded food items and foul smelling debris was noted on the ground near the large dumpster close to the building. Findings included: On 6/20/2017 at 2:35 p.m., a tour was conducted of the facility dumpster area outside of the building near the kitchen of the building. There were two dumpsters observed in the area. The cardboard garbage dumpster was observed to	F 372	1. The doors to the smaller dumpster for cardboard were immediately closed and the area by the large dumpster was pressure washed during the survey on June 20, 2017. 2. All residents are at risk when the dumpster areas not being sanitary with dumpster doors not closed at all times. The larger dumpster for garbage was replaced due to leakage caused by bad seals with a new dumpster on June 23, 2017. 3. The dietary staff will receive re-education by the Food Service Director by July 24, 2017 on keeping the dumpster area clean and doors closed at all times	7/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 372	Continued From page 66 have both doors open. The dumpster was full of cardboard boxes as well as food items including an empty aluminum can of soup, bottle of iced tea and other food items. The paved area around a larger dumpster used by the kitchen was filled with foul smelling debris. The Director of Dining Services (Admin F) stated around that the debris on the ground was the result of rain water. The surveyor asked if the foul smelling debris was oil and food. The Director of Dining Services stated that the large dumpster was emptied by a truck on a routine basis and that liquids might run out of the dumpster when it was turned over. Admin F stated the dumpster doors should be kept closed and there should be no debris outside of the dumpsters. On 6/21/2017 at 5:00 PM, The Administrator and Director of Nursing were made aware of the findings. The Administrator stated "Yes I know, and it has been cleaned up." No further information was provided.	F 372	with this task being added to the Dietary Daily cleaning schedule. 4. The Food Service Director/designee will audit the dumpster area twice weekly for 4 weeks, then weekly for 8 weeks and then monthly. The results of the audits will be reported quarterly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.	
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility;	F 425		7/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure that medications were available for administration for two residents (Residents #3 and #10) in a survey sample of 16 residents. 1. For Resident #3, Pyridium, a medication used for the treatment of urinary tract infections, was unavailable for administration on 5-5-17. 2. For Resident #10, Forteo, a medication used for the treatment of osteoporosis, was unavailable for administration on 5-5-17. The findings included: 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	F 425	1. Resident #3 and resident #10 families and providers were notified on July 10, 2017 by clinical manager of the medication omission that occurred on May 5, 2017. No adverse reaction from missed medications. 2. All residents in the facility are at risk for lack of medication availability and medication omissions. DON/designee will complete a 100% audit of current medication list to the medications being available in the med cart. 3. The licensed nurses will receive 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 68	F 425		

following day. There were no notes documented by staff in the clinical record for the omissions other than "unavailable" 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; med not in stat box", and a second note stated "Not administered". No nursing notes document this omission.

A thorough review of Resident #3's clinical record revealed that because of the Resident's cognitive level there was no evidence that he ever refused medications.

The nurse responsible for the 5-5-17 medication omission was not available during survey.

The physician progress notes, and nursing progress notes were reviewed in their entirety for May, and June of 2017. There was no indication that the responsible party, nor the physician was ever made aware that this medication omission occurred. As no one was notified, the pyridium was discontinued on the original schedule, meaning one dose was missed, and the order was never fully completed. The omitted dose of pyridium could have been administered at the end of the course of treatment, however, this option was also not instituted.

Resident #3's care plan was reviewed, and stated "administer medications as ordered".

On 6-21-17 at 2:30 p.m., the Director of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 69	F 425		

(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 medications were available for Resident #3. They were also made aware that the physician and the Responsible party were not notified of the omission, 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, dementia, and depression.

Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 70	F 425		

3-29-17 was coded as a significant change full assessment. Resident #10 was coded as having moderate cognitive impairment. Resident #10 was also coded as needing extensive to total assistance of one staff member to perform activities of daily living, and was a hospice patient.

Review of Resident #10's physician's 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 following day. There were no notes documented by staff in the clinical record for the omission other than "unavailable" on 5-5-17 in the MAR notes;

5-5-17, Forteo injection (Osteoporosis) 20 micrograms subcutaneously to be given every day in the morning (8:00 a.m. to 10:00 a.m.). The medication was omitted, and the reason given for the omission was documented in the MAR notes, as, "Not available" on 5-5-17.

The nurse responsible for the 5-5-17 medication omission LPN E stated she had no memory of the event. There were no nursing notes describing the omission.

The physician progress notes, and nursing progress notes were reviewed in their entirety for May, and June of 2017. There was no indication that the responsible party, nor the physician was ever made aware that these medication omissions occurred.

Resident #10's care plan was reviewed, and stated "administer medications as ordered".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 71 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 425		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 441		7/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

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

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 73	F 441		

must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility staff failed to maintain an effective infection control program.

The facility staff failed to ensure the ice machines in the kitchen, and the one serving the Long Term care halls, maintained an air gap to prevent the back flow of waste water.

The findings included:

On 6/20/2017 at 2:20 p.m., an initial tour of the kitchen was conducted with the Director of Dining (Admin F) and chef (Employee D). The ice machine in the kitchen was observed in the presence of the Dining Director. The ice machine was located along a wall adjacent to a room that was under construction. The surveyors and

1. The pipe leading from the ice machine in dietary was corrected the Maintenance Technician on June 20, 2017 to ensure the required air gap per regulation. The pipe leading from the ice machine by the nurse's station was corrected on June 22, 2017 the Maintenance Technician to ensure the required air gap per regulation between the pipe and the floor drain.

2. All residents are at risk for failure to maintain the air gap on all ice machines. All ice machines were inspected for appropriate air gap on June 22, 2017 by the Maintenance Technician.

3. Checking of the air gap has been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PRDVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 74 Admin F had to enter the construction area to observe the pipes and drain for the ice machine. There were two pipes each approximately an inch in diameter; one pipe was inside the drain and the other rested approximately an inch above the drain. There was no space, known as the air gap, between the end of the pipe and the floor drain. The air gap prevents waste water from entering back into the ice machine pipe should back flow from the floor drain occur. The Dining Director (Admin F) agreed that there was no air gap in place. He stated the pipes should not be inside the drain and that there should be an air gap of at least twice the diameter of the pipe. He stated the facility was under construction in the kitchen and the pipes could have been bumped by a construction employee. He stated he would remind the employees that the air gap must be maintained. On 6/22/2017 at 2:27 p.m., the ice machine that served all four halls, located across from the nurses station, was inspected with two nurses LPN (Licensed Practical Nurse) A and LPN B . The ice machine did not have an air gap. The drainage pipe was laying on top of the drain. There was no space, known as the air gap, between the end of the pipe and the floor drain. The Administrator and Director of Nursing were notified of the issue on 6/22/2017 at 2:45 p.m. The Administrator stated the Maintenance Director had corrected the problem and that an air gap should be maintained. No further information was provided.	F 441	added to the daily task list for the dietary staff. The Dietary Staff were in-serviced by the Food Service Director on maintaining the proper air gap per regulation on June 23, 2017. Maintenance Staff were in-serviced by the Director of Facilities on June 23, 2017 for maintaining the proper air gap per regulation. Maintenance staff will audit the nourishment room ice machine air gap daily following the updated task list. 4. The Food Service Director / Designee will audit the daily task check off list and visualize the air gap between the drain pipe and floor drain on the kitchen ice machine twice weekly for 4 weeks, then weekly for 8 weeks and then monthly. The Director of Facilities / Designee will audit the daily task list and visualize the air gap between the drain pipe and floor drain on the nourishment room ice machine twice weekly for 4 weeks, then weekly for 8 weeks and then monthly. The results of the audits will be reported quarterly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		7/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 75	F 514		

LE

(i) Medical records.
(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure a complete and accurate clinical

1. Residents # **7** and # 9 Food allergies were reviewed and corrected on June 22, 2017 by clinical manager in the electronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 76	F 514		

record for two residents (Residents #7 and #9) in the survey sample of 16 residents.

1. The facility staff documented Resident #7's food allergy in Resident #9's clinical record. Resident #7 was the spouse of Resident #9.

2. The facility staff documented Resident #9's food allergy in Resident #7's clinical record.

The Findings included:

1. Resident #7 was admitted to the facility on 4-22-17. Resident #7's diagnoses included, high cholesterol, neurogenic disease, dementia, anxiety, and transient ischemic attack (TIA).

The Minimum Data Set, which was an admission full assessment with an Assessment Reference (ARD) date of 4-29-17, coded Resident #7 being able to understand and be understood by others, in addition, he was coded as having a Brief Interview for Mental Status score of 14, out of a possible 15 points, indicating no cognitive impairment.

2. Resident #9 was admitted to the facility on 4-22-17, and was the spouse of Resident #7. Resident #9's diagnoses included, acute toxic encephalopathy, high cholesterol, congestive heart failure, pneumonia, hypertension, lumbar stenosis, vitamin deficiency, dementia and depression.

The Minimum Data Set, which was an admission full assessment with an Assessment Reference (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

medical record as well as the paper thinned record. The dietary department was notified clinical manager of the clarification orders June 22, 2017 and corrected the diet slips. Provider and Responsible Representative notified of error June 22, 2017 by clinical manager. The residents had no allergic reactions.

2. All residents admitted with look a-like, sound a-like names could potentially be affected by an order entry error where orders could be transposed. All current residentsl food allergies will be reviewed by DON/designee by July 24, 2017. Any discrepancies found will be immediately corrected.

3. The Licensed nurses will receive re-education by the DON/designee on order entry and verification of all nursing orders including allergies. A second nurse will review prior to activation of orders. Nutrition Services Communication Form will be reviewed and signed by two nurses prior to submission to dietary by July 24, 2017.

4. DON/Designee will audit all admissions at morning meeting for accuracy of allergies and nutrition services communication form. Results of admission audits will be reported at the QA meeting by the DON/designee for evaluation of compliance and ongoing for monitoring for continuous improvement analysis after the implementation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 77	F 514		

Interview for Mental Status score of 14, out of a possible 15 points, indicating no cognitive impairment.

The following is a review of both Resident's records, as the food allergies for these two Residents were exchanged in error by the facility staff.

On 6-20-17, a review was conducted of Resident #7's clinical record, revealing a signed "Nutrition Services Communication Form" sticking up out of the clinical chart as it was "flagged" to garner attention, along with two documents from the Resident's recent hospitalization. The document was dated 4-24-17, and read, "Food allergies Fish".

Physicians orders, the Medication Administration Record, and hospital admission records were all reviewed for Resident #7, and stated "No known Allergies".

The Resident's physician, Licensed Practical Nurse (LPN) C, and LPN B, were all interviewed and could not answer why the documents were flagged for attention, and the clinical chart was on top of the chart rack, instead of in the chart rack, filed under the room number.

Resident #7's care plan was reviewed, and also stated "no allergies".

On 6-20-17, at the end of day debrief at 5:00 p.m. The Director of Nursing (DON), and the Administrator, were 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 78	F 514		

stated that the Resident Had a fish allergy on all of her clinical records, with the exception of her most recent "Nutrition Services Communication Form". The form read, "No Food allergies".

On 6-21-17 at 11:00 a.m. the DON stated that the two Resident's forms had been mixed up by staff, and that Resident #9 actually had the fish allergy and Resident #7 had no allergies. The two Residents were spouses, and resided in the same room. The DON went on to say that dining services were aware of Resident #9's fish allergy, however, other staff could have been confused.

On 6-21-17, and 6-22-17 at the end of day debriefs, the DON and Administrator were made aware of the inaccurate clinical records of Resident's #7 and #9. The facility provided no further information.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	495369	A. BUILDING: _____ B. WING _____	6/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COL	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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
(1) 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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	495369	A. BUILDING: _____ B. WING _____	6/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COL	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	Continued From Page 1

On 6/21/17 at 8:40 a.m. a family interview was conducted with Resident #1's wife. She stated Resident #1 was admitted to the facility directly from home and didn't have a hospital stay prior to admission.

On 6/22/17 at 9:55 a.m. Resident #1's clinical record was reviewed. The review revealed the initial MDS with an ARD of 2/22/17 and a quarterly MDS with an ARD of 5/16/17 included Section A1800 "Entered From" coded as "03" which indicated Resident #1 was admitted from an "Acute Hospital."

On 6/22/17 at 2:45 p.m. an interview was conducted with MDS Registered Nurse-A (RN-A). Informed RN-A that during a family interview the surveyor was informed Resident #1 was admitted from home and not from a hospital as the MDS' coded him. RN-A stated she would look into it.

On 6/22/17 at 3:15 p.m. RN-A stated she "Did confirm he did come from home, so it was our mistake." No further information was provided by the facility staff.