STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/7/17 through 11/9/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The F314 citation was a Past Non-Compliance (PNC) at a harm level. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 196 certified bed facility was 146 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents #1 through #21) and 3 closed record reviews (Residents #21 through #24).	F 000	**The filing of this plan of correction does not constitute an admission that the alleged deficiencies did, in fact, exist. This plan of corrections is filed as evidence to comply with requirements of participation and continue to provide high quality resident centered care.**	
F 221 SS=D	RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.	F 221	F221-D 1) **Corrective Action for those residents found to be affected by the alleged deficient practice.** The bed sheet was immediately removed from around cited resident #13 and the Geri-chair. 2) **Like Residents-** Facility is currently restraint free. Residents who have been asses and found to be without physical restraints 3) **Systemic Changes put into place to ensure the alleged deficient practice does not recur.** Education completed by the Director of Nursing or designee to current staff on abuse, use of restraints, and the goal of providing the least restrictive environment. Staff education upon hire on staff on abuse, use of restraints, and the goal of providing the least restrictive environment.	

RECEIVED
NOV 30 2017
VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/30/17

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 221	Continued From page 1 (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed, for 1 resident (Resident #13) in the survey sample of 24 residents, to ensure that Resident #13 was free of a physical restraint. The facility staff failed to ensure that Resident #13 was free of being restrained by a bed sheet tied around a Geri-chair. The Findings included: Resident #13 was a 72 year old who was admitted to the facility on 8/20/16. Resident #13's diagnoses included Unspecified Dementia without Behavioral Disturbance, Bipolar Disorder, Insomnia, and Major Depressive Disorder. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 9/2/17, coded Resident #13 as having a Brief Interview of Mental Status Score of 3, indicating severely impaired cognition. On 11/7/17 at 2:45 P.M. an unannounced tour	F 221	4) **Corrective Actions taken for residents with potential to be affected by alleged deficient practice.** Director of Nursing or designee will complete audits of residents remaining restraint free 3x week for 3 months. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. 5) Date of compliance-12-15-17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 221	Continued From page 2 was conducted of the facility. Resident #13 was lying quietly in her bed. Resident #13 was on 1:1 supervision provided by a "Wing-Helper" (Employee A). When asked what a Wing-Helper's job functions were, she stated she sits with Resident #13, passes out ice, and makes the beds. She further stated that she was scheduled to take her Certified Nursing Assistant licensing examination that coming Saturday. On 11/8/17 at 9:00 A.M. a second observation was conducted of Resident #13. She was sitting quietly in her room with 1:1 staff supervision. On 11/8/17 a review was conducted of facility documentation, revealing a Facility Reported Incident dated 1/13/17, with a follow-up report dated 1/18/17. The facility reported that a Certified Nursing Assistant (CNA G) had been terminated for tying Resident #13 to a Geri-chair with a sheet. CNA G's Witness Statement was reviewed. She stated that she tied Resident #13 to her chair with a sheet because she wouldn't stay in bed. It read, "I tied her to the Geri chair because it was stressful, this was about 0630 (6:30 A.M.) and I didn ' t know what else to do. She continued to get up - she almost fell on the floor attempting to get up. I left and forgot to untie her. I was afraid she was going to fall." The facility documentation stated that Resident #13 was untied at about 8:15 A.M. on 1/13/17. She was assessed, and had no apparent injury. On 1/13/17 an Inservice Training was conducted with the nursing staff regarding the use of physical restraints.	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 221	Continued From page 3 On 11/9/17 at 9:00 A.M. an interview was conducted with the Director of Nursing (DON) (Admin. B). She stated, "We continue to have her on 1:1, that frees the other staff to just focus on their jobs. She's going to be on 1:1 as long as she needs to be. We're documenting her behaviors. When asked about what could have been done to prevent Resident #13 from being restrained during the January, 2017 incident, the DON stated, "She (CNA) should have reported to the nurse, other staff may have taken turns monitoring. Maybe she should have called the doctor and had her sent out." On 11/9/17 at 10:00 A.M. the Administrator (Admin. A) was informed of the findings. No further information was received.	F 221		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (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, clinical record review, and facility documentation review, the facility staff failed to follow the professional standards of practice for documentation of medication administration for 1 resident (Resident #8) in the survey sample of 24 residents.	F 281	F281-D 1) **Corrective Action for those residents found to be affected by the alleged deficient practice** Cited Residents- #8 MD/RP notified of missing documentation and resident not receiving supplements. No new orders or concerns. 2) **Like Residents** All Residents have the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 4 For Resident #8, the facility staff failed to document the administration of a dietary supplement on two occasions in August, 2017. The Findings included: Resident #8 was a 97 year old who was admitted to the facility on 3/19/17. Resident # 8's diagnoses included Generalized Muscle Weakness, Gastroesophageal Reflux Disease, and Severe Protein Calorie Malnutrition. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 9/20/17, coded Resident #8 as having a Brief Interview of Mental Status Score of 5, indicating severely impaired cognition. On 11/8/17 a review was conducted of Resident #8's clinical record, revealing the following signed physician's order: "8/1/17. Mighty Shake by mouth three times daily with meals. Record amount consumed." Resident #8's Medication Administration Record was missing documentation of administration of Mighty Shake on 8/18/17, and 8/29/17 at 6:00 P.M. In addition, the nursing progress notes did not contain documentation of administration or of the amount consumed. There was no subsequent fluctuation is Resident #8's weights. On 11/8/17 at 10:20 A.M. an interview was conducted with the Unit Manager (Registered Nurse A). She stated, "Mighty Shake is important for nutritional supplementation to prevent weight loss or further weight loss. It should be documented on the Medication Administration Record (MAR)." The Unit Manager further stated	F 281	3) **Systemic changes put into place to ensure the alleged deficient practice does not recur.** Education completed by the Director of Nursing/Designee to Licensed Nurses on accurate documentation to include signing of MAR/TAR records. 4) **Corrective Actions taken for residents with potential to be affected by alleged deficient practice.** Director of Nursing/Designee will audit for holes in MAR/TARs 3x weekly x 3months and then monthly. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. 5) Date of compliance-12/15/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 5 that the facility utilized Lippincott as their standard of nursing practice. Guidance for professional standards of nursing for documentation of medication administration was identified. "Document all medications administered in the patient's MAR or EMAR (electronic MAR). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions." Lippincott Solutions "Safe Medication Administration Practices, General" 10/02/2015. On 11/8/17 at 4:00 P.M. the facility Administrator (Admin. A), and Director of Nursing (Admin. B) were informed of the findings. No further information was received.	F 281		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 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	F 309	F309-D 1) **Corrective Action for those residents found to be affected by the alleged deficient practice.** Cited Resident #7- MD/RP notified of omitted documentation of blood glucose results, with no new orders or concerns. 2) **Like Residents-** All diabetic residents have the potential to be affected. 3) **Systemic Changes put into place to ensure the alleged deficient practice does not recur.** Education completed by the Director of Nursing/Designee to Licensed Nurses on the charting and documentation policy, and the charting errors, and/or omissions policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 6 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 review, and clinical record review, the facility staff failed to provide the highest practicable well-being for Resident #7. The facility staff failed to assure that physician ordered blood glucose testing was performed and documented, and insulin given, if necessary, for Resident #7. Findings included: Resident #7, a 79-year-old female, was admitted to the facility on 2/7/2017. Resident #7's diagnoses included neurogenic bladder, atrial fibrillation, cerebral vascular accident (stroke), hemiplegia/hemiparesis, dysphagia, high cholesterol, coronary artery disease, anemia, hypertension, and diabetes.	F 309	4) **Corrective Actions taken for residents with potential to be affected by alleged deficient practice.** Director of Nursing or designee will complete audits of proper documentation of the MAR/TAR holes 3x/week for 3 months and then monthly. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. 5) Date of compliance-12-15-17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 7 Resident #7's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/28/2017 was coded as a quarterly assessment. Resident #7 was coded a BIMS (Brief Interview of Mental Status) score of 5/15, indicating severe cognitive deficiency. Resident #7 was also coded as requiring total dependence of 2+ persons for her activities of daily living, and as being always incontinent of bowel. She required a Foley catheter for urinary elimination. A clinical record review was conducted on 11/8/2017 at 11:30 AM. It revealed a diabetic flow sheet (a facility form that documented blood glucose readings and insulin administration, if necessary) showing no blood glucose readings and subsequent insulin administration, if required, for the dates and times indicated for September 2017 and October 2017: 9/1-9:00 PM, 9/15-11:30 AM, 9/15-4:30 PM, 9/15-9:00 PM, 9/17-6:30 PM, 9/18-11:30 AM, 9/18-4:30 PM, 9/18-9:00 PM, 9/20-11:30 AM, 9/29-9:00 PM, 10/7-11:30 AM. There was no other documentation in any other part of the clinical record. A physician order was present in the clinical record stating "Blood glucose checks AC/HS (before meals and bedtime). There was a further order for Novolin R insulin administration depending upon blood glucose reading. An interview was conducted with Administration B, Director of Nursing on 119/2017 at 10:00 AM. She could offer no reason for the missing documentation.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 8 Facility policy "Insulin Administration" stated: Documentation: "1. Resident's blood glucose result as ordered. 2. Dose and concentration of the insulin injection 3. Size and gauge of the needle used 4. Injection site 5. How well the resident tolerated the procedure." Administration was informed of findings on 11/9/2017 at 10:30 AM.	F 309		
F 314 SS=G	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review the facility staff failed to assess and implement	F 314	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 314	Continued From page 9 interventions to prevent an unstageable pressure wound resulting in harm for Resident #5. This is a past non-compliance citation (PNC). The facility staff failed to monitor and assess Resident #5 resulting in the development of an unstageable pressure wound on her sacrum. Findings included: Resident #5, a 59-year-old female, was admitted to the facility on 11/2/2016. Her diagnoses included CVA (Cerebral Vascular Accident-stroke), left side hemiplegia/hemiparesis, convulsions, seizure disorder, aphasia, hypertension, and diabetes. Resident #5's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/8/2017 was coded as a quarterly assessment. Resident #5 was coded as having severely impaired cognition by staff assessment. She was also coded as being totally dependent on 1-2 persons for her ADL's (activities of daily living) and as being always incontinent of bowel and bladder. A review of Resident #5's clinical record was conducted on 11/7/2017 at 2:00 PM. MDS records showed that Resident #5 had no wounds on admission to the facility. Braden scale is a clinical tool for predicting pressure wound risk. It consists of 6 categories-sensory, moisture, activity, mobility, nutrition, and friction/shear. Total scores can range from 6-23, with lower scores indicating a higher risk. Resident #5's Braden scale score on 6/7/2017	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 314	Continued From page 10 was 16/23, indicating a mild risk for pressure wound development. Progress notes revealed a note dated 6/7/2017 stating "Change in condition noted related to resident noted with open areas to left buttock and sacrum. This change in condition started on 6/7/2017". A "Pressure Injury Record" described this new wound as originating on 6/7/2017 and being a facility acquired wound to the sacrum. This record described the wound as "unstageable 3.5 cm (centimeters) x 1.8 cm x 0.1 cm containing 100% yellow necrosis". "Wound Care Specialist Initial Evaluation", a report by a contracted wound care physician, dated 6/14/2017 stated that the wound was caused by "pressure" and described it as "unstageable necrosis 3.2 cm x 1.5 cm x 0.1 cm". The physician surgically debrided the wound and prescribed Dakins moistened gauze with dry protective dressing daily. The physician followed up with Resident #5 every 7-10 days. An additional progress note dated 6/14/2017 stated "Sacral wound noted at unstageable with 100% necrotic tissue in the wound bed." A review of Resident #5's Care Plan revealed interventions dated 11/14/2016 related to skin integrity as follows: "Barrier crème to perianal area/buttocks as needed' "Encourage and assist to reposition" "Observe skin condition with ADL (activities of daily living) care daily; report abnormalities"	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 314	Continued From page 11 "Pressure redistributing device for bed/chair" "Provide preventative skincare routinely and PRN (as needed)" "Suspend/float heels as able" On 11/8/2017 at 10:10 AM an interview was conducted with RN (Registered Nurse) C, wound care nurse. She verified that the wound on Resident #5's sacrum was initially found at an unstageable wound. Resident #5 was seen in her room on 11/8/2017 at 10:00 AM with RN C to examine the wound. The wound was seen at the bottom of the sacrum within the gluteal folds. The measurements were 1.4 cm x 1.5 cm x 0.5 cm. Muscle below the subcutaneous tissue was visible. It was a Stage 3 at this point. At the end of day meeting on 11/8/2017 at 4:00 PM Administration A, Administrator; Administration B, Director of Nursing; Administration C, Corporate RN Consultant; and Administration D, Corporate RN Consultant were informed of the possibility of a harm level citation for Resident #5's wound. On 11/9/2017 at 9:00 AM Administration B, Director of Nursing and Administration C, Corporate RN Consultant stated that the facility had identified problems identifying and preventing pressure wounds as a result of a mock survey performed in July 2017. Resident #5 was included in the mock survey. A plan of correction was developed based on these findings with an AOC (Allegation of Compliance) date of 8/3/2017. Resident #5's wound was found on 6/7/2017, prior to the AOC date.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 314	Continued From page 12 The Plan of Correction is as follows: 1. Residents with potential for wounds-Review new admissions Bradens x 4 weeks. Utilize calendar sheets to help track dates due for Bradens. Care plan updates need to be verified at change of skin condition. Foley catheter care plans need to include the size of the catheter and balloon. Update all as needed. 2. Like residents-all residents are potential like residents. 3. Education to staff on completing Bradens, fall interventions, and skin/Foley/fall care plans. 4. Audits-all new admissions for Braden scheduling, skin/catheter/fall care plans records. Three times per week. 5. AOC date 8/3/2017 A total of 7 Residents with pressure wounds was included in the survey. Resident #5 had the only wound subject to a deficiency. Administration was informed of findings on 11/9/2017 at 11:00 AM.	F 314		
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the	F 315	F315-D 1) **Corrective Action for those residents found to be affected by the alleged deficient practice.** Cited Resident #4- Foley Cath anchor applied immediately. 2) **Like Residents-** Audit completed residents with foley catheters to ensure securement devices in place. Review completed by the Director of Nursing or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 315	Continued From page 13 facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure tubing for a urinary catheter was anchored for one of 24 residents in the survey sample. The tubing for Resident #4's urinary catheter was not anchored to minimize tension on the tubing as required in her plan of care. The findings include: Resident #4 was admitted to the facility on	F 315	3) **Systemic Changes put into place to ensure the alleged deficient practice does not recur.** Education completed by the Director of Nursing/Designee to Licensed Nurses on ensuring placement of foley anchors each shift. 4) **Corrective Actions taken for residents with potential to be affected by alleged deficient practice.** Director of Nursing or designee will complete audits of residents with foley catheters to ensure foley catheter anchors are present weekly x4 weeks for 3 months. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. 5) Date of compliance-12-15-17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 315	Continued From page 14 3/10/17 with diagnoses that included end stage renal disease, sacral pressure ulcer, COPD (chronic obstructive pulmonary disease), peripheral vascular disease, stroke and anemia. The minimum data set (MDS) dated 10/28/17 assessed Resident #4 as cognitively intact. On 11/8/17 at 9:10 a.m., accompanied by registered nurse (RN) C and RN (D) responsible for wound care, the position of Resident #4's urinary catheter tubing was observed during a dressing change to the resident's sacral pressure ulcer. The catheter tubing was not anchored in any manner to the resident's upper leg and/or thigh area to minimize tension on the tube with movement. RN (C) was interviewed at the time of this observation about an anchor for the tubing. RN (C) stated the tubing should be anchored but she did not see an anchor in use. On 11/8/17 at 9:40 a.m. the licensed practical nurse (LPN) D caring for Resident #4 was interviewed about the catheter in use without an anchor for the tubing. LPN (D) stated the catheter tubing was supposed to be anchored. LPN (D) stated the anchor was supposed to be positioned on the resident's upper leg to hold the tubing in place. Resident #4's clinical record documented a physician's order dated 9/26/17 for a Foley urinary catheter due to management of a stage 4 sacral pressure ulcer. The resident's plan of care (revised 10/16/17) documented the resident used an indwelling urinary catheter due to a sacral pressure ulcer. Plan of care interventions to prevent catheter complications included, "Secure catheter with securement device."	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 315	Continued From page 15 The Lippincott Manual of Nursing Practice 10th edition on page 781 states concerning management of a patient with an indwelling catheter, "Secure the indwelling catheter to patient's thigh using tape, strap, adhesive anchor, or other securement device...Properly securing the catheter prevents catheter movement and traction on the urethra... Pulling on the catheter may be painful. Backward and forward displacement of the catheter introduces contaminants into the urinary tract..." (1) These findings were reviewed with the administrator and director of nursing during a meeting on 11/8/17 at 3:55 p.m. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.	F 315		
F 362 SS=D	SUFFICIENT DIETARY SUPPORT PERSONNEL CFR(s): 483.60(a)(3)(b) (a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. (b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, Family and Resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, facility staff failed to employ sufficient support staff to provide timely serving of meals and feeding assistance for 1	F 362	F362-D 1) **Corrective Action for those residents found to be affected by the alleged deficient practice.** Cited Resident # 9. Tray was delivered promptly. 2) **Like Residents-** Residents who received their meals from the Dietary Department had the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 362	Continued From page 16 resident (Resident #9) in the survey sample of 24 residents. Facility staff failed to provide delivery of the Lunch meal tray and feeding assistance in a timely manner for Resident #9. The Findings included: Resident #9 was admitted to the facility on 10-20-17. Resident #9's diagnoses included: Malignant neuro-endocrine tumors, hypertension, diabetes, high cholesterol, dementia, Muscle Weakness, anemia, and arthritis. The Minimum Data Set, was a full admission Assessment, with an Assessment Reference Date (ARD) of 10-27-17, coded Resident #9 as usually being understood and usually able to understand. In addition, Resident #9 was coded as requiring extensive assistance of one staff member for all activities of daily living including feeding during meals, and set-up of meals. On 11-7-17 at 2:30 P.M., after the initial tour of the facility, Resident #9's spouse approached the surveyor at the nursing station, and stated "I am really angry about your meal problem here," speaking rapidly, and giving the surveyor no time to introduce herself. The Spouse of Resident #9 assumed the surveyor was a staff member. The spouse of Resident #9 rapidly went on to say I am here every day now at meal time because I can't trust the staff here to feed my wife. The spouse of Resident #9 allowed the surveyor at this point to speak and introduce self, and then he explained what the issues were. Three nursing staff members were present during the encounter (the unit manager, the nurse working with	F 362	3) **Systemic Changes put into place to ensure the alleged deficient practice does not recur**. Education completed by the Director of Nursing/Designee changing staffing assignment for prompt tray delivery 1 to 2 additional staff members to deliver trays & 1 to 2 additional staff members to start assist with meals when trays are delivered. 4) **Corrective Actions taken for residents with potential to be affected by alleged deficient practice**. Director of Social Services or designee will complete observation/questionnaire regarding prompt tray delivery and checking daily staffing to ensure there are enough staff for tray delivery x3 months. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. 5) Date of compliance-12-15-17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 362	Continued From page 17 Resident #9, and a medication nurse). Resident #9's spouse stated it was well after 2:00 p.m. every day before Resident #9 received the lunch meal, and stated that the staff just replaced one tray with another, as the breakfast tray was removed when the lunch tray arrived. The surveyor observed the lunch tray being taken into Resident #9's room and the time was 2:30 p.m. "she has been here three weeks", the spouse stated, "and this has happened every day since we got here." An interview was conducted with LPN F at the nursing station, with the unit manager standing beside her, immediately after the encounter with Resident #9's spouse. LPN F stated there were 2 reasons why the tray was so late. She stated, "number one, we have to deliver trays to all of the Residents who can feed themselves first, and then we take the trays to the feeders, who have to be fed, and number two, there are not enough of us to do both at the same time." After the staff interview was conducted, the surveyor proceeded to the room of Resident #9, where her spouse was attempting to feed her, and asked her how her meal tasted. Resident #9 stated "cold", I don't want it, it is too late." During observations and interviews, the food cart was observed to be sitting in the hallway with several untouched food trays in it. The "cart arrival time on units" form was reviewed and stated that 2 food carts would arrive on Resident #9's unit for lunch between 11:55 a.m., and 12:40 p.m. The Resident was noted to have a gastrostomy tube, and was receiving enteral feeding through	F 362		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 362	Continued From page 18 the tube for extra nutrition as well as being able to eat a regular diet, for which the Resident had a current physician's order. The Nutritional Care Plan was reviewed, and read, "Will tolerate regular diet through next review...", and, "provide diet as ordered...." The care plan was dated 10-23-17. Resident #9's nursing progress notes were reviewed and documented on 11-2-17 a significant weight loss, and it was thought to be related to end of life issues. The Resident was ordered to have hospice services on 11-7-17, and was planning to be discharged home at a later undisclosed date with hospice services. On 11-8-17 a review of the facility policy on feeding assistance was conducted. The policy stated that nursing personnel will provide assistance with feeding when a resident is unable to do so independently. On 11-8-17, and 11-9-17, at the end of day debrief, the Administrator, and Director of Nursing were made aware of the findings. No further information was submitted by the facility.	F 362	F371-D 1) **Corrective Action for those residents found to be affected by the alleged deficient practice.** Dishes/pots & pans were rewashed & dried immediately at that time. Staff member also educated on wet nesting that day. 2) **Like Residents-** Pots & pans assessed to ensure drying that time. Review completed by the Director of Dietary or designee.	
F 371 SS=E	Complaint Deficiency FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 19 (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. (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, staff interview and facility document review, the facility staff failed to prepare and distribute food in a sanitary manner from the main kitchen. Ten large baking pans, identified as ready for use, were stored nested and wet. The findings include: On 11/7/17 at 12:45 p.m. accompanied by the food services director, the kitchen was inspected. Ten large baking pans, identified by the food services director as ready for use, were stored on a rack nested and wet. As the pans were separated, moisture was observed and felt on the baking surfaces of the pans. The food services director was interviewed at the time of this	F 371	3) **Systemic Changes put into place to ensure the alleged deficient practice does not recur.** Education completed by the Director of Dietary/ Designee with kitchen staff on correct method for stacking dishes to allow proper airflow for drying of dishes. 4) **Corrective Actions taken for residents with potential to be affected by alleged deficient practice.** Director of Dietary or designee will complete audit of kitchen dishes for wet nesting after each meal 3x week x 3 months. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. 5) Date of compliance-12-15-17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 20 observation about the wet pans. The food services director stated the pans were not supposed to be stacked and stored wet. The food services director stated all pans were washed and sanitized in the three compartment sink and were supposed to dry on the designated drying rack prior to stacking/storing. The facility's dietary services policy titled Sanitization (revised December 2008) stated, "The food service area shall be maintained in a clean and sanitary manner... Food preparation equipment and utensils that are manually washed will be allowed to air dry whenever practical." These findings were reviewed with the administrator and director of nursing during a meeting on 11/8/17 at 3:55 p.m.	F 371		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (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	F 431	F431-D 1) **Corrective Action for those residents found to be affected by the alleged deficient practice.** Expired vials discarded immediately. 2) **Like Residents-** Medication refrigerators audited immediately for expired meds/vials. All units audited for proper dating of vials/medications.-Review completed by the Director of Nursing or designee. 3) **Systemic Changes put into place to ensure the alleged deficient practice does not recur.** Education completed by the Director of Nursing/Designee with licensed staff on dating vials/medications after opening & discarding vials/medications before expiration dates.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 431	Continued From page 21 pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to ensure biologicals and medications were stored	F 431	4) **Corrective Actions taken for residents with potential to be affected by alleged deficient practice.** Director of Nursing or designee will complete audits of unit refrigerators for dating of medications and expiration dates weekly x4 weeks then monthly x3 months. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. 5) Date of compliance - 12-15-17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 431	Continued From page 22 appropriately on three of three units. 1. On The Monroe Unit , one PPD (purified protein derivative) dated as opened 9/27/17 was available for administration to Residents. A second vial was opened with no date when opened. PPD is only good for 30 days after opened and accessed; 2. On the John Tyler Unit, a vial of flu vaccine was opened without a date. 3. On the Madison unit, two vials of flu vaccine was open without a date. The findings included: 1. On The Monroe Unit , one PPD (purified protein derivative) dated as opened 9/27/17 was available for administration to Residents. A second vial was opened with no date when opened. PPD is only good for 30 days after opened and accessed. On 11/7/17 at 12:55 PM, during the initial tour, a vial of opened PPD was dated as having been opened on 9/27/17, over 30 days old. PPD is a solution that is utilized to test Residents and staff for exposure to tuberculosis. When interviewed,LPN (licensed practical nurse) A stated at the time of the observation, "it's expired." She removed the PPD solution from the medication refrigerator. Drug Storage requirements provided by the facility were the following instructions: "Remove 30 days after opening."	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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 431	Continued From page 23 Guidance was also provided at www.fda.gov: "Vials in use for more than 30 days should be discarded." 2. On the John Tyler Unit, a vial of multidose flu vaccine was opened without a date. On 11/7/17 at 1:20 PM, during the initial tour, one vial of flu vaccine had been opened. There was no date when the vial was opened. RN (registered nurse) A stated, "We will throw it out. We should date it." 3. On the Madison unit, two vials of flu vaccine was open without a date. On 11/7/17 at 1:25 PM, during the initial tour, two vials of multidose flu vaccine had been opened. There was no date when the vials were opened. RN (registered nurse) B stated, "We are supposed to date it." On 11/7/17 at approximately 2:00 PM, the Director of Nursing was notified of the above findings.	F 431		