PRINTED: 03/18/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF D	DOVIDED OD CUDDUED	493303	B: *******	CT	EDEET ADDRESS CITY STATE ZID CODE	03	/06/2019
NAME OF PI	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
COLISEU	M CONVALESCENT AND	REHABILITATION CENTER			05 MARCELLA ROAD		
				Н	AMPTON, VA 23666		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)			(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	(complaint) survey wa 3/6/19. Three compla during the survey. Co	dicare/Medicaid abbreviated as conducted 3/5/19 through aints were investigated orrections are required for 42 CFR Part 483 Federal irements.					
F 684 SS=D	157 at the time of the consisted of 2 Reside resident review (Residence record review (Residence)	0 certified bed facility was survey. The survey sample ent reviews: One current dents #1) and 1 closed ents #2).	F	684			4/15/19
	applies to all treatment facility residents. Bas assessment of a residents receive accordance with profestice, the comprehence plan, and the residents.	ndamental principle that int and care provided to ed on the comprehensive dent, the facility must ensure is treatment and care in essional standards of mensive person-centered					
	Based on a complain record review, staff, r it was determined the conduct complete and assessments in according comprehensive assess of 2 residents (Resident The facility staff failed accurate assessment)	d accurate skin			<ol> <li>Resident #2 was seen by the wour physician and admitted to the hospital of 2/20/19. Therefore, no further actions were taken.</li> <li>The Director of Nursing/Designee completed a head to toe assessment or residents with darker skin tones to ensit these residents have a complete and accurate skin assessment. Any variance will have a treatment order, care planned and MD/RR notifications as indicated.</li> </ol>	on f ure ce	
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		-	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/18/2019

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

**Electronically Signed** 

Facility ID: VA0068

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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COLISEUI	W CONVALESCENT AND	REHABILITATION CENTER		H	AMPTON, VA 23666			
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F 684	The findings include:  Resident #2 was adm on 1/16/18 with diagn dementia, hyperlipide osteoarthritis, osteopo vascular disease (PV Resident #2's Admiss (MDS) assessment direction Resident #2 on the Bistatus (BIMS) with a score of 15 which indiseverely impaired in timaking. The resident two staff for bed mobingiene. The resident dependent on two staff transfers. Resident #2 dependent on one staff locomotion on and off range of motion limital lower extremities. The with any pressure ulcassessment to be at a Braden Scale Assess assessments. The reshave any foot problem wounds or skin integrity was coded to require for chair and bed, and interventions to mana.	ditted to the nursing facility oses that included ma, hypertension, prosis and peripheral D).  Sion Minimum Data Set ated 1/23/18 coded rief Interview for Mental score of 7 out of a possible ficated the resident was he skills needed for decision was assessed to require flity, dressing and personal towas coded totally fif for toilet use and 2 was assessed totally aff for bathing and the unit. The resident had attended to the resident was not assessed ers upon admission, but risk for them based on the ment and clinical sident was not coded to ns or any other rashes, ity problems. Resident #2 pressure reducing devices a nutrition and hydration age skin problems.	F	684	3. The policy and procedure on performing complete and accurate skin assessment along with pressure ulcer prevention was reviewed.  RNs/LPNs/CNAs were reeducated on performing complete and accurate skin assessments. The in-service included was not limited performing complete ar accurate skin assessments on resident with darker skin tones and pressure are prevention and treatment.  4. The Director of Nursing/designee of audit weekly 15 residents for 6 weeks of darker skin tones to ensure an accurate and complete skin assessment will be completed.  The Director of Nursing/Designee report any trends or variance to Quality Assurance Performance Improvement Committee at least a quarterly	but nd s ea will with		
	11/27/18 were identic	8, 5/29/18, 8/24/18 and all areas of bred the resident with a 16						

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F 684	Continued From pag that indicated the residevelopment of press. The care plan dated identified Resident # ulcers related to decit that the staff set for the approaches to accomplish included check skin for the care plan dated identified Resident # disease. The goal see was that the skin on through next review. The staff would imple included check feet at tears, swelling or preany signs of skin breskin assessments and examine feet and tring the following informal lateral foot wound:	dident was at risk for the sure ulcers.  "1/31/18 to present"  2 was at risk for pressure reased mobility. The goal the resident was that she skin breakdown. Some of ecomplish the set goal for redness, discoloration, swelling or pressure areas of skin breakdown. Use liges to reduce pressure on points, and turn/reposition.  "1/31/18 to present"  2 had peripheral vascular the to the staff for the resident feet/legs will remain intact. Some of the approaches ment to accomplish this goal and legs for redness, skin issure areas daily. Report akdown. Perform complete and record. Podiatrist to in nails.		584			
	an open area on late 2.0 centimeters (cm) 0.1 depth with seroal noted the resident had entered in her note the related. Order: Clear extended release to dry dressing daily.	are nurse's notes indicated ral right foot that measured long by (x) 2.0 wide cm x nquinous drainage. She as a history of PVD, thus she nat the area was vascular use *SilvaSorb topical gel wound bed and cover with SilvaSorb Gel is infused with ly for sustained antimicrobial					

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F 684	donating or absorbin (https://www.medline er-Antimicrobial-Wood 5-PF00181)  -4/11/18-The wound following the residencm x 1.4 cm x 0.2 cm Treatment changed the apply *Collagen Ag the dry dressing every two normalitivitamins. Should be the computer of the	d fluid handling capable of g moisture e.com/product/SilvaSorb-Silvund-Gel/Antimicrobial-Gel/Z0 care specialist started t. The wound measured 1.2 m. with serous exudate. to cleanse with normal saline, to wound bed and cover with two days. Appetitive fair and the had been ordered e appetite. Cannot detect DP ty, DP and PT pulse detected in right extremity. *Collagen ten Matrix Dressing with Silver in partial- and full-thickness source.com/product/dermacol dressing-silver).	F 6	84		

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F 684	recommendations wextremities. Need to under calves. Sheep equivalent) *Mepilex (or equivalent). * Me Soft silicone Foam Dand maintains a hear environment (https://www.exmed.x-ag-antimicrobial-scpx). An interview war of Nursing (DON) and Operations (DNO) or regardless of the vast that the area was prespecialist who recomsurgeon's consult did nor did she update hexpertise assessmenulcer. They stated the to protect the heels, positioning which was that the area was prespecialist who recomsurgeon's consult did nor did she update hexpertise assessmenulcer. They stated the did order for the Prevalor Treatment Administrations and she curled up were ferred to lay on heart to tally dependent on remained in the posi re-positioned by nurse Protector with Integrates in the production of the prediction of	wer extremity PVD". His ere "pressure relief lower off load feet by placing foam of skin booties to both feet (or AG to right foot ulcer daily pilex AG is a Antimicrobial pressing absorbs exudate lithy, moist wound  net/p-1987-molnlycke-mepile off-silicone-foam-dressing.as is conducted with the Director of the Director of Nursing in 3/6/19 where it was stated scular surgeons assessment essure, the wound care inmended the vascular of not accept the assessment, her records to reflect his int of the area as a pressure iney initiated *Prevalon boots pillows and wedges for its placed on the care plan. Inot initiate a physician's on boots or enter them on the action Record (TAR) to be the each shift, but placed the the plan as a nursing order. In resident was non-ambulatory	F 6	34				

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F 684			F 6	884				
	he documented "pres foot *"unstageable".	ne podiatrist's routine visit, ssure ulcer " to lateral right						
	extent of tissue dama be confirmed becaus (brown to light brown eschar (black hard no (https://www.npuap.co	d tissue loss in which the age within the ulcer cannot e it is obscured by slough soft necrotic tissue) or						
	resolved. No further of assessment of pulses	s in either lower extremity sment by the wound care						
		nsed nurse conducted a kin assessment and indicted es were identified.						
	Podiatrist, he identifice "large eschar (black large pressure ulcer to late the Podiatrist document findings with the would be included by the podiatrist document."	routine visit from the ed as his first assessment nard necrotic tissue) ral right foot, unstageable". Hented that he discussed his nd care nurse and ordered foot and a wound care						
	wound and documen	nd care nurse evaluates the ts "5.0 cm x 6.2 cm 0.0 determined) wound color icated the Resident						

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F 684	of the lateral right for with a return call fro Unit Manager #1 do the lateral right foot opening to the right and hard. Sanguine Area cleansed, dres measures 4 cm x 6  -On 2/20/19, the Nu indicated in her proglateral foot was asses specialist and that the wound as necropulse was present be history if a similar woreferral for a vascula documents under dipressure injury of sk daily dressing to right specialist assessed 2/20/19 with orders. The resident was trace ER on 2/20/19 and amputate the right of During an interview 3/6/19 that began at was their expectation during bathing and the Assistants (CNA) we discolored areas during bathing and the signal and the	) was notified of the condition not via a voicemail message m the RR on 2/19/19. The cumented her assessment of on 2/18/19 as "porous type lateral foot, skin discolored ous drainage noted with odor. ssing applied as ordered. Area	F 68	34				

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				HAMPTON, VA 23666					
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F 684	Continued From page	e 7	F 6	584					
F 084	She further stated she wound on 2/18/19, aft routine visit found it, a porous, hard and blad person like (Resident skin toned, you cannot problems. So the staf problem because her make accurate skin a interview the LPN Un reiterated that accura not be made with skir darker skin toned residual how should accurate by nursing staff with a #2's history and in gedarker skin tone, she use a bright light to exthe areas for boggine.  During the aforement care nurse, LPN #2 jo p.m. She stated she can unless it was determined wound was a *Stage know about the sever *A stage III pressure of skin, in which adipout ulcer and granulation wound edges) are oft eschar may be visible.	e was asked to evaluate the ter the Podiatrist on his and she described it as ck. She stated, "With a #2's name) skin who dark of see where there are skin f cannot tell if there is a skin is dark, it is hard to ssessments." During the it Manager #1 consistently te skin assessments could a issues or breakdown on idents. The DNO was asked skin assessments be made dark skin in light of Resident neral for all residents with stated, "The staff should examine the skin and depress ss, hardness, etc.".  ioned interview, the wound bined the interview at 12:00 did not see any wounds ned from the nurse the III or above, thus she did not city of the lateral right foot. Lulcer is a full-thickness loss ose (fat) is visible in the tissue and epibole (rolled en present. Slough and/or	F 6	384					
	d-clinical-resources/n/).	puap-pressure-injury-stages							
	demonstrated where Resident #2 by taking	trview, the wound care nurse the wound was located on off her shoe and pointing to on the lateral right foot. She							

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F 684	of this foot would have hours she said, "No, prior, but I would not Stage III's and above me to evaluate an are evaluate the area unt Podiatrist requested foot because it was bethat the lateral right for to an acute ischemic suddenly on 2/18/19. hospital recorded supthrough their Doppler  The hospital's PVL stelevel moderate to sevarterial insufficiency. extremity arterial insufficiency. extremity arterial insufficiency. extremity arterial insufficiency. extremity arterial insufficiency extremity arterial insufficiency. Extremity arterial insuf	ack, hard with some /hen asked if the condition e occurred in less than 24 it had to have been there have seen it because I see or when a nurse request ea. No one asked to me to il 2/18/19 when the to assess the right lateral lack." The DNO indicated bot blackened area was due incident that happened She also stated that the exported this information a studies/PVL studies.  udies dated concluded "multi exer right lower extremity Moderate left lower officiency at the level of the extry. When compared to the med on 3/26/15 there is no ion History and Physical infected gangrenous skin limited to breakdown of the I dry with no swelling of oratory results indicated a emming from the foot ulcer, umentation of a right leg	F	884				

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F 684	amputation. The DON would look into it and another niece contact 2/25/19 and schedule the corporate office. So of the nieces were properties of the nieces of the	asking about what he resident had to have an N stated she told her she get back to her. They stated ted the corporation on ed a meeting for 2/27/19 at She stated the RR and one esent and the second niece he meeting via phone. The y members were concerned eteriorated to the point of y were told the wound had formed them otherwise. He further about the details of  h., the DON and DNO education with sign in sheets Prevention, Power Point and els" with a date of ten on side of date). A "2" "1" making the date from When asked why the hed since they affirmed schemic event and not DNO stated they wanted to all bases since the meeting T/19. They could not explain aining was before the eined that the training of different skin tones for to include darker skin. This e training and validated it sment techniques. Out of 30 sheet, only 5 were identified They stated the licensed	F 68	4	

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F 684	Continued From page 10		F	884				
	on the sign in sheet to essential training.	o have completed the						
	the Unit Managers ar Assistants (CNA) on	views were conducted with nd Certified Nursing all three units to determine if cs regarding assessment of						
	LPN UM #3 stated sh training, but she would	n., on the Monroe Unit, the ne did not have any recent ld not examine skin ther resident regardless of						
	Unit, whose name wa training, stated she w differences, but if she	n., CNA #1 on the Monroe as listed on the inservice as not aware of any as saw anything unusual she attention of the nurse to						
	(LPN) #4 on the Mon the training, but that s asked if there was an to know, but she con- assessments as assi- stated if the CNA's br	gned on a weekly basis. She ing forth anything unusual regarding skin she follows						
	Unit (where Resident been interviewed ear where she stated "Wi #2's name) skin who see where there are	anager) #1 on Armistead #2 had resided) had already lier on 3/6/19 at 11:30 a.m. ith a person like (Resident dark skin toned, you cannot skin problems. So the staff a problem because her skin						

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F 684	Continued From page	e 11	F	884				
	on the in-service sign dated 2/25/19.	Init Manager's name was not in sheets for the training						
	Unit stated although 2/25/19 training, she skin sheets a head to was old or new, such discoloration, sores, tone. She stated she appears reddened bl physician is called ar obtained if there is a	n., LPN #5 on the Armistead she had not attended the documented on the weekly to toes assessment if an area as moles, skin tears, scabs regardless of skin checks to see if an area that anches. She stated the not further orders are problem. She said if an area agets the wound care nurse						
	involved to make furt she had not had any addressed special at	her assessment. She stated training that specifically tention to dark skin tones stionable skin problems.						
	Unit, stated she had sure she told the nurs	n., CNA #2 on the Armistead been trained about making se or Unit Manager if during problems, but nothing nt skin tones.						
	Unit checked the sign training dated 2/25/19 not on the list. She sa assigned weekly skinday or evening shift vassessments and the on a sheet and then She stated, "The are you think on dark skinhave to take a much	n., LPN #6 on the Hampton in in sheets for the in-service g and stated her name was aid the licensed nurse's are assessments either on the with head to toe e information is documented entered into the computer. a may be more in depth than in than light skin and you closer look." She said, "The locks off during bathing to						

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F 684 Cont	inued From page	e 12	F 6	584				
wash breal to ma ask t conta	n resident's feet a kdown or suspici ake an assessma he wound nurse act the physician ated the Hampto	as well and report any ous area to a licensed nurse ent, at which time we would to take a look or we can for treatment orders." LPN on Unit did not have a Unit						
cond state the lashoc black exam with a beca She aprobait was from no broclose enco Nursi eschaindica nursi anyw negle and pasubs amputat (#2's excuras was was shown as was subsequenced.	ucted with the condition of they were made ateral right foot at ked to learn on 2 carea on the lateral right foot at ked to learn on 2 carea on the lateral right foot an immediate new use of the sever stated the wound ably an ischemic sont. She said, the previous numeral conditions on the factor one of the factor one	n., a telephone interview was omplainant. The complainant de aware in late summer that rea was healed and were 2/18/19 there was a large eral right foot which was and care doctor on 2/20/19 ded to send the hospital de condition of the right foot. It doctor said that it was event, which they found out "We moved Resident #2 sing facility where she had bever to a facility that was amily members, and she was a d knew that necrosis, black de occurred in the short time try, and she was told by ere were no areas d the family felt the staff assess the resident's skin are to the foot which to other choice than to "I am not blind to the fact but it did not automatically sment and pressure relief, revious facility to these type of residents and						

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NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	7.00.2010	
COLISEU	M CONVALESCENT AND	REHABILITATION CENTER		305 MARCELLA ROAD			
OOLIOLOI	W CONVALLOGENT AND	THE INDICATION OF THE REAL PROPERTY.		HAMPTON, VA 23666			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 684	Continued From page	e 13	F 6	884			
1 004	We regretted transfer name), so after the ar her back to the previor care will be monitored spent 6 months there.  On 3/6/19 at approximate before survey exit, the Past Non Compliance integrity" penciled in they were using this aproblem this surveyor during the survey. It training on "skin integwould be completed and been presented an	ring her to (current facility's imputation we chose to send ous nursing facility where her dimore closely. She had with no skin problems."  mately 3:45 p.m., 30 minutes a DNO and DON present a complete (PNC) document with "skin over another topic and stated as a template to address the problems to their attention was penciled in that the prity" started 2/25/19 and on 3/8/19. The training that earlier to this surveyor dated "Pressure Ulcer Prevention, assure Ulcer Models." It was could not be accepted as of presenting the PNC of education content and wiedge from the upper de the Unit Managers, as as that were responsible to in assessments, and those were mostly composed of insed Nurses. Another it be accepted was due to					
		issue loss in wounds other					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495305	B. WING			С	
NAME OF D		495305	B. WING _	0.TDEET ADDRESS SITV STATE 71D SS	•	3/06/2019	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  305 MARCELLA ROAD  HAMPTON, VA 23666			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	O3/Final_Quick_T  The facility's policulcer prevention/nthe interventions of indicated "at least to the potential charterise to the identified charter by Registered Nurfor condition chanter breakdown" a resident's suscepressure ulcers in impaired/decrease ability, impaired degeneralized ather arterial insufficien may be the first tisusually over a born may need to be esupport surfaces, effective intervent pressure ulcer or one), determine if include orthosis, the are contractures integrity should go implementation of should be included critical for resident dependent on stars support the lower with the bed pillow measures may be care staff should in the prevention of t	page 14  ap.org/wp-content/uploads/2012/ reatment_for_web_2010.pdf).  y and procedures titled pressure monitoring for effectiveness of dated as last reviewed on 4/3/14  daily, staff should remain alert anges in the skin condition of should evaluate and document ange. Weekly skin assessment rese (RN)/LPN. Monitor residents ges that might increase the risk "Risk factors that may increase aptibility to develop or to not heal clude, but are not limited to: and mobility, decrease functional diffuse or localized blood flow rosclerosis, lower extremity and the bone and the bone and the bone and the session of a common and the residents: positioning (a common and the resident's skin and the development and and the repositioning plans which and the repositioning of a resident's skin and the care plan, which is the swho are immobile or and the repositioning. To effectively and the development of the repositioning of the repositio	Fé	684			

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495305	B. WING _			C 03/06/2019		
	ROVIDER OR SUPPLIER  M CONVALESCENT AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 305 MARCELLA ROAD HAMPTON, VA 23666				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 684	The supervisory level	se should assess the ne appropriate interventions. I nurse/UM should be charge nurse of any areas of	F6	84				
F 726 SS=D		Staff (4)(c)	F 7	26		4/15/19		
	provide nursing and r resident safety and at practicable physical, i well-being of each res resident assessments and considering the n diagnoses of the facil	elated services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care						
	licensed nurses have and skill sets necessaneeds, as identified the	cility must ensure that the specific competencies ary to care for residents' nrough resident secribed in the plan of care.						
	limited to assessing,	ng care includes but is not evaluating, planning and it care plans and responding						
	to demonstrate comp	ure that nurse aides are able						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	DOLUBER OF CLIEBULE	495305	B. WING _		•	3/06/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	JE		
COLISEU	M CONVALESCENT AN	ID REHABILITATION CENTER		305 MARCELLA ROAD			
				HAMPTON, VA 23666			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 726	Continued From pag	ge 16	F 72	26			
	needs, as identified	through resident					
		lescribed in the plan of care.					
		IT is not met as evidenced					
	-	int investigation, clinical		Staff involved in the care	e of resident #		
	-	resident and family interview,		2 were reeducated on techni	ques of		
		ne facility staff failed to ensure		performing an accurate and	complete skin		
	licensed nurses and	I nurse aides had the specific		assessment on a resident wi	th darker		
	competencies and s	skill sets to provide nursing		toned skin.			
	and related services	s to assure residents					
		est physical well-being for 1 of		Licensed staff will be even			
	2 residents (Reside	nt #2) in the survey sample.		determine competency in ski			
				techniques in order to condu	•		
	The facility staff faile			and accurate skin assessme			
		and techniques necessary to		residents with darker skin tor	ies.		
		nd accurate assessments of		0 50 450 460 4			
		pased on dark skin tone which		3. RNs/LPNs/CNAs were r			
	-	n identification, treatment and		competency in skills and tecl			
	care to her right out	er loot uicer.		conduct complete and accura			
	The findings include	•		skin tone. This included but			
	The infangs include	•		to techniques such as using			
	Resident #2 was ad	mitted to the nursing facility		temperate, color and feel of t			
	on 1/16/18 with diag			during assessments.	IIC SKIII		
	dementia, hyperlipio			during accessiments.			
		porosis and peripheral		4. The Director of Nursing/	designee will		
	vascular disease (P			audit 10 staff member per we	•		
	(	,		weeks to ensure they demon			
	Resident #2's Admis	ssion Minimum Data Set		competency in skills and tecl			
	(MDS) assessment	dated 1/23/18 coded		necessary to conduct comple	ete and		
	Resident #2 on the	Brief Interview for Mental		accurate assessments. The	Director of		
	Status (BIMS) with a	a score of 7 out of a possible		Nursing/Designee will report	any trends or		
		dicated the resident was		variance to the Quality Assur			
		the skills needed for decision		Performance Improvement C	committee at		
		nt was assessed to require		least a quarterly basis.			
		bility, dressing and personal					
		nt was coded totally					
		taff for toilet use and					
	transfers. Resident	#2 was assessed totally					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495305	B. WING		C 03/06	/2019	
NAME OF PROVIDER OR SU		D REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP ( 305 MARCELLA ROAD HAMPTON, VA 23666		03/06/2019 CODE		
PREFIX (EACH			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
locomotion range of molower extrer with any present assessment Braden Scalassessment have any for wounds or significant was coded for chair and intervention.  The Braden surveyor da 11/27/18 we assessment that indicate development. The care plaidentified Regulars relate that the staff would remain the approach included chebruises, operand report a pillows, paddiels and public that the staff would remain the approach included chebruises, operand report apillows, paddiels and public that the staff would remain the approach included chebruises, operand report apillows, paddiels and public that the staff was the staff was that the staff was the st	on one stand of one and of the an	aff for bathing and If the unit. The resident had ations in both upper and e resident was not assessed bers upon admission, but risk for them based on the sment and clinical esident was not coded to ms or any other rashes, rity problems. Resident #2 expressure reducing devices d nutrition and hydration age skin problems.  Sesessments presented to this 18, 5/29/18, 8/24/18 and cal in all areas of ored the resident with a 16 sident was at risk for the	F 7	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495305	B. WING _			C <b>03/06/2019</b>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00,00,2010	
COLISEIII	M CONVALESCENT AND	REHABILITATION CENTER		305 MARCELLA ROAD			
COLISEUI	W CONVALESCENT AND	REHABILITATION CENTER		HAMPTON, VA 23666			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 726	Continued From page	e 18	F 7	26			
	included check feet a tears, swelling or pre- any signs of skin brea	nd legs for redness, skin ssure areas daily. Report akdown. Perform complete d record. Podiatrist to					
	lateral foot wound: -2/9/18-The wound can open area on later 2.0 centimeters (cm) 0.1 depth with serosa noted the resident has entered in her note the related. Order: Clean extended release to ward dressing daily. *S ionic silver technology protection; Advanced donating or absorbing (https://www.medline)	are nurse's notes indicated ral right foot that measured long by (x) 2.0 wide cm x inquinous drainage. She is a history of PVD, thus she hat the area was vascular se *SilvaSorb topical gel wound bed and cover with ilvaSorb Gel is infused with y for sustained antimicrobial fluid handling capable of g moisture indicated in the com/product/SilvaSorb-Silvind-Gel/Antimicrobial-Gel/Z0					
	following the resident cm x 1.4 cm x 0.2 cn Treatment changed to apply *Collagen Ag to dry dressing every two no multivitamins. She Remeron to increase pulse in left extremity by portable Doppler in Ag is a sliver Collage is intended for use or wounds	appetite. Cannot detect DP , DP and PT pulse detected n right extremity. *Collagen n Matrix Dressing with Silver n partial- and full-thickness ource.com/product/dermacol					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495305	B. WING			C 3/06/2019	
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  305 MARCELLA ROAD  HAMPTON, VA 23666			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 726	were completed on significant arterial sor right lower extremity borderline.  -4/25/18-New orders specialist: Cleanse to topical gel, extended wound bed. Recommended to specialist: Cleanse to topical gel, extended wound bed. Recommended to specialist: Cleanse to topical gel, extended wound bed. Recommended to specialist: Cleanse to topical gel, extended wound bed. Recommended to specialist: -5/8/18-Vascular cor consulted due to "portion". He evaluated the area to be "pressimoderate bilateral lorecommendations we extremities. Need to under calves. Sheep equivalent) *Mepiles (or equivalent) *Mepiles (or equivalent). *Mepiles (or equival	care specialist fal Doppler studies which 4/20/18 which indicated blerotic disease involving the r and the left lower extremity  s from the wound care with normal saline, SilvaSorb d release once a day to mendations for a vascular  asult indicated he was for healing wound to right the right foot and diagnosed sure ulcer right lateral foot, fower extremity PVD". His forer "pressure relief lower for fload feet by placing foam of skin booties to both feet (or a AG to right foot ulcer daily epilex AG is a Antimicrobial oressing absorbs exudate	F 72	, , , , , , , , , , , , , , , , , , ,			
	that the area was pr specialist who recor surgeon's consult di nor did she update h expertise assessme	scular surgeons assessment essure, the wound care nmended the vascular d not accept the assessment, ner records to reflect his nt of the area as a pressure hey initiated *Prevalon boots					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495305	B. WING		C 03/06/2019	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  305 MARCELLA ROAD  HAMPTON, VA 23666	03/06/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 726	positioning which was They stated they did order for the Prevalor Treatment Administrations signed off as in place treatment on the care They also stated the and she curled up who preferred to lay on he totally dependent on remained in the position re-positioned by nurs Protector with Integrate designed to help reduinjury while keeping to position (https://www.woundscheel-protector-integrations.)  -On 5/18/18, during the documented "prestoot *"unstageable".  *Unstageable Pressufull-thickness skin and extent of tissue dama be confirmed because (brown to light brown eschar (black hard net (https://www.npuap.od-clinical-resources/m/).  -On 8/29/18, the area resolved. No further cassessment of pulses	poillows and wedges for a placed on the care plan. The placed on the care plan. The placed on the care plan. The placed on the care plan on the plan as a nursing order. The plan as a nursing	F 72	6		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495305	B. WING				C 06/2019
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		305	REET ADDRESS, CITY, STATE, ZIP CODE MARCELLA ROAD MPTON, VA 23666	1 00	00/2010
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 726	Continued From page	e 21	F	726			
		nsed nurse conducted a kin assessment and indicted es were identified.					
	Podiatrist, he identifie "large eschar (black l pressure ulcer to late The Podiatrist docum findings with the wou	routine visit from the ed as his first assessment nard necrotic tissue) ral right foot, unstageable". Hented that he discussed his nd care nurse and ordered foot and a wound care					
	wound and documen depth (depth cannot black". The notes ind Representative (RR) of the lateral right foo with a return call from Unit Manager #1 doc the lateral right foot copening to the right land hard. Sanguineo	was notified of the condition t via a voicemail message the RR on 2/19/19. The umented her assessment of an 2/18/19 as "porous type ateral foot, skin discolored us drainage noted with odor. ing applied as ordered. Area					
	lateral foot was assesspecialist and that the the wound as necrotic pulse was present but history if a similar woreferral for a vascular documents under diapressure injury of ski	se Practitioner (NP) ress note that the the right ssed by the wound care e wound care nurse reported c and malodorous. The it poor, that she had had a und and had an ongoing r consult in place. The NP gnosis and assessment, n, unspecified injury state, it foot. The wound care					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495305	B. WING			03/	06/2019
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
COLISEII	M CONVALESCENT AND	REHABILITATION CENTER		3	05 MARCELLA ROAD		
COLISEON	W CONVALESCENT AND	REHABILITATION CENTER		H	HAMPTON, VA 23666		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 726	Continued From page	e 22	F	726			
-		he right lateral foot on		. 20			
		send to ER immediately.					
		nsferred to the local hospital					
	ER on 2/20/19 and a	•					
		tremity above the knee.					
		and the same of the same of					
	During an interview w	ith the DON and DNO on					
	_	10:00 a.m., they stated it					
		that socks are removed					
	during bathing and th	at Certified Nursing					
	Assistants (CNA) wor	uld report any and all					
	discolored areas duri	ng bathing. There there					
	were no nurse's note:						
	•	ed by the Podiatrist as large,					
	_	lateral foot on 2/18/19. The					
		I joined the interview at					
		ed she saw drainage on a					
		ecall when in February 2019.					
		e was asked to evaluate the					
	i i	ter the Podiatrist on his					
		and she described it as ck. She stated, "With a					
	•	: #2's name) skin who dark					
	, ,	ot see where there are skin					
	· •	ff cannot tell if there is a					
	•	skin is dark, it is hard to					
		ssessments." During the					
		it Manager #1 consistently					
		ite skin assessments could					
	not be made with skir	n issues or breakdown on					
	darker skin toned res	idents. The DNO was asked					
	how should accurate	skin assessments be made				ſ	
	by nursing staff with o	dark skin in light of Resident					
	, ,	neral for all residents with				ſ	
		stated, "The staff should					
		xamine the skin and depress				ĺ	
	the areas for boggine	ess, hardness, etc.".					
	During the aforement	ioned interview, the wound					

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONST	RUCTION	(X3) DATE SURVEY COMPLETED	
		495305	B. WING _				C 06/2019
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		305 MAR	ADDRESS, CITY, STATE, ZIP CODE CCELLA ROAD ON, VA 23666	<u>,                                    </u>	<u> </u>
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 726	p.m. She stated she unless it was determ wound was a *Stage know about the seve *A stage III pressure of skin, in which adip ulcer and granulation wound edges) are of eschar may be visible (https://www.npuap.cd-clinical-resources/r/).  During the above intedemonstrated where Resident #2 by taking the center bony area stated it was large, bdrainage and odor. Vof this foot would have hours she said, "No, prior, but I would not Stage III's and above me to evaluate an an evaluate the area un Podiatrist requested foot because it was be that the lateral right for an acute ischemic suddenly on 2/18/19. hospital recorded sugthrough their Dopples.  The hospital's PVL state in the sufficiency extremity arterial insufficiency extremity arterial insufficiency.	did not see any wounds ined from the nurse the III or above, thus she did not rity of the lateral right foot. ulcer is a full-thickness loss ose (fat) is visible in the a tissue and epibole (rolled ten present. Slough and/or ee org/resources/educational-an inpuap-pressure-injury-stages derview, the wound care nurse the wound was located on goff her shoe and pointing to on the lateral right foot. She lack, hard with some when asked if the condition or occurred in less than 24 it had to have been there have seen it because I see or when a nurse request ea. No one asked to me to til 2/18/19 when the to assess the right lateral black." The DNO indicated boot blackened area was due incident that happened She also stated that the opported this information or studies/PVL studies.	F	726			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495305	B. WING		C 02/05/2040
NAME OF PROVIDER OR SUPPLIER  COLISEUM CONVALESCENT AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP 305 MARCELLA ROAD HAMPTON, VA 23666	03/06/2019 • CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION DATE
F 726	change". The admisindicated their was ulcer of the right for skin, malodorous at either lower leg. La systemic infection is but there was no do acute ischemic eve amputation of the ri 2/22/19 and the resanother nursing fact 2/28/19.  On 3/6/19 at 1:02 p with the DON and the received a call from on 2/20/19 around ER with the resident happened because amputation. The DO would look into it at another niece contact 2/25/19 and schedut the corporate office of the nieces were pwas participating in DNO stated the famabout how the foot amputation when the healed and no one They did not elabor the meeting.  On 3/6/19 at 1:34 ppresented in-servicion " Pressure Ulcer Modern and the result on " Pressure Ulcer Modern and the right of the result on " Pressure Ulcer Modern and the right of the result on " Pressure Ulcer Modern and the right of the right	ormed on 3/26/15 there is no ssion History and Physical a infected gangrenous skin of, limited to breakdown of the end dry with no swelling of boratory results indicated a stemming from the foot ulcer, ocumentation of a right leg ent. An above the knee ght leg was performed on ident was discharged to illity for skilled services on  I.m., during further interview the DNO, the DON stated she one of Resident #2's nieces 4:30 p.m., while she was in the transition to have an DN stated she told her she and get back to her. They stated exted the corporation on alled a meeting for 2/27/19 at a she stated the RR and one oresent and the second niece the meeting via phone. The hilly members were concerned deteriorated to the point of they were told the wound had informed them otherwise, attended to the details of the education with sign in sheets are prevention, Power Point and	F	726	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495305	B. WING			06/ <b>2019</b>	
NAME OF PROVIDER OR SUPPLIER  COLISEUM CONVALESCENT AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIF 305 MARCELLA ROAD HAMPTON, VA 23666	•	06/2019	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 726	2/15/19 to 2/25/19. education was presthere was an acute pressure related, the proactive to cowith the family on 2 that the date of the meeting. It was excovered assessments as licensed nurses nurses were responsasessments of skongoing. None of on the sign in sheet essential training.  Several random into the Unit Managers Assistants (CNA) of they knew the special darker skin tones:  On 3/6/19 at 1:45 pt LPN UM #3 stated training, but she with differently than any skin tone.  On 3/6/19 at 2:00 pt Unit, whose name training, stated she differences, but if states and control of the sign in sheet training.	the "1" making the date from When asked why the sented since they affirmed a ischemic event and not the DNO stated they wanted to the DNO stated the meeting the DNO stated the meeting the DNO stated the raining was before the the plained that the training the training and validated it the state the licensed the state the licensed the state the licensed the state the licensed the Unit Managers were listed the to have completed the the training was the Unit Managers were listed the to have completed the the training assessment of the training was the units to determine if the training assessment of the training was the did not have any recent to the Unit, the the she did not have any recent to the training was the she did not the wanter of any the she did not the inservice the was not aware of any the saw anything unusual she the attention of the nurse to	F	726			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495305		` '	<b>1</b> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			(X3) DATE SURVEY COMPLETED	
		495305	B. WING			C 03/06/2019	
NAME OF PROVIDER OR SUPPLIER  COLISEUM CONVALESCENT AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COI 305 MARCELLA ROAD HAMPTON, VA 23666	I	03/06/2019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 726	(LPN) #4 on the Monithe training, but that is asked if there was an to know, but she condassessments as assig stated if the CNA's brithey find during care up with a skin assess.  The LPN UM (Unit May Unit (where Resident been interviewed early where she stated "Wit #2's name) skin who see where there are seen cannot tell if there is a sis dark, it is hard to massessments." The U on the in-service sign dated 2/25/19.  On 3/6/19 at 2:16 p.m. Unit stated although is 2/25/19 training, she skin sheets a head to was old or new, such discoloration, sores, stone. She stated she appears reddened blaphysician is called an obtained if there is a pis questionable, she ginvolved to make furth she had not had any addressed special atternals.	a., Licensed Practical Nurse one Unit, stated she missed she would make sure she ything special she needed ducts head to toe gned on a weekly basis. She ing forth anything unusual regarding skin she follows ment.  anager) #1 on Armistead #2 had resided) had already ier on 3/6/19 at 11:30 a.m. th a person like (Resident dark skin toned, you cannot skin problems. So the staff a problem because her skin ake accurate skin nit Manager's name was not in sheets for the training  a., LPN #5 on the Armistead she had not attended the documented on the weekly toes assessment if an area as moles, skin tears, scabs regardless of skin checks to see if an area that anches. She stated the	F7	726			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED  C 03/06/2019	
		495305	B. WING _				
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	ODE	,	
COLISEUM CONVALESCENT AND REHABILITATION CENTER			305 MARCELLA ROAD				
COLISEUI	W CONVALESCENT AND	REHABILITATION CENTER		HAMPTON, VA 23666			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCE	ION SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 726	Continued From page	e 27	F 7	726			
	On 3/6/19 at 2:25 p.n Unit, stated she had I sure she told the nurs bathing she saw skin specific about difference. On 3/6/19 at 2:35 p.n Unit checked the sign training dated 2/25/19 not on the list. She sa assigned weekly skin day or evening shift wassessments and the on a sheet and then of She stated, "The area you think on dark skin have to take a much	n., CNA #2 on the Armistead been trained about making se or Unit Manager if during problems, but nothing nt skin tones.  n., LPN #6 on the Hampton in sheets for the in-service of and stated her name was aid the licensed nurse's are assessments either on the					
	wash resident's feet a breakdown or suspici to make an assessme ask the wound nurse contact the physician	as well and report any ous area to a licensed nurse ent, at which time we would to take a look or we can for treatment orders." LPN on Unit did not have a Unit					
	conducted with the constated they were made the lateral right foot an shocked to learn on 2 black area on the late examined by the wou with an immediate new because of the seven She stated the wound probably an ischemical it was not. She said,	n., a telephone interview was omplainant. The complainant de aware in late summer that rea was healed and were 2/18/19 there was a large eral right foot which was and care doctor on 2/20/19 and to send the hospital econdition of the right foot. It doctor said that it was event, which they found out "We moved Resident #2 rsing facility where she had					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		495305	B. WING _			C 03/06/2019		
NAME OF PROVIDER OR SUPPLIER  COLISEUM CONVALESCENT AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 305 MARCELLA ROAD HAMPTON, VA 23666	•			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG			(X5) COMPLETION DATE		
F 726	closer to one of the encounters breakdor. Nurse Practitioner a eschar would not hat indicated by the factor of the encounters breakdor. Nurse Practitioner are eschar would not hat indicated by the factor of the encounter of the	ge 28 soever to a facility that was family members, and she own." She stated she was a and knew that necrosis, black are occurred in the short time ility, and she was told by there were no areas ted the family felt the staff ly assess the resident's skin care to the foot which no other choice than to, "I am not blind to the fact name) has PVD, but it did not le lack of assessment and was done in the previous ely protect these type of severe conditions that lead to gretted transferring her to me), so after the amputation er back to the previous re her care will be monitored and spent 6 months there with similar to another topic and stated as a template to address the or brought to their attention at was penciled in that the regrity" started 2/25/19 and don 3/8/19. The training that dearlier to this surveyor dated the "Pressure Ulcer Prevention, rescure Ulcer Models". It was C could not be accepted ress of presenting the PNC by of education content and	F 7.	26				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495305 B		B. WING	B. WING			C <b>06/2019</b>		
NAME OF PROVIDER OR SUPPLIER  COLISEUM CONVALESCENT AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 305 MARCELLA ROAD HAMPTON, VA 23666			06/2019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
F 726	titles, the lack of known anagement to inclused as charge nurse complete accurate sithat were on the list of CNAs with only 4 lice reason PNC could not those that were on the verbalize the method dark skin tones, which why the right lateral of detected and identified his routine visit.  The National Pressure that a pressure ulcers be used to describe than pressure ulcers (https://www.npuap.co//s/Final_Quick_Treations/pressure ulcers are resident and show the interventions date indicated "at least date to the potential change by Registered Nurse for condition change for breakdown" "Riar esident's susceptive pressure ulcers inclusing impaired/decreased ability, impaired diffur (generalized atherosystem)"	wledge from the upper ide the Unit Managers, as is that were responsible to kin assessments, and those were mostly composed of ensed Nurses. Another of be accepted was due to be list were not able to it of assessing resident's with the was stated was a reason foot ulcer was missed, easily ed first by the Podiatrist on the classification system cannot the classification of the classification of education of the classification of education of education of the skin condition of the classification of the skin condition of the classification of the skin condition of the classification of the skin condition of the	F	726					
	for condition changes for breakdown" "Ri a resident's suscepti pressure ulcers inclu impaired/decreased ability, impaired diffu (generalized atheros arterial insufficiency) may be the first tissu	s that might increase the risk sk factors that may increase bility to develop or to not heal de, but are not limited to: mobility, decrease functional se or localized blood flow clerosis, lower extremity							

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		495305	B. WING			03/	06/2019	
NAME OF PROVIDER OR SUPPLIER  COLISEUM CONVALESCENT AND REHABILITATION CENTER				3	TREET ADDRESS, CITY, STATE, ZIP CODE 05 MARCELLA ROAD IAMPTON, VA 23666			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 726	support surfaces, pose effective intervention pressure ulcer or who one), determine if me include orthosis, bracare contractures. Assintegrity should guide implementation of the should be included in critical for residents with the bed pillows, measures may be us care staff should report a potential pressure rintegrity to the head/of The head/charge nur resident and determine The supervisory level	uated for at risk residents: sitioning ( a common for an individual with a o is at risk of developing edical device is in use to ces, etc. and whether there resessment of a resident's skin of the development and repositioning plans which of the care plan, which is who are immobile or or repositioning. To effectively to raise feet from contact foam wedges, or other red. CNAs and other direct ort any signs or symptoms of related impairment of skin charge nurse immediately. se should assess the me appropriate interventions. I nurse/UM should be charge nurse of any areas of resessment.	F	726				