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 02/25/2019

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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/20/19 through 02/25/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 2/20/2019 through 2/25/2019. Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety report will follow. Four complaints were investigated during the survey. The census in this 196 certified bed facility was 155 at the time of the survey. The survey sample consisted of 59 resident reviews	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		4/2/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 03/21/2019

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.

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 02/25/2019

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 550 Continued From page 1

access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interview, and clinical record review, the facility staff failed to maintain respect and dignity for two residents (Resident #87, Resident #29) in a sample size of 59 residents.

The findings include:

1. For Resident #87, the facility staff failed to protect Resident #87's private space. A facility vendor was observed entering the room without knocking on the door.

Resident #87, a 66-year old female was admitted

F 550

Corrective Action for those residents found to be affected by the alleged deficient practice.
Facility vendor representative received immediate education on resident privacy.

Like Residents.
Residents admitting into the facility have the potential to be affected.

Systemic Changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the Director of

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 02/25/2019

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 550	Continued From page 2 to the facility on 06/03/2018. Diagnoses include but not limited to cerebral palsy, Parkinson's disease, dysphagia, schizoaffective disorder, bipolar, quadriplegia, and gastroesophageal reflux. Resident # 87's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/16/2019 was coded as a quarterly assessment. Resident # 87 was coded with a Brief Interview of Mental Status (BIMS) score of "5" out of possible 15 indicating severe cognitive impairment. Functional status for eating, dressing, and personal hygiene was coded as extensive dependence on staff. On 02/20/2019 at 11:26, Employee C was observed walking into rooms 316, 313, 309, 308, and 306 without knocking. Resident #87 was in her bed with the privacy curtain only partially drawn. When asked if he was a facility employee, Employee C stated "No." He went on to say he was a plumber hired by the facility and "we're doing construction here." On 02/20/19 01:38 PM, Resident #87 was observed lying in her bed, watching TV, with the head of the bed elevated approximately 60 degrees. Resident #87 was dressed in a shirt, no pants, wearing a disposable brief, and covers at the foot of the bed. When asked about her pants, she stated, "They're around here somewhere; I keep the curtain drawn" and motioned to the partition curtain which was partially drawn. On 02/21/19 at 08:07 AM, Resident #87 was observed lying on her right side, sleeping in bed.	F 550	Maintenance to facility vendors to ensure the privacy of residents. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Maintenance will complete 5 random privacy audits on vendors in the facilities weekly x 4 then 10 random privacy audits monthly x 2. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process monthly. Date of compliance-4/2/19	

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 02/25/2019

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 550	Continued From page 3	F 550		

She was covered with a sheet up to her chest.

On 02/21/2019 at approximately 12:50 PM, Resident #87 was observed lying in bed watching TV, She had a shirt on and covered with a blanket up to her chest.

On 02/22/19 at 08:28 AM, Resident #87 was observed lying in her bed while watching TV. She was wearing a shirt and covered with a sheet.

On 02/25/2018 at 11:15 AM, the Administrator and DON were notified of concerns. When asked was the expectation is of vendors entering resident rooms, the Administrator stated, "They should be knocking." A policy addressing dignity/vendors working in the facility was requested.

On 02/25/2019 at approximately 6:30 PM, the Administrator stated they don't have a policy pertaining to this issue. The Administrator and DON offered no further information or documentation.

2. For Resident #29, the facility staff failed to protect Resident #29's private space. A facility vendor was observed entering the room without knocking on the door.

Resident #29, an 85-year old female was admitted to the facility on 05/27/2016. Diagnoses include but not limited to cerebrovascular disease, Alzheimer's disease, aphasia, contracture left hand, and diabetes.

Resident # 29's most recent Minimum Data Set (MDS) with an Assessment Reference Date

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 02/25/2019

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 550	Continued From page 4	F 550		

(ARD) of 12/07/2018 was coded as an annual assessment. Resident # 29 was not coded with a Brief Interview of Mental Status (BIMS) score but cognitive skills for daily decision-making were coded as severely impaired. Functional status for dressing and toileting were coded as requiring extensive assistance from staff. Functional status for eating and personal hygiene were coded as total dependence on staff.

On 02/20/2019 at 11:26, Employee C was observed walking into rooms 316, 313, 309, 308, and 306 without knocking. Resident #29 was in her room receiving care by an aide and the privacy curtain was drawn.

When asked if he was a facility employee, Employee C stated "No." He went on to say he was a plumber hired by the facility and "we're doing construction here."

On 02/20/19 at 01:49 PM, Resident #29 was observed dressed and seated in a high back wheelchair.

On 02/21/19 at 08:08 AM, Resident #29 was observed lying in bed with her covers pulled up to mid-chest level. Resident was awake and the TV was on.

On 02/21/19 at 12:50 PM, Resident #29 was observed lying in bed in her room and the TV was on.

On 02/22/19 at 12:40 PM, Resident #29 was observed sleeping in her bed.

On 02/25/2018 at 11:15 AM, the Administrator and DON were notified of concerns. When asked

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 02/25/2019

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 550	Continued From page 5 was the expectation is of vendors entering resident rooms, the Administrator stated, "They should be knocking." A policy addressing dignity/vendors working in the facility was requested. On 02/25/2019 at approximately 6:30 PM, the Administrator stated they don't have a policy pertaining to this issue. The Administrator and DON offered no further information or documentation.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review the facility staff failed for 1 resident (Resident #115) of 59 residents in the survey sample to ensure the resident had been assessed to self administer medications. 1) For Resident # 115, the facility staff failed to remain with the resident during administration of nebulizer treatment and failed to assess the resident to determine if self administration of medication was clinically appropriate and safe. 2) For Resident #510, the facility staff failed to provide supervision and oversight of medication administration during a nebulizer treatment and failed to assess the resident to determine if self administration of medication was clinically	F 554	Corrective Action for those residents found to be affected by the alleged deficient practice Self administration test were completed and added to their medical record for residents #115, #510, and #76. Like Residents Residents admitting into the facility with respiratory treatments and topical creams have the potential to be affected. Residents who are able to safely administer their own respiratory treatments or topical creams were assessed as applicable. Systemic changes put into place to ensure the alleged deficient practice does	4/2/19

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 02/25/2019

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 554	Continued From page 6 appropriate and safe. 3. For Resident #76 the facility staff failed to provide supervision and oversight of topical medication and failed to assess the resident to determine if self administration of medication is clinically appropriate and safe. The findings included: Resident #115, a 76 year old, was admitted to the facility on 1/24/19. Resident #115's diagnoses included but were not limited to: Respiratory Failure with hypoxia, Acute Respiratory Failure with Hypercapnia, Pneumonia, Hypertension, Atrial Fibrillation, Diabetes, Gout, Anemia and Sleep apnea. The most recent Minimum Data Set assessment was an Admission assessment with an assessment reference date of 1/30/19. Resident # 115 was coded with a Brief Interview of Mental Status score of 14 out of 15, indicating no cognitive impairment. Resident # 115 required extensive assistance of one to two staff persons with activities of daily living except for eating. Resident # 115 required supervision and set up only for eating. On 2/20/19 at 11:42 a.m., Resident #115 was in his room sitting in a wheelchair in front of the overbed table and watching television. Resident # 115 had oxygen via nasal cannula infusing at 3 liters per minute. On 2/20/2019 at 11:48 a.m., Licensed Practical Nurse (LPN) F was observed passing medications to Resident # 115. LPN F was observed putting the medication in the nebulizer and applying the mask. LPN F then left the room	F 554	not recur. Education completed by the Director of Nursing to Licensed Nurses on completing the self-administration test to include a physician order of respiratory treatments and topical medications if applicable. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing will audit self-administration of medications 3x weekly x 4 weeks and then monthly x2. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process monthly. Date of compliance-4/2/19	

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 02/25/2019

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 554	Continued From page 7	F 554		

and went next door to another resident (Resident # 43) stating she was going to give more medications to Resident # 43.

On 2/20/2019 at 11:57 a.m., LPN F returned to Resident # 115's room and removed the nebulizer.

On 2/20/2019 at 3:45 p.m., an interview was conducted with Resident # 115 who stated the nurses often leave while the nebulizer treatment is being administered.

Review of the Physicians orders revealed documentation of an order for Albuterol inhale contents of 1 vial via nebulizer every four hours while awake.

Review of the clinical record revealed no assessment for self administration of medications.

On 2/22/2019 at 12:15 p.m., LPN D was observed administering a nebulizer treatment to Resident # 131. LPN D was observed standing in the doorway of Resident # 115's room during the administration of the nebulizer.

Review of directions of how to administer a nebulizer treatment revealed:

- Put the mouthpiece in your mouth between your teeth and close your lips around it.
- Hold the nebulizer in an upright position. This prevents spilling and promotes nebulization.
- Assure deep breathing throughout the treatment.
- Occasionally tapping the side of the nebulizer helps the solution drop to where it can be misted."

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 02/25/2019

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 554	Continued From page 8	F 554		

On 2/25/2019 at 3:05 p.m., an interview was conducted with LPN D who was asked how nebulizer treatments should be administered. LPN D stated that nurse should put the medication in the nebulizer and apply the mask. LPN D stated the nurses were expected to remain with the residents while administering nebulizer treatments.

During the end of day debriefing on 2/25/19, the Administrator, Director of Nursing (DON) and Corporate Nurse were informed that for Resident # 115, the nebulizer and mask were applied by the nurse and the nurse left the bedside. Resident # 115 finished the nebulizer treatment without supervision. When asked if it was okay that LPN F left Resident # 115 while the nebulizer treatment was being administered, the DON stated no. When asked if Resident #115 had been assessed to self administer medications, the DON stated no. The DON and Corporate Nurse stated the expectation was that nurses should remain with residents until the nebulizer treatments were completed and should complete an assessment for self administration of medications to determine if clinically appropriate and safe for residents to self-administer medications.

No further information was provided.

2. For Resident #510, the facility staff failed to provide supervision and oversight of medication administration during a nebulizer treatment and failed to assess the resident to determine if self administration of medication was clinically

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 02/25/2019

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 554	Continued From page 9	F 554		

appropriate and safe.

Resident #510, is a 72 year old male, was admitted to the facility on 2/9/19. His diagnosis included but were not limited to: chronic pulmonary edema, Muscle weakness, Difficulty in walking, other symptoms and signs involving the musculoskeletal system, cognitive communication deficit, hear failure, type 2 diabetes, sepsis, morbid obesity, hypertension, atherosclerotic heart disease, acute respiratory failure with hypoxia, disorder of kidney and ureter and shortness of breath.

Resident #510 did not have a complete MDS (minimum data set) (an assessment tool), due to being a new admission.

On 2/20/19 at 11:43 am, during an initial observation of Resident #510 he was observed sitting in his room with a nebulizer mask on with the nebulizer machine running. No staff were present in his room or in visual line of sight of the resident.

A review of physician's orders dated 2/9/19 and signed on 2/11/19 showed there was no order for self administration of medications. A physician's order dated 2/18/19 for the Duoneb gives no instruction for self administration of medication.

A record review conducted on 2/21/19 showed there was no documentation of an assessment of Resident #510 to determine that he was assessed for self administration of medication.

During a staff interview with Employee B on 2/25/19, Employee B stated "if he is self administering medications he should have an

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 02/25/2019

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 554	Continued From page 10	F 554		

assessment but I don't see one either."

A facility record review of the Self-Administration of Medications Policy Statement reads, "residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so."

The facility Administrator and Director of Nursing were informed of the findings on 2/25/19.

No further information was provided.

3. For Resident #76 the facility staff failed to provide supervision and oversight of topical medication and failed to assess the resident to determine if self administration of medication is clinically appropriate and safe.

Resident #76, is a 63 year old female, was initially admitted to the facility on 12/16/16 with a recent readmission on 1/14/18. Her diagnosis include Chronic obstructive pulmonary disease, phantom limb syndrome with pain, diabetes mellitus, conversion disorder with seizures or convulsions, anxiety disorder, major depressive disorder, urinary tract infection, gastro-esophageal reflux disease, pain in right leg, difficulty walking, other symptoms and signs involving the musculoskeletal system, candidiasis, cellulitis of right lower limb, pain in right hip, pain in right knee, pain in right shoulder, hypotension, overactive bladder, pure hypercholesterolemia, anemia insomnia, hypertension, peripheral vascular disease, acquired absence of left leg below knee.

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 02/25/2019

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 554 Continued From page 11 F 554

Resident #76's most recent MDS with an ARD (assessment reference date) of 12/20/18 was coded as a quarterly assessment. Resident #76 was coded as having a BIMS (Brief Interview for Memory Status) score of 15 indicating no cognitive impairment. She was also coded as requiring supervision with her activities of daily living except coded as requiring limited assistance of one staff member for dressing.

On 2/21/19 at 04:31 PM, Resident #76 was observed to have on her overbed table two small cups with a cream in one and a powder in the other. When asked, the resident stated "the powder is nystatin and I don't know the name of the cream, but the nurses bring it to me several times a day to put on my rash."

Review of physician's order sheets for 2/1/19-2/28/19, signed by the MD on 2/11/19 showed no order for self administration of medications. The orders read "nystatin cream apply topically to affected area twice daily as needed for 360 days".

A physician's order dated 2/5/19 read, "nystatin powder under bilat (bilateral) breaks & abd (abdominal) folds TID (three times per day) x 14 days".

A physician order dated 2/11/19 read, "Ketoconazole cream 2% apply to bilateral groin & abd folds BID (twice a day) x 10 days.

A facility record review of the Self-Administration of Medications Policy Statement read, "residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to

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 02/25/2019

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 554	Continued From page 12 do so." The facility Administrator and Director of Nursing were informed of the findings on 2/25/19. No further information was provided.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced	F 561		4/2/19

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 02/25/2019

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 561	Continued From page 13 by: Based on observation, resident and staff interview, facility documentation and clinical record review, the facility failed to, for one resident (Resident #78), in a survey sample of 59 residents, to allow the resident to choose his own preferred activities. Resident #78 stated the facility would not let him go outside in his wheel chair. The findings included: Resident #78, was admitted to the facility on 10-5-05 and was readmitted on 1-1-19. Diagnoses included; stroke, anxiety, history of small bowel obstruction and hypothyroidism. Resident #78's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1-8-19 was coded as a significant change in status assessment. Resident #78 was coded as having no memory deficits, did not refuse care, and was able to make own daily life decisions. The Resident was also coded as needing extensive assistance of one to staff members to perform his activities of daily living, except for independent locomotion, both on and off the units. On 2/20/19 at 1:23 PM an interview was conducted with Resident #78. He stated, "I am unable to go across the street." The resident stated he had an electric wheel chair and stated, "It's like imprisonment." On 2/22/19 at 12:42 PM, Resident #78's was observed in his room. Resident #78 stated, "Have you found out if I can go outside yet?"	F 561	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #78 was assessed for safety to use electric wheelchair out of the facility by the rehab department. Like Residents- Residents admitting into the facility utilizing electric wheelchairs have the potential to be affected. Review completed by Director of Nursing to assess other residents for wheelchair safety outside of the facility as applicable. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to nursing department and therapy department on resident rights to include the right to self-determination of activities such as utilizing the wheelchair out of the facility. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing or designee will complete audits weekly x 4 weeks and monthly x 2 to include residents who utilize electric wheelchairs to be able to safely go off of facility campus. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process monthly.	

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 02/25/2019

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 561	Continued From page 14 Review of the resident's care plan revised 1-17-19 read as follows: "Enjoys activities such as watching TV and movies in room, visiting friends in center and calling Bingo. He travels independently throughout the facility in his electric wheel chair and also in the community. He has signed a safety waiver." The goal was "...riding out in wheelchair as he desires and weather permits." One of the interventions for this care plan was, "Resident to check out red flag for wheel chair when leaving building and to return red flag when he returns." On 2/22/19 at approximately 1:00 PM, the Administrator stated, "I don't know why he can't go out, I know residents have to be assessed for safety outside."	F 561	Date of compliance-4/2/19	
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, hospital record review, and in the course of a complaint	F 607	Corrective Action for those residents found to be affected by the alleged deficient practice.	4/2/19

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 02/25/2019

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 607	Continued From page 15 investigation, the facility staff failed to implement their abuse/neglect policies for 1 Resident (Resident #210) in a survey sample of 59 residents. The facility failed to verify if disciplinary action in effect against professional license before hire for 6 of 25 employees and failed to provide training/orientation programs that include topics such as abuse prevention for 6 of 7 employees. 1. For Resident #210, the facility staff failed to report an allegation of neglect. The allegation of neglect was bought to the attention of the facility staff by a family member of the Resident, who filed a grievance with them on 11-22-18. It was never reported to the State Agency, and the investigation was not timely, taking at least 12 days. 2a. The facility failed to verify if disciplinary action in effect against professional license before hire for six employees. 2b. CNA B, CNA I, CNA K, CNA M, CNA N, and CNA P were found to have abuse training and other training on dates that they didn't work or were coded as having more inservice hours than they actually worked on the day of the inservice. The finding included: 1. For Resident #210, the facility staff failed to report an allegation of neglect. The allegation of neglect was bought to the attention of the facility staff by a family member of the Resident, who filed a grievance with them on 11-22-18. It was never reported to the State Agency, and the investigation was not timely, taking at least 12	F 607	Resident #210 has since been discharged from the facility. Like Residents- Residents admitting into the facility have the potential to be affected. Employees hired into the facility have the potential to be affected. Recent grievances were assessed and reported to the state health department as applicable according to abuse/neglect policy and procedures. Employee in-service sheets updated with a date column to reflect proper signing/dating of the employee signature while being physically in-serviced at the facility Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to nursing leadership on reporting requirements for abuse/neglect and to ensure staff are signing the in-service with proper dates while being in the facility during the education in-service . Education completed by the Administrator to the payroll benefits coordinator on ensuring license verifications are completed before date of hire and within 30 days of employee start date. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing will complete audits weekly x4 weeks for 3 months on in-service sheets to ensure proper signatures with dates to reflect time	

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 02/25/2019

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 607

Continued From page 16

days.

Resident #210 was admitted to the hospital on 11-16-18, and discharged to the facility on 11-19-18. Resident #210 stayed in the facility until 11-26-18, and was discharged back to the hospital on 11-26-18. Diagnoses for Resident #210 at the time of hospitalization on 11-16-18 included, bruising of the thorax from one fall in the last 3 months at home, urinary tract infection, spinal stenosis and cervical degenerative disk disease, high cholesterol, hypertension, arthritis, history of kidney stones, and depression.

Review of the nursing and physician progress notes revealed that upon admission to the facility on 11-19-18, the admission nursing assessment documented that the Resident was oriented to person, place, and time. Her respiratory status was without difficulty and 98% oxygen perfusion on room air. The Resident was continent of bowel and bladder, with normal bowel sounds in all 4 quadrants. The Resident required only 1 staff assistance with activities of daily living such as ambulation (walking), bed mobility, bathing, dressing, eating, toileting, and transfers. The Resident was coded as having no weight loss during her stay.

Resident #210's Minimum Data Set (MDS, an assessment protocol) was an admission assessment with an Assessment Reference Date (ARD) of 11-26-18. The document was not completed until 12-1-18. Resident #210 was coded on this document (after her discharge) with a Brief Interview of Mental Status (BIMS) score, of unable to complete, with severe cognitive impairment. Resident #210 was coded as requiring extensive to total assistance of one to

F 607

attended. Administrator will audit employee files weekly x4 weeks and monthly x 2 to ensure license verifications are completed and in employee files before hire date and within 30 days of the start date and will audit grievances weekly x 4 and monthly x2 for reporting requirements as applicable.

Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process monthly.

Date of compliance- 4-2-19

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 02/25/2019

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 607	Continued From page 17 two staff members for all activities of daily living at the end of her stay in the facility. The Resident was coded as having no pain during this stay, and, as having had 2 falls during this stay. Resident #210 was coded as now incontinent of bowel and bladder. This document reveals a significant change in all areas for this Resident from the facility admission assessment, and the discharge documents from the hospital on 11-19-18. The Resident was on a "Regular, with thin liquids, diet." The facility policy for abuse/neglect was reviewed and revealed the facility Abuse policy read, "Our Residents have the right to be free from abuse, neglect......" Investigate and report allegations within the federally required time frames." Neglect is defined as "the failure of the facility, it's employees or service providers to provide goods and services to a Resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." The Administrator was interviewed on 2-22-18, and information was requested regarding the allegation of neglect submitted to her on 11-22-18 by the responsible (RP) party for this Resident. The RP filed a written grievance with the Administrator on that day documenting plainly that the facility had neglected the Resident. The Administrator submitted copies of the forms and grievance document for review. The documents revealed that the Administrator stated she answered all of the RP's questions, and documented on the grievance form "Reportable to state agency" "NO", "no identified areas of neglect during this complaint." The initial report, nor the 5 day follow up report, were ever submitted to the state agency by the facility, as	F 607		

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 02/25/2019

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 607	Continued From page 18	F 607		

per regulation.

Found in those documents was a statement written by the Director of Nursing as a "Witness statement" quoting the nurse (NP) practitioner on 12-4-18 (7 days after the Resident was discharged, and 12 days after the allegation of neglect), which was part of the facility investigation, and documented the following; "RP complained of patient not eating and declining, not as active as she was on admission. DON (Director of Nursing) called NP - NP stated she was en route and wanted to see the patient before she gave order to send out. Approximately 5-10 minutes later NP in building gave order to send patient to ER (emergency room) due to family request. Patient with no signs of pain/distress. Patient not as verbal as usual. Patient was sent to ER.

On 2-25-19 at 11:30 a.m., a follow-up interview was conducted with the Administrator, regarding the omission in reporting the allegation of neglect that was made on 11-22-18. She stated, "Allegations of abuse/neglect are expected to be reported immediately, within 24 hours.

On 2-25-19 the Administrator and the Director of Nursing were informed that they failed to report to the state agency an allegation of neglect, and the investigation was ongoing for at least 12 days after the allegation of neglect was initiated. No additional information was submitted.

2a. The facility failed to verify if disciplinary action in effect against professional license before hire for six employees.

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 02/25/2019

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 607	Continued From page 19	F 607		

The facility failed to verify if disciplinary action in effect against professional license before hire for 6 of 25 employees, (employees LPN K and CNA O, CNA P, CNA Q, LPN L, LPN N). During employee record review on 2/25/19 no license verification prior to hire could be found for (employees LPN K and CNA O, CNA P and CNA Q.) LPN L was hired 5/9/17 and her license was verified 2/17/17 which is greater than 60 days prior to hire. LPN N's hire date was 8/7/18 and her license verification was completed on 10/30/17.

2b. CNA B, CNA I, CNA K, CNA M, CNA N, and CNA P were found to have abuse training and other training on dates that they didn't work or were coded as having more inservice hours than they actually worked on the day of the inservice.

Employee CNA I whose hire date is 2/20/18 was recorded on individual employee education record as attending 7 hours of orientation training on 2/21/18 which included abuse/neglect/rights and payroll records indicate CNA I worked 5.75 orientation hours on 2/21/18. CNA B whose hire date was 12/18/18 was recorded on the individual employee education record as attending 8 hours of education/orientation training on 12/18/18 which included abuse/neglect/rights and review of facility payroll records indicate CNA B had no hours for the date of 12/18/18. CNA K with a hire date of 11/30/18 was recorded on the individual employee education record as attending 12 hours of education/orientation on 11/30/18 and review of facility payroll records indicate CNA K worked 4.75 hours of orientation time on 11/30/18. CNA M was recorded on the individual employee

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 02/25/2019

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 607	Continued From page 20 education record as attending 12 hours of training to include abuse/neglect/rights on 10/17/18, review of payroll records indicate CNA M worked 7.75 hours that day. CNA N was recorded on the individual employee education record as attending 3 hours of training on 8/9/18 and 2 hours on 8/10/18 which included abuse/neglect/rights and review of payroll records for CNA N she didn't have any hours on 8/9/18 or 8/10/18. CNA P was recorded on the individual employee education record as attending 6 hours of training on 3/12/18 and 6 hours which included training on abuse/neglect/rights on 3/13/18. Review of employee payroll records for CNA P she had no hours on 3/12/18 and worked 4 hours on 3/13/18. On 2/25/19 15:23 interview with RN D about the training records and hours recorded, she stated "these hours on here are wrong then, I can not verify when these people did it." When asked about the signature on the forms as to who signed off that the training was complete RN D stated "that is my signature." Facility record review of "Abuse Prevention Program" policy reads: "As part of the resident abuse prevention, the administration will: 2. conduct employee background checks and will not knowingly employ or otherwise engage any individual who has been found guilty of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law; have had a finding entered into the state nurse aide registry concerns abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of	F 607		

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 02/25/2019

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 607	Continued From page 21 abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. 4. Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior." The Administrator and DON were made aware of the findings on 2/25/19. No further information was provided.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		4/2/19

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 02/25/2019

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 609	Continued From page 22 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation, the facility staff failed to report to the state agency allegations of abuse or neglect for two residents (Resident #72, #210) in a sample size of 59 residents. 1. For Resident #72, the facility staff failed to report resident-to-resident altercation to the state agency. 2. For Resident #210, the facility staff failed to report an allegation of neglect. The allegation of neglect was bought to the attention of the facility staff by a family member of the Resident, who filed a grievance with them on 11-22-18. It was never reported to the State Agency, and the investigation was not timely, taking at least 12 days. The findings include: 1. For Resident #72, the facility staff failed to report resident-to-resident altercation to the state agency. Resident #72, a 74-year old female, had an initial admission date of 03/01/2017. Diagnoses included but not limited to cerebrovascular disease, cerebral infarction, hemiplegia, depression, anxiety, schizophrenia, and schizoaffective disorder. A diagnosis of dementia	F 609	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #210 has since been discharged from the facility. Resident #72 and the other involved party were assessed without any injuries. Like Residents- Residents admitting into the facility have the potential to be affected. Recent grievances were assessed and reported to the state health department as applicable according to abuse/neglect policy and procedures. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nurses on reporting resident to resident altercations to the state health agency and on the abuse/neglect policies and procedures to include timely reporting requirements. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Administrator will audit will audit grievances weekly x 4 and monthly x2 for reporting requirements as applicable.	

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 02/25/2019

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 609	Continued From page 23 (with an onset date of 10/30/2018) was added to the facility list of diagnoses in the medical record on 02/22/2019 during the survey process. Resident #72's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/03/2019 was coded as an annual assessment. Resident #72's Brief Interview for Mental Status (BIMS) was coded as "9" out of possible "15" indicative of moderate cognitive impairment. Functional status for eating was coded as requiring limited assistance from staff. Functional status for dressing, toileting, and personal hygiene were coded as requiring extensive assistance from staff. Wandering presence was coded as behavior not exhibited and wandering impact was not coded. Excerpts of SBAR (Situation, background, appearance, review) note dated on 01/07/2019 at 1 p.m. documented, "Change in condition noted related to reported today that Resident entered another residence room and when she was asked to leave she hit the resident." "Patient does not have a possible or active infection." " Physical aggression noted." "MD was notified on 01/07/2019 at 1:15 PM." A complaint grievance report dated 1-7-2019 was presented by Administration. Under the section "describe concern in detail", it was handwritten that the daughter of another resident was told by her mother that another pt (patient) [Resident #72] "came into her- stated going through roommate's belongings and when she asked her (illegible) pt (patient) [Resident #72] hit her in the back and she hit resident #72 back (in the back)." Under the section "Findings of the investigation" it was documented, "DON met with (other resident)	F 609	Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process monthly. Date of compliance-4/2/19	

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 02/25/2019

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 609	Continued From page 24	F 609		

- stated Resident #72 pointed her out in the hallway and stated pt (patient) [Resident #72] came into me - hit her and she hit her back. Pt (patient)[Resident #72] then left with no problems (stated pt (patient) [Resident #72] was messing with roommate's clothing). Resident #72 could not remember the incident."

On 02/22/2019 at 9:15 AM, an interview with RN A was conducted. When asked about behaviors for Resident #72, she stated Resident #72 has crying episodes, she can be verbally aggressive, and she can have loud outbursts. When asked about interventions in place when behaviors arise, RN A stated "we leave her alone until she calms down and redirect". RN A stated Resident #72 also "wanders; she goes from room to room every now and then" entering other resident's rooms and, at times, using their bathroom. When asked if Resident #72 had ever hit another resident, RN A stated "if I recall, she hit a resident recently." When asked about triggers for Resident #72, RN A stated she was "not aware of triggers" for Resident #72.

On 02/25/19 at 11:45 AM, the Administrator was asked if the resident-to-resident altercation was reported to the state agency. She stated that if both residents have dementia and no injuries "we don't have to report."

On 02/25/2019 at approximately 6:30 PM, the Administrator and DON were notified of findings and they offered no further documentation or information.

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 02/25/2019

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 609	Continued From page 25	F 609		

2. For Resident #210, the facility staff failed to report an allegation of neglect. The allegation of neglect was bought to the attention of the facility staff by a family member of the Resident, who filed a grievance with them on 11-22-18. It was never reported to the State Agency, and the investigation was not timely, taking at least 12 days.

Resident #210 was admitted to the hospital on 11-16-18, and discharged to the facility on 11-19-18. Resident #210 stayed in the facility until 11-26-18, and was discharged back to the hospital on 11-26-18. Diagnoses for Resident #210 at the time of hospitalization on 11-16-18 included, bruising of the thorax from one fall in the last 3 months at home, urinary tract infection, spinal stenosis and cervical degenerative disk disease, high cholesterol, hypertension, arthritis, history of kidney stones, and depression.

Review of the nursing and physician progress notes revealed that upon admission to the facility on 11-19-18, the admission nursing assessment documented that the Resident was oriented to person, place, and time. Her respiratory status was without difficulty and 98% oxygen perfusion on room air. The Resident was continent of bowel and bladder, with normal bowel sounds in all 4 quadrants. The Resident required only 1 staff assistance with activities of daily living such as ambulation (walking), bed mobility, bathing, dressing, eating, toileting, and transfers. The Resident was coded as having no weight loss during her stay.

Resident #210's Minimum Data Set (MDS, an

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 02/25/2019

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 609	Continued From page 26 assessment protocol) was an admission assessment with an Assessment Reference Date (ARD) of 11-26-18. The document was not completed until 12-1-18. Resident #210 was coded on this document (after her discharge) with a Brief Interview of Mental Status (BIMS) score, of unable to complete, with severe cognitive impairment. Resident #210 was coded as requiring extensive to total assistance of one to two staff members for all activities of daily living at the end of her stay in the facility. The Resident was coded as having no pain during this stay, and, as having had 2 falls during this stay. Resident #210 was coded as now incontinent of bowel and bladder. This document reveals a significant change in all areas for this Resident from the facility admission assessment, and the discharge documents from the hospital on 11-19-18. The Resident was on a "Regular, with thin liquids, diet." The facility policy for abuse/neglect was reviewed and revealed the facility Abuse policy read, "Our Residents have the right to be free from abuse, neglect......" Investigate and report allegations within the federally required time frames." Neglect is defined as "the failure of the facility, it's employees or service providers to provide goods and services to a Resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." The Administrator was interviewed on 2-22-18, and information was requested regarding the allegation of neglect submitted to her on 11-22-18 by the responsible (RP) party for this Resident. The RP filed a written grievance with the Administrator on that day documenting plainly that the facility had neglected the Resident. The	F 609		

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 02/25/2019

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 609	Continued From page 27 Administrator submitted copies of the forms and grievance document for review. The documents revealed that the Administrator stated she answered all of the RP's questions, and documented on the grievance form "Reportable to state agency" "NO", "no identified areas of neglect during this complaint." The initial report, nor the 5 day follow up report, were ever submitted to the state agency by the facility, as per regulation. Found in those documents was a statement written by the Director of Nursing as a "Witness statement" quoting the nurse (NP) practitioner on 12-4-18 (7 days after the Resident was discharged, and 12 days after the allegation of neglect), which was part of the facility investigation, and documented the following; "RP complained of patient not eating and declining, not as active as she was on admission. DON (Director of Nursing) called NP - NP stated she was en route and wanted to see the patient before she gave order to send out. Approximately 5-10 minutes later NP in building gave order to send patient to ER (emergency room) due to family request. Patient with no signs of pain/distress. Patient not as verbal as usual. Patient was sent to ER. On 2-25-19 at 11:30 a.m., a follow-up interview was conducted with the Administrator, regarding the omission in reporting the allegation of neglect that was made on 11-22-18. She stated, "Allegations of abuse/neglect are expected to be reported immediately, within 24 hours. On 2-25-19 the Administrator and the Director of Nursing were informed that they failed to report to the state agency an allegation of neglect, and the	F 609		

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 02/25/2019

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 609	Continued From page 28 investigation was ongoing for at least 12 days after the allegation of neglect was initiated. No additional information was submitted.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete an accurate MDS (minimum data set) RAI (Resident Assessment Instrument) for one Resident (Resident #210) in a survey sample of 59 Residents. For Resident #210, the facility staff failed to accurately code her falls prior to admission in Section J-B, and weight loss in Section K-0300. The findings included: Resident #210 was admitted to the hospital after a fall at home. Hospital admission occurred on 11-16-18, and she was discharged to the nursing facility on 11-19-18. Resident #210 stayed in the facility until 11-26-18, and was discharged back to the hospital on 11-26-18. Diagnoses for Resident #210 at the time of hospitalization on 11-16-18 included, bruising of the thorax from one fall in the last 3 months at home, urinary tract infection, spinal stenosis and cervical degenerative disk disease, high cholesterol, hypertension, arthritis, history of kidney stones, and depression. Review of the nursing and physician progress	F 641	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #210 has since been discharged from the facility. Like Residents- Residents admitting into the facility have the potential to be affected. Review completed on recently transmitted resident MDS to ensure reflection of falls and weight loss. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to the licensed clinical reimbursement nurse team on ensuring falls and weight loss are captured on the minimum data set. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. The clinical reimbursement coordinator will conduct audits on admissions into the	4/20/19

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 02/25/2019

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 641

Continued From page 29

notes revealed that upon admission to the facility on 11-19-18, the admission nursing assessment documented that the Resident was oriented to person, place, and time. The Resident was continent of bowel and bladder. The Resident required only 1 staff assistance with activities of daily living such as ambulation (walking), bed mobility, bathing, dressing, eating, toileting, and transfers. The Resident was coded as having no weight loss during her stay.

Resident #210's Minimum Data Set (MDS, an assessment protocol) was an admission assessment with an Assessment Reference Date (ARD) of 11-26-18. The document was not completed until 12-1-18. Resident #210 was coded on this document (after her discharge) with a Brief Interview of Mental Status (BIMS) score, of unable to complete, with severe cognitive impairment. Resident #210 was coded as requiring extensive to total assistance of one to two staff members for all activities of daily living at the end of her stay in the facility. The Resident was coded as having no pain during this stay, and, as having had 2 falls during this stay. Resident #210 was coded as now incontinent of bowel and bladder. This document reveals a significant change in all areas for this Resident from the facility admission assessment, and the discharge documents from the hospital on 11-19-18. The Resident was on a "Regular, with thin liquids, diet."

The Resident's weight records were reviewed from the hospital and facility, and revealed an unexpected and undesired significant weight loss. Those weights follow below.

Hospital discharge on 11-19-18 (173.63 pounds)

F 641

center weekly x4 weeks and monthly x2 to ensure falls and weight loss are captured according to the resident assessment instrument manual.

Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process monthly.

Date of compliance-4/2/19

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 02/25/2019

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 641	Continued From page 30 Facility admission on 11-19-18 (172.4 pounds) Discharge from facility on 11-26-18 (151.6 pounds) indicating a loss of 20 pounds in 1 week. No falls prior to admission were coded, and no significant weight loss was coded. The MDS was completed on 12-1-18, 5 days after the discharge of the Resident. The administrator, and DON (director of nursing),were informed of the failure of the staff to accurately code falls, and weights on 2-25-19, no further information was provided.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State	F 645		4/2/19

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 02/25/2019

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 645	Continued From page 31	F 645		

intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).

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 02/25/2019

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 645	Continued From page 32 (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review and in the course of a complaint investigation the facility failed ensure they had (Pre Admission Screening And Resident Review) PASARR screening prior to admission for 2 Residents (#69 & #212) in a survey sample of 59 Residents. 1. For Resident #212 the facility failed to ensure Resident had PASARR Screening prior to admission. 2. For Resident #69 the facility failed to ensure the Resident had PASARR Screening prior to admission. The findings include: 1. For Resident #212 the facility failed to ensure Resident had PASARR Screening prior to admission. Resident #212 an 87 year old woman admitted to the facility on 4/24/15 with diagnoses of but not limited to(End Stage Renal Disease) ESRD requiring Hemodialysis three (3) days a week, (Resident had Hemodialysis Port in Upper Right Chest) heart failure unspecified, Type 2 Diabetes, anxiety, major depressive disorder, Depression, Psychosis, Dementia and Anemia. Resident #212's most recent (Minimum Data Set)	F 645	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #69 PASARR has been completed and placed in resident record. Resident #212 has since been discharged from the facility. Like Residents- Residents admitting into the facility have the potential to be affected. Review completed on current admissions to ensure PASARRs were resident records. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Administrator to the admissions team on ensuring PASARRs are obtained before admission into the facility. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Admissions will complete audit on PASARRs weekly x4 weeks then monthly x2 months. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process	

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 02/25/2019

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 645	Continued From page 33 MDS (screening tool) was a quarterly completed on 10/19/18 and coded Resident as having a (Brief Interview of Mental Status) score of 99 meaning Severe Cognitive Impairment. On 2/22/19 during the course of an investigation involving Resident #212 the entire closed record was requested. The DON met with this surveyor and stated " I have the entire closed record but I do not have the PASARR apparently it was not done prior to admission, and unfortunately she has expired as you know so we cannot do one now." On 2/25/19 during end of day conference PASARR was discussed with the Administrator and no further information was provided. 2. For Resident #69 the facility failed to ensure the Resident had PASARR Screening prior to admission. Resident #69 an 84 year old Resident admitted to the facility on 09/29/16 with diagnoses of but not limited to (Chronic Obstructive Pulmonary Disease) COPD, delusional disorder, insomnia, vertigo, anemia, Dementia without behavioral disturbance. On 2/20/19 during a clinical record review, the surveyor requested several documents for Resident #69. The DON stated she was having trouble locating the PASARR but submitted the other documents that were asked for The DON stated she would continue to look for the PASARR documentation. On 2/21/19 at end of day briefing PASARR	F 645	monthly. Date of compliance-4/2/19	

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 02/25/2019

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 645	Continued From page 34 documents were requested for several Residents to be given to surveyors by 2/22/19. On 2/22/19 in an interview with the DON, the DON stated she did not have PASARR Level I Screening from admission for Resident #69. The DON submitted a PASARR Level I dated 2/22/19. She stated she was aware the CMS was still going to "Tag us for not having the PASARR but we could do it now to avoid future tags." The PASARR was discussed during end of day conference on 2/25/19 and no further information was given.	F 645		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		4/2/19

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 02/25/2019

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 657	Continued From page 35 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation the facility failed to review and revise care plans for 2 Residents (#212 and #69) in a sample size of 59 residents. 1. For Resident # 212 the facility failed to develop and implement a care plan that addressed the behaviors of pulling at dialysis port and uncapping dialysis ports. 2. For Resident #69 the facility did not update care plan to add Resident is on thickened liquids and only family may give water / thin liquids. The finding include: 1. For Resident # 212 the facility failed to develop and implement a care plan that addressed the behaviors of pulling at dialysis port and uncapping dialysis ports. Resident #212 an 87 year old woman admitted to the facility on 4/24/15 with diagnoses of but not limited to (End Stage Renal Disease) ESRD requiring Hemodialysis three (3) days a week, (Resident had Hemodialysis Port in Upper Right Chest) heart failure unspecified, Type 2 Diabetes, anxiety, major depressive disorder,	F 657	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #212 has since been discharged from the facility and #69 careplan updated to thickened liquid status. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents admitting into the facility have the potential to be affected. Review completed by Director of Nursing on progress notes and physician orders to ensure careplan revisions were completed as necessary. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nursing personnel and Registered Nurse Assessment Coordinator(s) on revising careplans at the time of any change in resident care to include behaviors and diet status changes. Monitoring of corrective action to ensure the alleged deficient practice does not	

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 02/25/2019

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 657	Continued From page 36 Depression, Psychosis, Dementia and Anemia. Resident #212's most recent (Minimum Data Set) MDS (screening tool) was a quarterly completed on 10/19/18 and coded Resident as having a (Brief Interview of Mental Status) score of 99 meaning Severe Cognitive Impairment. On 2/21/19 during clinical record review and it was discovered that the care plan for Resident #212 did not specifically address the behavior of pulling at dialysis port or uncapping dialysis port. The care plan for this Resident on page 16 reads: FOCUS: Resistive / non-compliant with treatment / care pulling at dialysis port while at dialysis/LTCF removing oxygen related to cognitive impairment and anxiety. (Dated 7/7/16 no revision until 11/7/19 after resident expired) INTERVENTIONS: Allow for flexibility in ADL routine to accommodate mood preferences and customary routine Ask physician to explain the need for treatment Elicit family input for best compliance Provide education about Risks of not complying with therapeutic regimen Provide non care related conversation proactively before attempting ADL's Psych consult as needed. (Dated 7/7/16 no revision until 11/7/19 after resident expired) On page 23 of the care plan the following was entered on 8/1/16:	F 657	recur. Director of Nursing will complete audits of 5 resident careplans weekly x 4 weeks and 10 residents' careplans monthly x 2 months for careplan revisions. 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. Date of compliance-4/2/19	

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 02/25/2019

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 657	Continued From page 37	F 657		

FOCUS:
At risk for behavior symptoms related to Dementia with psychosis. Resident has a history of pulling at port, Scratches self.

INTERVENTIONS:
Administer medication per physician order
Attempt psychotropic drug reduction per physician order
Observe for mental status/behavioral changes when new medication is started or with change in dosage
Psych referral as needed
Use consistent approaches when giving care
Wander guard bracelet (canceled on 8/29/17)

On 2/21/2019 at 5:00 pm, an interview with the DON was conducted. The DON she stated she was not in the facility when the Resident was there. The DON was asked what the expectation was for nurses and CNA's for a Cognitively Impaired Resident with a known history of pulling at her dialysis port. She stated she wound expect frequent rounding, a bandage might cause her to pick at it more. When asked what is frequent, the DON stated every 2 hours,

On 2/21/19 at 5:10 pm an interview was conducted with the Administrator. The Administrator stated that they do not have any other cognitively impaired residents that pulls at the dialysis port. She stated she was aware the staff made rounds every two hours at minimum.

On 2/21/29 at 5:30 pm, an interview was conducted with RN A. When asked what the facility did about the Resident pulling at the dialysis port, RN A stated we used to wrap it in

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 02/25/2019

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 657	Continued From page 38 gauze. When asked if it was a deterrent to the Resident RN A stated "Not really it slowed her down but didn't really stop her from doing it." When asked was this in the Residents care plan, RN A stated she didn't know. When shown the care plan, RN A stated that it was not in the care plan. On 2/22/19 the Administrator and DON were made aware that the care plans were not updated to include the taping or the dressing the facility placed on the dialysis port when she returned from the dialysis center. The care plans were also not updated to include any other interventions. No further information was provided. 2. For Resident #69 the facility did not update care plan to add Resident is on thickened liquids and ONLY family may give water / thin liquids. Resident #69 an 84 year old Resident admitted to the facility on 09/29/16 with diagnoses of but not limited to (Chronic Obstructive Pulmonary Disease) COPD, delusional disorder, dysphagia, insomnia, vertigo, anemia, Dementia without behavioral disturbance. On 2/20/19 during initial tour, this Resident was observed drinking thickened liquids with her lunch. On 2/20/19, a clinical record review was being conducted. The review showed the (Physicians Order Sheet) POS for January and February 2019 stated:	F 657		

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 02/25/2019

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 657	Continued From page 39 "FAMILY ONLY TO PROVIDE WATER-THIN LIQUIDS, STAFF TO PROVIDE NECTAR THICKENED LIQUIDS AS ORDERED" Resident #69's care plan states: FOCUS: Potential for nutrition/fluid imbalance d/t medication side effects with disease process of Parkinson's, HLD, Basal Cell CA of Skin, CHF, and dysphagia. INTERVENTIONS: Critical care Active QD (2/14/19) No weights as ordered (08/16/19) ST to evaluate and treat as indicated FEES TEST ordered (10/24/17) Magic Cup BID [twice a day] (10/24/17) Administer medications as ordered (10/7/16) Administer vitamin/mineral supplements as ordered (10/7/16) Fortified Foods (1/3/17) Honor Food Preferences (10/7/16) Notify physician and responsible party of significant weight changes) (10/7/16) Obtain labs as ordered and notify physician of results (10/7/16) Provide diet as ordered Regular- Thin, No Straws (10/7/16) On 2/22/19, the DON was asked why the Resident's care plan stated Regular -Thin No Straws but the Physicians Orders Stated that only family may give her water-thin liquids. The DON responded that the Resident's (Responsible Party) RP had spoken to the doctor and been informed by the doctor of the risks of giving her thin liquids, they accepted that responsibility and the doctor wrote the order so that the staff knew that they could only use thickened liquids and the	F 657		

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 02/25/2019

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 657	Continued From page 40 family could give thin liquids. The DON further stated you can see the Regular-Thin No straws was initiated 10/7/16 and must not have been updated to include the order for family not to give Nectar consistency thickened liquids. On 2/25/19 the Administrator was made aware no further information was provided.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility documentation review, and clinical record review, the facility staff failed to follow professional standards of practice for medication and treatment administration for 4 Residents (Residents #49, #115, #510, and #211) in a survey sample of 59 Residents. 1. For Resident #49, the facility staff failed to ensure medications were documented as having been administered. 2. For Resident # 115, the facility staff failed to remain with the resident during administration of nebulizer treatments. 3. For Resident #510, the facility staff failed to obtain an Arterial Brachial Index (ABI), and to clarify the frequency of dosing for prednisone medication, which were ordered by a physician.	F 658	Corrective Action for those residents found to be affected by the alleged deficient practice. Medication error forms were completed for missed medications for resident #49. Residents #115, #510, and #211 have since been discharged from the facility. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents admitting into the facility have the potential to be affected. Review completed by Director of Nursing on medication administration/treatment records and physician orders for completion and updates made as necessary. Self-administration test completed for residents with respiratory treatments as applicable.	4/2/19

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 02/25/2019

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 658	Continued From page 41	F 658		

4. For Resident #211, the facility staff failed to obtain a physician's order for treatment of a skin tear.

The findings included;

1. Resident #49 was initially admitted to the facility 5-8-18, and readmitted after a hospitalization on 2-1-19. Diagnoses included; anxiety, diabetes, anemia, urinary retention, hypertension, congestive heart failure, asthma, heart surgery, encephalopathy, glaucoma, bacteremia, pressure ulcer, and gout.

Resident #49's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12-18-18 was coded as a full significant change assessment. The Resident was coded with a BIMS (Brief Interview of Mental Status) score of 15, cognitively intact. Resident #49 was coded as needing extensive assistance of one staff member to perform activities of daily living.

On 2-20-19 during initial tour of the facility an interview was conducted with the Resident. At that time she was asked if she had any concerns that she would like to discuss. Resident #49 stated that she was satisfied with her care at the facility, but, "Every once in a while they (nursing staff) will have a problem with my medications." When asked if she received her medications as ordered by the physician, Resident #49 said, "not every time."

Review of Resident #49's clinical record and MARs (Medication Administration Records) revealed no documentation that the following

Systemic Changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the Director of Nursing to licensed nursing personnel on signing medication/treatment administration records, getting discontinuation orders for skin alterations that have healed, on completing physician ordered test, clarifying physician orders, and completing self-administration forms on residents who can safely self-administer medications.

Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of Nursing will complete audits of 5 resident medication/treatment administration records, physician orders, and respiratory treatment 3x week x 4 weeks and 10 residents monthly x 2 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.

Date of compliance-4/2/19

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 02/25/2019

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 658	Continued From page 42	F 658		

medications were administered on the days and times indicated:

Eliquis 2.5 milligrams (mg) 1 tablet by mouth twice per day at 9:00 a.m., and 6:00 p.m. omitted 2-7-19, and 2-10-19 at 6PM.

Insulin Lantus (units) u-100 subcutaneous 40 units every night at 9:00 p.m. omitted 2-10-19.

Lasix 40 mg twice per day at 9:00 a.m., and 6:00 p.m. omitted 2-6-19 at 6:00 p.m.

Dialysis site access checks every shift, (11p.m., to 7 a.m. shift omitted 2-9-19, and 2-11-19), and (3 p.m. to 11 p.m. shift omitted 2-10-19).

Dialysis site capped and clamped checks every shift, 11 p.m. to 7 a.m. omitted 2-11-19), and (3 p.m. to 11 p.m. shift omitted 2-10-19, 2-17-19, and 2-20-19), and (7 a.m. to 3 p.m. shift 2-8-19).

Valid physician's orders were evident for the medications and assessments not documented as having been administered.

On 2-22-19 at approximately 1:00 p.m., the director of nursing (DON) was asked about the medications and assessments that were not documented as having been administered. The DON said "if they are not documented they are not done."

The facility policy entitled "General Guidelines for the Administration of Medications read;

"Procedure #3 The nurse observes the 5 rights in administering each medication." #10 "The nurse records the administration in the medication

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 02/25/2019

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 658	Continued From page 43	F 658		

administration record."

The administrator and DON were informed of the failure of the staff to document the above mentioned medications as having been administered, during the end of day debrief on 2-22-19.

2. For Resident # 115, the facility staff failed to remain with the resident during administration of nebulizer treatments.

Resident # 115 nebulizer and mask were applied by the nurse and the nurse left the bedside. Resident # 115 finished the nebulizer treatment without supervision.

Resident #115, a 76 year old, was admitted to the facility on 1/24/19. Resident #115's diagnoses included but were not limited to: Respiratory Failure with hypoxia, Acute Respiratory Failure with Hypercapnia, Pneumonia, Hypertension, Atrial Fibrillation, Diabetes, Gout, Anemia and Sleep apnea. The most recent Minimum Data Set assessment was an Admission assessment with an assessment reference date of 1/30/19. Resident # 115 was coded with a Brief Interview of Mental Status score of 14 out of 15, indicating no cognitive impairment. Resident # 115 required extensive assistance of one to two staff persons with activities of daily living except for eating. Resident # 115 required supervision and set up only for eating.

On 2/20/19 at 11:42 a.m., Resident #115 was in his room sitting in a wheelchair in front of the overbed table and watching television. Resident

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 02/25/2019

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 658		F 658		

Continued From page 44
115 had oxygen via nasal cannula infusing at 3 liters per minute.

On 2/20/2019 at 11:48 a.m., Licensed Practical Nurse (LPN) F was observed passing medications to Resident # 115. LPN F was observed putting the medication in the nebulizer and applying the mask. LPN F then left the room and went next door to another resident (Resident # 43) stating she was going to give more medications to Resident # 43.

On 2/20/2019 at 11:57 a.m., LPN F returned to Resident # 115's room and removed the nebulizer.

On 2/20/2019 at 3:45 p.m., an interview was conducted with Resident # 115 who stated the nurses often leave while the nebulizer treatment is being administered.

Review of the Physicians orders revealed documentation of an order for Albuterol inhale contents of 1 vial via nebulizer every four hours while awake.

On 2/22/2019 at 12:15 p.m., LPN D was observed administering a nebulizer treatment to Resident # 131. LPN D was observed standing in the doorway of Resident # 115's room during the administration of the nebulizer.

Review of directions of how to administer a nebulizer treatment revealed:

- Put the mouthpiece in your mouth between your teeth and close your lips around it.
- Hold the nebulizer in an upright position. This prevents spilling and promotes nebulization.

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 02/25/2019

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 658		F 658		

Continued From page 45
- Assure deep breathing throughout the treatment.
- Occasionally tapping the side of the nebulizer helps the solution drop to where it can be misted.

The facility cited Lippincott as the resource used for professional nursing standards. Guidance was given from Lippincott, Fundamentals of Nursing, which reads: "To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to these rights:
1. The right medication
2. The right dose
3. The right patient
4. The right route
5. The right time
6. The right documentation"

On 2/25/2019 at 3:05 p.m., an interview was conducted with LPN D who was asked how nebulizer treatments should be administered. LPN D stated that nurse should put the medication in the nebulizer and apply the mask. LPN D stated the nurses were expected to remain with the residents while administering nebulizer treatments.

During the end of day debriefing on 2/25/19, the Administrator, Director of Nursing (DON) and Corporate Nurse were informed of the failure of the staff to provide supervision of medication administration during a nebulizer treatment. When asked if it was okay that LPN F left Resident # 115 while the nebulizer treatment was being administered, the DON stated "no." The DON and Corporate Nurse stated the facility's

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 02/25/2019

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 658	Continued From page 46	F 658		

expectation was consistent with the professional nursing standard that nurses should remain with residents until the nebulizer treatments were completed.

No further information was provided.

3. For Resident #510 the facility staff failed to obtain an arterial brachial index (ABI), and to clarify the frequency of dosing for prednisone medication, which were ordered by a physician.

Resident #510, is a 72 year old male, was admitted to the facility on 2/9/19. His diagnosis included but were not limited to: chronic pulmonary edema, Muscle weakness, Difficulty in walking, other symptoms and signs involving the musculoskeletal system, cognitive communication deficit, hear failure, type 2 diabetes, sepsis, morbid obesity, hypertension, atherosclerotic heart disease, acute respiratory failure with hypoxia, disorder of kidney and ureter and shortness of breath.

Resident #510 did not have a complete MDS (minimum data set) (an assessment tool) due to being a new admission.

On 2/21/19 physician orders for resident #510 were reviewed and revealed an order for an ABI and arterial Doppler to bilateral lower extremities r/t (related to) wound on 2/13/19. Review of other clinical documents revealed that on 2/14/19 a mobile x-ray company performed the Doppler study and noted "ABI was not possible due to lower extremity too large for the BP cuff to fit."

Review of nursing notes provided no

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 02/25/2019

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 658	Continued From page 47 documentation that the physician was notified the order was unable to be carried out. On 2/21/19 physician orders for Resident #510 were reviewed and revealed an order on 2/18/19 that reads "Prednisone 40mg x 5 day dx: SOB" (shortness of breath). There was no route or frequency noted in this order. Review of additional orders and nurses notes show no contact with the physician to clarify the order as to how the resident is to receive the medication or how often per day. Review of the Medication record for Feb. 2019 showed the order was written as "Prednisone 40mg po (by mouth) daily x 5 days". There was no physician order to indicate the resident is to receive the medication once daily as the medication administration record shows the resident was receiving. Review of the facility's policy entitled "Medication Orders" included: "Recording Orders 1. Medication orders- when recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered." Review of the facility's policy entitled: "Physician Orders: Obtaining and Transcribing" included: "Medication orders should include the following information in the text of the order: name of medication, strength, dosage, route frequency, parameters pertaining to administration i.e. blood pressures; blood sugars, etc., diagnosis/reason for administration, stop dates should be included as indicated and for: antibiotics, medrol pak, tapered drugs."	F 658		

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 02/25/2019

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 658	Continued From page 48 The facility stated they utilized "Lippincott" as their professional nursing standard. Guidance for nursing standards for the administration of medication is provided by "Lippincott", Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. Medications and treatments are given in accordance with physician's orders. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation." The facility Administrator and Director of Nursing were notified of the findings on 2/25/19. No further information was provided. 4. For Resident #211, the facility staff failed to obtain a physician's order to assess, treat, and monitor a skin tear on her upper left arm. Resident #211 was admitted to the facility on 03/16/2017 and discharged on 10/01/2018. Diagnoses for Resident #211 included but are not limited to coronary artery disease, hypertension,	F 658		

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 02/25/2019

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 658 Continued From page 49 F 658

gastroesophageal reflux, diabetes, stroke, hemiparesis/hemiplegia, and Alzheimer's disease.

Resident #211's most recent quarterly Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 08/17/2018 coded Resident #211 Brief Interview of Mental Status (BIMS) as 15 out of possible 15 indicative of no cognitive impairment. Functional status was coded as requiring extensive assistance from staff for transferring, dressing, toileting, and personal hygiene.

A closed record review was conducted.

Nurse's notes ranging from 06/02/2018 through 07/31/2018 were reviewed. A nurse's note dated 6/5/2018 at 7:51 PM documented, "Resident has new order; site was cleaned with normal saline skin approximated steristrips and kling applied. Site red/pink with scant blood 3cm x 3cm to upper left arm. Resident has new order for Geri-sleeves to wear as tolerated, to both upper extremities r/t (related to) skin tear caused by resident hitting arm on wheelchair arm rest. R/P (responsible party) aware." There were no further entries in the nurse's notes pertaining to assessment or treatment of the skin tear on Resident #211's upper left arm.

The skin assessment documentation ranging from 06/04/2018 through 07/31/2018 was reviewed. There were no entries addressing assessment or treatment of the skin tear to Resident #211's left upper arm.

The SBAR (situation, background, appearance, review) documentation dated 06/05/2018 was

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 02/25/2019

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 658	Continued From page 50	F 658		

reviewed. Under Situation, it was documented, "Writer noted skin tear to left upper arm 3cm x 3cm, scant blood noted to site, clean, skin approximated, steri strips applied. resident hit her arm on armrest of wheelchair." Under Review, it was documented physician was notified on 06/05/2018 at 5:05 PM. Under Ordered Tests and Interventions, there were none.

The provider notes ranging from 06/04/2018 through 07/31/2018 were reviewed.
Excerpts of an entry by the nurse practitioner dated 6/7/2018 at 9:45 AM documented, "I was asked to see patient for a skin tear to her left arm. no recent injury noted did not recall hitting it on anything. patients skin is thin and likely to have skin tears easily." (sic) "Small skin tear covered with steri strips, minimal bleeding but over all looks fine" "Assessment/plan: skin tear: keep it clean and covered"

Excerpts of an entry dated 06/08/2018 at 9:24 AM documented, "follow up on recent skin tear to her left arm, wound is healing appropriately. Patient denies any issues and no other skin tears noted." "small skin tear covered with steri strips, bleeding has stopped" "assessment/plan: skin tear: keep it clean and covered"

An excerpt of an entry dated 06/20/2018 at 12:50 PM documented, "small skin tear covered with steri strips, bleeding has stopped" There were no further provider notes addressing the skin tear to Resident #211's upper left arm.

Physician's orders ranging from 06/01/2018 through 07/31/2018. A telephone order dated 06/05/2018 at 5:10 PM documented, "Resident to wear protective sleeves as tolerated to BUE

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 02/25/2019

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 658	Continued From page 51	F 658		

(bilateral upper extremities)" There were no orders addressing assessment or treatment of the skin tear on Resident #211's left upper arm on 06/05/2018 through 06/10/2018. Excerpts of a telephone order dated 06/11/2018 (no time included) documented, "Continue: Monitor steri strips to (L) (left) (upper) arm qshift (every shift) until healed. Change film dsg (dressing) q 7 days (every 7 days) until healed." There are no further orders addressing the skin tear to Resident #211's upper left arm.

The Treatment Administration Records ranging from 06/01/2018 through 07/31/2018 were reviewed. The treatment "Monitor steri strips to left upper arm q shift until healed" was signed as administered once on day shift on 06/06/2018 and every shift thereafter (three times a day) for the month of June 2018. For the month of July 2018, the treatment was signed off as administered on night shift (07/10, 07/11, 07/12, and 07/14), day shift (07/01, 07/12, 07/14, and 07/15), and evening shift (07/01, 07/05, 07/06, 07/07, 07/09-07/12, 07/14, and 07/15). In the column beyond 07/15/2018, it was documented, "D/C (discontinued) 07/15/2018 healed", five weeks after the steri-strips had been applied.

The facility policy for skin tears was reviewed. Under the section, "Steps in the Procedure" an excerpt of item #16. Documented, "Cleanse the wound with ordered cleanser." An excerpt of item #18. Documented, "Apply the ordered dressing and secure with tape or bordered dressing per order."

The care plan was reviewed.
A focus initiated on 06/05/2018 documented,

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 02/25/2019

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 658	Continued From page 52	F 658		

"Actual skin breakdown related to left upper arm skin tear." It had one intervention: "Administer treatment per physician's orders."

On 02/25/2019 at 11:10 AM, the DON was asked about the nursing practice expectations when a resident gets a skin tear. She stated an SBAR (situation, background, appearance, review/notify) should be completed and the nurse should obtain doctor's orders. When asked what reference guides their professional standards, the DON stated "Lippincott." The physician's orders pertaining to the skin tear on Resident #211's left upper arm were requested.

On 02/25/2019 at 11:50 AM, the DON stated, "I don't have any orders" associated with Resident #211's skin tear to the left upper arm.

In summary, there were no physician's orders for assessment or treatment plan of skin tear on Resident #211's left upper arm. There was no subsequent monitoring, assessment, or documentation of wound appearance by the nursing staff.

According to Lippincott Manual of Nursing Practice, 10th Edition, 2014, departures from standards in nursing care include, "failure to assess the patient properly or in a timely fashion, follow physician's orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record" (Nettina, 2014, p. 1169).

On 02/25/2019 at approximately 6:30 PM, the Administrator and DON were notified of findings. They confirmed they do not have standing orders

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 02/25/2019

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 658	Continued From page 53 addressing skin tears. They offered no further information or documentation.	F 658		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, hospital record review, and in the course of a complaint investigation, the facility staff failed to ensure the highest practicable well being for 4 Residents (Residents #76, #78, #260, and #210), resulting in harm for Resident #76 in a survey sample of 59 residents. 1. For Resident #76, the facility staff failed to provide care and treatment for a skin condition, resulting in increased depression and social isolation. This is harm. 2. Resident #78 had two episodes of impaction without timely treatment, resulting in nausea and vomiting and admissions to the hospital. 3. Resident #260 did not receive his antifungal for complaints of thrush timely. 4. The facility staff failed to assess and	F 684	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #260 and #210 have since been discharged from the facility. Resident #76 skin condition is healed. Resident #78 is on routine bowel protocol. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents admitting into the facility have the potential to be affected. Review completed by Director of Nursing on residents with skin conditions to ensure proper treatment in place, for residents on bowel protocol for proper treatment, on progress notes for residents who medications are documented as not available, and addressed as applicable. Systemic Changes put into place to	4/2/19

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 02/25/2019

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 684	Continued From page 54 implement bowel protocol for Resident #210. The finding included: 1. For Resident #76, the facility staff failed to provide care and treatment for a skin condition, resulting in increased depression and social isolation. This is harm. Resident #76, a 63 year old female, was initially admitted to the facility on 12/16/16 with a recent readmission on 1/14/18. Her diagnosis include Chronic obstructive pulmonary disease, phantom limb syndrome with pain, diabetes mellitus, conversion disorder with seizures or convulsions, anxiety disorder, major depressive disorder, urinary tract infection, gastro-esophageal reflux disease, pain in right leg, difficulty walking, other symptoms and signs involving the musculoskeletal system, candidiasis, cellulitis of right lower limb, pain in right hip, pain in right knee, pain in right shoulder, hypotension, overactive bladder, pure hypercholesterolemia, anemia insomnia, hypertension, peripheral vascular disease, acquired absence of left leg below knee. Resident #76's most recent MDS with an ARD (assessment reference date) of 12/20/18 was coded as a quarterly assessment. Resident #76 was coded as having a BIMS (Brief Interview for Memory Status) score of 15 indicating no cognitive impairment. She was also coded as requiring supervision with her activities of daily living except coded as requiring limited assistance of one staff member for dressing. She is coded as being occasionally incontinent of bladder and frequently incontinent of bowel.	F 684	ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nursing personnel on initiating bowel protocol, on providing treatment for skin conditions per skin protocol, and for ensuring medications are available in a timely manner from pharmacy. Monitoring of corrective action to ensure the alleged deficient practice does not recur. Director of Nursing will complete audits of residents on the daily dashboard for clinical alerts to include resident bowel movements, progress notes, and skin alteration sheets 3x week x 4 weeks and monthly x 2 months to ensure residents who are on bowel protocol are addressed as applicable, skin alteration sheets have proper treatments in place, and progress notes for medications documented as unavailable. 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. Date of compliance-4/2/19	

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 02/25/2019

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 684	Continued From page 55	F 684		

On 2/21/19 at 4:31 PM, during interview with Resident #76, she was observed with two small cups on her over bed table. One with a cream and a powder in the other. When the resident was asked about it she stated "the powder is nystatin and I don't know the name of the cream but the nurses bring it to me several times a day to put on my rash." Resident #76 stated, "I have rashes due to my pull ups and I can't put any clothes on, it gets really red and bloody. They said there was nothing else they can do for me because the company doesn't make anything else due to the size. I've talked to [Employee H] but she said she can't find any other big ones. This has gone on for quite some time, Dr. has put me on antibiotics and some cream before. I'm getting depressed because I don't know what to do, do I stay in my room in my housecoat all the time?" Resident #76 has not been assessed, nor found to be safe to self administer medications.

On 2/22/19 at 10:03am, during an interview with Resident #76, she stated "I have tried underwear with the pad but I soak right through them. I can't live in my housecoat and gown all the time." "I can't go in a gown with no pants on. I feel isolation and depressed, I loved to go to activities and now I can't." [Employee H] "tells me there is nothing else."

A record review on 2/22/19 revealed Resident #76 is on Oxybutynin tab 5mg 1 tablet by mouth twice daily for overactive bladder. She is also on bethanechol tab 25 mg 2 tablets (50mg) by mouth twice daily for urinary frequency. Her MDS with an ARD of 12/20/18 was coded that she needs supervision, set-up help only with toileting. It was also coded that she is "occasionally incontinent"

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 02/25/2019

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 684	Continued From page 56 of bladder and "frequently incontinent" of bowel. Nursing Notes dated 12/20/18 state "resident offered briefs and mesh liners. Resident is able to use bathroom for toileting but chooses not to." During an observation of Resident #76's groin by another surveyor on 2/22/19 at 10:07am with LPN A present, the surveyor stated; "it is bleeding with red open weeping areas, and looks like moisture, it doesn't look like yeast," LPN A stated "yeah, it's moisture." LPN A asked the resident "what kind of soap are you using?" Resident #76 states she went 2 weeks without wearing clothes and it got better. LPN A stated "this has been a concern of hers, she has voiced her concern about her briefs, they have been trying to see if the company has anything else." Employee H "talked to me two weeks ago or about a month ago. She has talked to the Nurse Practitioner". On 2/22/19 at 10:19am during interview with Employee H, she stated "I've talked to her several times and have offered the best solution, she has the largest pullup the manufacturer offers. I have offered mesh underwear with pads but she doesn't want to do that, says she tried it in the past and it didn't work. She said they are too tight in the leg area and I told her we don't offer a different brand". When asked how long Resident #76 has been complaining, Employee H said "its been going on for the last month but she spoke with me about it before about four months ago, I wish I could help her, I really do." When asked , if they had considered cloth options employee H said "I would have to see, its not on my formulary, I may have to call and get them to add it." On 2/22/19 at 10:57am Employee H returned and stated "I called my manufacturer and they don't	F 684		

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 02/25/2019

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 684	Continued From page 57	F 684		

offer it, my representative said they had never heard of them but she's not going to go for this. She told me it was too tight, not that it was breaking her out, she said it was rubbing her legs, today y'all are the first ones to tell me it was a rash."

Review of weekly skin assessment reports for Resident #76 showed her groin area was pink on 12/10/18. Weekly skin assessments dated 1/7/19, 1/21/19, and 1/28/19 noted treatment to groin area. The assessment dated 2/4/19 indicated there was redness with treatment. The 2/11/19 assessment indicated treatment to groin, and the 2/18/19 assessment indicated redness with treatment.

A review of progress notes on 2/22/19 showed Resident #76 reported to the nurse practitioner on 12/19/18 that she had chronic groin discomfort. On 12/20/18, the resident reported to the Nurse Practitioner that her "groin discomfort improved" and the Nurse Practitioner wrote to "continue with warm compresses and epson salt." There was no further evidence in the clinical record review that the warm compresses were being administered. On 1/3/19 nursing note read, "patient does not have a possible or active infection." A note dated 1/8/19 read, "patient does not have a possible or active infection."

A review of Resident #76's treatment record dated 12/1/18-12/31/18 had the following orders to the groin:
"Nystatin Cream apply topically to affected area twice daily." However, this was not signed off as being completed on two occasions on 12/14, 12/21, 12/26, and 12/27.

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 02/25/2019

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 684 Continued From page 58 F 684

"Epsom Salt Gra [sic] Topical soaks to bilateral groin and ABD (Abdominal) folds q (every) shift." This was started on 12/19/18. However, the treatment record showed this treatment was not provided on: 12/28, two omissions on 12/29, two omissions on 12/30, and 12/31.

"Clobetasol ointment 0.05% apply thin layer topically to affected area twice daily." However this was not signed off as being administered any for the month of Dec.

"Bacitracin Ointment 500/gm cleanse right side groin area with normal saline and apply bacitracin to affected area topically every shift." However, this was not signed off on 7a-3pm shift on 12/12, 12/13, 12/14, 12/17, 12/18, 12/19, 12/20, 12/21, 12/22, 12/23, 12/24, 12/26, 12/27, 12/28, 12/31; and was not signed off as being administered on 3p-11p shift on 12/14, 12/23, 12/24, 12/27. 12/31; and was not signed off as being administered on 11p-7a shift on 12/12, 12/17.

Review of Resident #76's treatment record dated 1/1/19-1/31/19 had the following orders to the groin:
"Nystatin Cream apply topically to affected area twice daily." However, this was not signed off as being completed on 1/28, 1/29, 1/30, 1/31.

"Epsom Salt Gra [sic] Topical soaks to bilateral groin and ABD (Abdominal) folds q (every) shift." However, the treatment record showed this treatment was not provided on: 1/1, 1/28, 1/29, 1/30, 1/31 .

"Bacitracin Ointment 500/gm cleanse right side groin area with normal saline and apply bacitracin to affected area topically every shift." However,

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 02/25/2019

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 684	Continued From page 59	F 684		

this order was not administered on the following dates: 1/6, 1/9, 1/10, 1/11, 1/13, 1/14, 1/15, 1/25, two omissions on 1/28, 1/19, 1/30 and two omissions on 1/31.

Review of Resident #76's treatment record dated 2/1/19-2/28/19 has the following orders to the groin:
"Nystatin Cream apply topically to affected area twice daily."

"Epsom Salt Gra [sic] Topical soaks to bilateral groin and ABD (Abdominal) folds q (every) shift." The order was discontinued on 2/5/19. However, the treatment record indicates this treatment was not provided on: three omissions on 2/2, two omissions on 2/3, 2/4.

"Bacitracin Ointment 500/gm cleanse right side groin area with normal saline and apply bacitracin to affected area topically every shift." However, this order was not administered on 2/15, 2/20.

Review a physician's order dated 2/5/19 read, "diflucan 150mg po (by mouth) qd (every day) x 2 doses, nystatin powder under bilat (bilateral) breaks & abd (abdominal) folds TID (three times per day) x 14 days".

Another physician order dated 2/11/19 read, "Dry gauze to abdominal folds (BID) twice daily and prn (as needed) x 7 days; Ketoconazole cream 2% apply to bilateral groin & abd folds BID (twice a day) x 10 days. Although the Ketoconazole cream was ordered 2/11/19, it was not on the treatment record for February.

During an interview with Resident #76 on 2/21/19 at 04:31 PM, it was observed on her overbed

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 02/25/2019

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 684	Continued From page 60	F 684		

table two small cups with a cream in one and a powder in the other. When the resident was asked about it she stated "the powder is nystatin and I don't know the name of the cream but the nurses bring it to me several times a day to put on my rash." She indicates that staff bring it to her for her to apply herself.

A review of Resident #76's most recent MDS with an ARD of 12/20/18 which was a quarterly assessment indicated she scored 00 for mood interview indicating she has no sign or symptoms of depression. During resident interviews on 2/21/19, 2/22/19 and 2/25/19 she verbalized being depressed and became tearful, which she relates to the rash on her groin.

On 02/25/19 at 11:45 AM, during follow up interview with resident in her room, Resident #76 was asked if anyone followed up with her about her incontinence supplies she says "I haven't seen anyone. I don't know what they are going to do. The nurse practitioner is here and asked how I was doing, so I told her not good [RN A] kept asking about the soap I am using." Resident #76 became tearful and said "I just want to wear clothes and be out there with everyone else."

On 02/25/19 at 11:56 AM, an interview was conducted with Employee D, the Activity Director. When Employee D was asked about her activity participation she stated Resident #76 is "very independent, likes Bingo, parties, crafts, goes on Lunch Bunch". Employee D further stated when Resident #76 attends group activities she wears "regular clothes, sometimes shorts". Employee D acknowledged that her participation has decreased "slightly, she told the assistant she doesn't feel well".

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 02/25/2019

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 684	Continued From page 61	F 684		

A review of activity progress notes from 11/1/16-1/2/19 showed that "she participates in at least 3 OOR (out of room) activities each week", "was happy to resume activities and the socialization with others", "attends activities of choice 5-7 times per week", "Participates in activities of choice daily both in room and out of room", "resident continues to participate in activities of choice both independently and OOR groups on a daily basis". The review of her activity attendance indicated the Resident #76 attended 22 group activities in December, attended 17 in January and has attended 9 from February 1st until 2/24/19.

The administrator and DON were made aware of the findings on 2/25/19.

No further information was provided.

2. Resident #78 had two episodes of impaction without timely treatment, resulting in nausea and vomiting and admissions to the hospital.

Resident #78, was admitted to the facility on 10-5-05 and was readmitted on 1-1-19. Diagnoses included; stroke, anxiety, history of small bowel obstruction and hypothyroidism.

Resident #78's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1-8-19 was coded as a significant change in status assessment. Resident #78 was coded as having no memory deficits, did not refuse care,

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 02/25/2019

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 684	Continued From page 62	F 684		

and was able to make own daily life decisions. The Resident was also coded as needing extensive assistance of one to staff members to perform his activities of daily living, except for independent locomotion, both on and off the units.

On 2/20/19 at 1:30 PM: An interview was conducted with Resident #78. He stated he had weight loss due to recent "problems with intestines."

Review of the resident's bowel movements (BM) from 9-20-18 to 9-23-18 (4 days), showed Resident #78 had no BM during this time. A laxative protocol was not initiated, usually consisting of milk of magnesia, dulcolax suppository, and then enemas.

On 9-24-18, nurse's notes documented noted with nausea and vomiting three times that day. Senna 8.6 mg (milligrams) 1 tablet was ordered, which was not given. A KUB (x-ray of kidneys, ureters and bladder) revealed an "early or incomplete small bowel obstruction, with small bowel maximum diameter measuring 4.5 cm (centimeters), minimal stool." Citrate of Magnesia was ordered the same day and was given.

On 9-25-18 at the 6:33 AM, nurse's note recorded: "Resident continues with nausea but no vomiting. Unable to hear bowel sounds times 4 quadrants."

On 9-25-18 at 3:00 PM, the nurse's notes read: "Monitoring continue (sic) related to bowel obstruction and nausea and vomiting resident has bowel sounds times 4 quads sluggish noted,

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 02/25/2019

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 684	Continued From page 63	F 684		

nausea and vomiting times 2, clear liquid diet in place... alert and verbal denies abdominal pain states "its tender there" remains in bed."

On 9-25-18 at 4:44 PM, the nurse's notes read: "Resident continues nausea and vomiting noted, vomitus brown in color about 200 cc (cubic centimeters) without sediment. Nurse Practitioner (name) updated. New orders to send resident to emergency room, sent to ER at 5:30 PM." The resident was admitted to the hospital at 9:10 PM with a small bowel obstruction.

Review of the hospital records for the admission dated 9-25-18 revealed the diagnosis was "small bowel obstruction, vomiting." "came to emergency room after having nausea vomiting and abdominal pain for the last 3 days, workups done in the ER shows small bowel obstruction. "The history and physical notes, "NG (nasal gastric tube) with low suction, patient has copious amount of bloody drainage."

Review of the resident's care plan dated 5-11-15 revealed: "Potential for constipation related to decreased mobility and medications (antipsychotic). The goal was "Will have a BM at least every 3 days." Interventions included: "Enemas per physician order, record bowel movements and report abnormalities. Report signs and symptoms of constipation such as abdominal cramping, diarrhea, nausea and vomiting, no bowel movement for 3 days."

On 12/25/18, review of the resident's BM from 12/25/18 to 12/28/18 (4 days), the BM record revealed no bowel movements during this time period.

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 02/25/2019

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 684	Continued From page 64	F 684		

12/29/18 nurse's notes documented: "Writer unable to obtain urine specimen via straight (Catheter). During procedure resistance met. NP made aware, new orders to monitor output for 8 hours, if no results, send to ER." There was no documentation that the constipation was reported or treated. Documentation from 12/24-18 through 12-29-18 revealed the resident was refusing his Senna (laxative). There was no rationale provided why the resident was refusing this medication (nausea, vomiting, etc). 12/30/18 nurse's notes documented Clysis (intravenous fluids into the tissues). A KUB was ordered and showed a small bowel obstruction. The resident was readmitted to the hospital 12-31-18 for a small bowel obstruction. There was no documentation his constipation was recognized or treated until 12/30/18.

Review of the hospital records for this admission date of 12/30/18, the discharge diagnosis was "acute urinary retention and small bowel obstruction." The final report read: "Patient had a poor appetite last 4 days, abdominal swelling has gotten worse, is nauseated he threw up once as well."

On 2/22/19 at 11:05 AM an interview with an LPN (licensed practical nurse) was conducted... She stated the resident had problems with his bowels and had been diagnosed with a bowel obstruction. She stated the bowel protocol as followed: "We monitor BM's and if no BM for 3 days, we let the MD know and we can give prn laxatives." She went on to state there is a flow sheet that the unit manager checks every day to see who is flagging for no BM for three days.

On 2/22/19 at 11:10 AM an interview with the unit

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 02/25/2019

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 684	Continued From page 65	F 684		

manager a registered nurse about the BM monitoring was conducted. She stated it will flag on the "dash board", and she would know who is flagging. She stated the system will flag due to no BM's for 3 days.

On 2/22/19 at 11:44 AM Review of the policy for bowel protocol read as followed: "Assessment and Recognition: "As part of the initial assessment, the staff and physician will help identify individuals with previously identified lower gastrointestinal tract conditions and symptoms. This should include a review of gastrointestinal problems during any recent hospitalizations, results of previous barium studies, endoscopies, etc." There was no laxative protocol for no BM for 3 days.

On 2/25/19 at 3:10 PM The Administrator, DON (director of nursing) and corporate nurse were informed of the concerns.

3. Resident #260 did not receive his antifungal for complaints of thrush timely.

On 2/20/19 at 2:26 PM: During the initial interview, the resident stated, "I haven't gotten my swish/swallow for "days." Resident stated he had thrush; he opened his mouth and the tongue has cracks on it. He stated it was making it hard for him to eat.

On 2-20/19 at 3:29 PM Review of the clinical record (SBAR- situation, background, assessment, review) dated 2-16-19 addressed: "Change in condition noted to resident had complaints of certain areas in his mouth bothers him when he is eating anything... mouth has

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 02/25/2019

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 684	Continued From page 66	F 684		

areas of redness and signs of irritation." No recommendations were obtained.

On 2-18-19, there was a physician's order for Diflucan (treatment for thrush) and Nystatin swish and swallow four times daily. The swish and swallow was noted on the MAR (medication administration record) but had not been given. On the back of the MAR, it was noted the medication was "not available" for 6 doses.

Later on 2-20-19 Resident #260 was observed at the nurse's station, asking for the swish and swallow.

On 2-20-19 (No time on order) a physician's order for Clotrimazole (another treatment for thrush) twice daily for thrush.

On 2-21-19 at approximately 9:15 AM, Resident #260 was observed receiving the Clotrimazole for treatment of his thrush.

4. The facility staff failed to assess and

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 02/25/2019

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 684	Continued From page 67 implement bowel protocol for Resident #210. Resident #210 was admitted to the hospital on 11-16-18, and discharged to the facility on 11-19-18. Resident #210 stayed in the facility until 11-26-18, and was discharged back to the hospital on 11-26-18. Diagnoses for Resident #210 at the time of hospitalization on 11-16-18 included, bruising of the thorax from one fall in the last 3 months at home, urinary tract infection, spinal stenosis and cervical degenerative disk disease, high cholesterol, hypertension, arthritis, history of kidney stones, and depression. Review of the nursing and physician progress notes revealed that upon admission to the facility on 11-19-18, the admission nursing assessment documented that the Resident was oriented to person, place, and time. Her respiratory status was without difficulty and 98% oxygen perfusion on room air. The Resident was continent of bowel and bladder, with normal bowel sounds in all 4 quadrants. The Resident required only 1 staff assistance with activities of daily living such as ambulation (walking), bed mobility, bathing, dressing, eating, toileting, and transfers. The Resident was coded as having no weight loss during her stay. Resident #210's Minimum Data Set (MDS, an assessment protocol) was an admission assessment with an Assessment Reference Date (ARD) of 11-26-18. The document was not completed until 12-1-18. Resident #210 was coded on this document (after her discharge) with a Brief Interview of Mental Status (BIMS) score, of unable to complete, with severe cognitive impairment. Resident #210 was coded as requiring extensive to total assistance of one to	F 684		

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 02/25/2019

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 684	Continued From page 68	F 684		

two staff members for all activities of daily living at the end of her stay in the facility. The Resident was coded as having no pain during this stay, and, as having had 2 falls during this stay. Resident #210 was coded as now incontinent of bowel and bladder. The Resident was on a "Regular, with thin liquids, diet."

The Resident's weight records were reviewed from the hospital and facility, and revealed an unexpected and undesired significant weight loss. Those weights follow below.

Hospital discharge on 11-19-18 (173.63 pounds)
Facility admission on 11-19-18 (172.4 pounds)
Discharge from facility on 11-26-18 (151.6 pounds) indicating a loss of 20 pounds in 1 week.

Meal consumption records were reviewed and indicated that the Resident consumed the following;
Breakfast - 50-75% every day including 11-26-18.
Lunch - 50-75% 11-20-18 through 11-23-18, 25-50% on 11-24-18, nothing on 11-25-18, and 50-75% on 11-26-18.
Dinner - 50-75% 11-20-18 through 11-23-18, nothing 11-24-18 through 11-26-18.

Progress notes indicated that the Resident was unresponsive on 11-26-18 from 10:00 a.m., until discharge at 2:00 p.m., and could not have consumed any meals that day. The bedtime snack record also indicated no consumption for 11-21-18, 11-24-18, and 11-25-18.

The Bladder and Bowel continence records indicated that the Resident became completely incontinent of bowel and bladder on 11-24-18. The record goes on to show that the Resident did

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 02/25/2019

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 684	Continued From page 69	F 684		

not have any urine production on 11-24-18, and 11-25-18 on the 3p.m.-11p.m. shift, and on 11-25-18 on the 11p.m.-7a.m. shift. The bowel record documented that the Resident had a "medium bowel movement every day shift from 1:00 p.m. to 3:00 p.m." with the exception of 11-23-18 when there was no bowel movement. No other shifts record any other bowel movements occurring at any other time or day the descriptions were exactly identical, and documented by the same individual every day during this stay.

Further review of the nursing and physician progress notes revealed the following pertinent findings in chronological order;

11-19-18 - Admission - 3:30 p.m., Resident was oriented to person, place, and time. Her respiratory status was without difficulty and 98% oxygen perfusion on room air. The Resident was continent of bowel and bladder, with normal bowel sounds in all 4 quadrants. The Resident required only 1 staff assistance with activities of daily living such as ambulation (walking), bed mobility, bathing, dressing, eating, toileting, and transfers.

11-20-18 - Resident continues to adjust well, no discomfort or distress noted, per nursing.

11-20-18 - The nurse practitioner was in to see the Resident that day and documented left flank and abdominal pain with movement or palpation, but improving, urinary tract infection resolving, alert and oriented to person and place, follows commands speaks little English, is Spanish speaking, and granddaughter (daughter) translates, no respiratory problems, no weight

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 02/25/2019

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 684	Continued From page 70	F 684		

loss, and is tolerating diet without any issues.

11-20-18 - the social worker was in to see the Resident and documented that the granddaughter posted her phone number in the room so staff could call her as needed and use her as a translator.

11-21-18 - The doctor was in to see the Resident, and documented the Resident had no acute findings and would receive physical therapy for ambulation and stair climbing.

11-21-18 - Nursing notes document ambulating with assistance from staff and continent of bowel and bladder, and a new order was received to decrease pain medication from 1-2 tablets of 50 milligram tramadol every 6 hours as needed for pain, to one tablet 4 times per day on a routine schedule.

11-22-18 - Nursing notes indicate a change in condition due to 2 falls, occurring at approximately 4:00 a.m., and at 6:50 a.m. Resident with no new injuries noted, able to make her needs known, eating meals with no assistance needed. A left hip x-ray with KUB (kidneys/ureters/bladder) view was ordered and obtained. The result was normal with no problems.

11-23-18 - the nurse practitioner was in to see the Resident who has a cough and is producing mucus, and has indigestion. The nurse practitioner documented "Prilosec for indigestion", and "speech following". No speech therapy orders were ever received, and no speech therapy notes existed in the clinical record according to examination of the clinical record by

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 02/25/2019

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 684	Continued From page 71	F 684		

surveyors, and a statement by the medical records staff member, "there are none".

11-24-18 - The Resident has a productive cough/congestion, thick phlegm, wheezing, shortness of breath, abnormal lung sounds, and oxygen saturation perfusion is at 87% (dangerously low), oxygen is ordered via nasal cannula at 2 liters per minute for shortness of breath, Duoneb inhaled medicine via nebulizer is ordered to open airways, mucinex is ordered to relieve mucus and a chest x-ray is ordered to be performed STAT (immediately) at 1:00 p.m. The chest x-ray was completed and results obtained at 4:00 p.m. that day, which showed mild congestive heart failure. The physician ordered lasix 40 milligrams every day, on that day, however, the Resident did not receive it until the following day. The Lasix was in the building in the emergency box, and available to be given, when it was ordered. At 10:45 p.m. the doctor documented general weakness ongoing, and resident was worse.

11-25-18 - Change in condition, Resident eating less than 50% of meal in 24 hours, no diagnosis of heart failure, no respiratory issues noted, new order for daily weights, notify MD (doctor) of weight gain greater than 3 pounds per day or greater than 5 pounds per week. Mighty shake supplements were started, to be given with each meal, three times per day. The narcotic pain medication Tramadol was changed back again to one 50 milligram tablet every 6 hours as needed, from the 4 times per day routinely which was started on 11-21-18.

11-26-18 - The diet order was changed from regular to no added salt. No dietician evaluation

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 02/25/2019

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 684	Continued From page 72 was completed for this Resident until 11-26-18, at 1:14 p.m., just before discharge. The dietician note states not able to ascertain weight status because of "refusals/omissions". However, the Resident had a weight obtained that morning at 6:47 a.m., and revealed weight loss. The note goes on to say "average meal intake 50-75%." Meal consumption records indicated that the Resident consumed that at breakfast, however, at lunch the Resident consumed 25-50% on 11-24-18, and nothing on 11-25-18, and 11-26-18. At dinner nothing 11-24-18 through 11-26-18. 11-26-18 - The Social worker wrote at 10:35 a.m., that the Resident was non-responsive to questioning, and her eyes were closed. At 2:10 p.m., - nursing documented diagnosis of heart failure, compared to baseline the following was observed "decreased level of consciousness, decreased mobility, needs more assistance with activities of daily living." 11-26-18 - The doctor wrote at 2:52 p.m., that the Responsible party was at bedside, poor appetite - ongoing, altered mental status, non-verbal, no command following, deficits noted, diminished lung sounds, send to ER (emergency room) for evaluation, on lasix x 3 days, however, she had only taken the 40 milligrams of lasix 2 days. The nursing home transfer form indicated the Resident was sent to the hospital at 3:00 p.m., on 11-26-18. Hospital records were reviewed for the admission on 11-26-18. The records revealed "(The Resident) was "a week ago walking and talking and now is bedridden and not talking/eating." "Spanish speaking only, brought in due to	F 684		

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 02/25/2019

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 684	Continued From page 73	F 684		

unresponsiveness." "Last meal Saturday (11-24-18) in the morning very small amount." "Admitted with hyperkalemia (high blood potassium) of 7", (normal is 3.5-5.0, a reading of 7 is considered severe hyperkalemia). "Creatinine sodium and chloride were also high, and a "Kayexalate enema was administered to bring the numbers down, twice, but with poor results as the Resident was so constipated." "The Resident had an abdominal x-ray on admission which shows generalized impaction." "After D50 (dextrose intravenous infusion) and insulin, (the Resident was not diabetic this was to decrease the high minerals in her blood) the Resident improved." The Resident was started on fluid resuscitation for dehydration from not consuming fluids, and began to have a good urinary output. Her abdomen was described as soft, tender, and distended, a frontal radiograph of her abdomen was obtained and stated "No bowel obstruction" (such as cancer etc), "Large quantity of fecal material mainly in the ascending, transverse, and descending colon."

The Resident's care plan was reviewed and revealed no dietary care plan until 11-27-18, after the Resident was discharged on 11-26-18, and no bowel care plan at all. There was an incontinence care plan which stated assist as needed with incontinence. The Resident was not incontinent on admission.

The facility policy for Bowel disorders was reviewed and revealed That the staff and physician will identify risk factors related to bowel dysfunction such as recent antibiotic use, (diuretics, antidepressants) medications that may cause dysmotility (movement, narcotics), symptoms such as abdominal pain, presence of

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 02/25/2019

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 684	Continued From page 74 cramps or bloating, localized tenderness." The nurse shall assess/document/report signs of dehydration (such as) altered levels of consciousness, lethargy, dizziness, recent change in mental status, dry mucus membranes, decreased urine output." (failing to eat or drink). In summary, the Resident was administered opioid, diuretic, cardiac, prilosec, mucinex, and antibiotic medications on a routine basis. The Resident had become immobile, and stopped eating and drinking, and no dietary or bowel management programs had been instituted for this Resident. The Resident stopped eating and drinking on 11-24-18, lost significant weight, weakening the Resident, she became bowel impacted, and dehydrated causing the need for re-hospitalization, and treatment. On 2-25-19 the Administrator and the Director of Nursing were informed of the findings. No additional information was submitted.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(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	F 686		4/2/19

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 02/25/2019

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 686 Continued From page 75

new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to, for one resident (Resident 143) in a survey sample of 59 residents, to ensure wound care was provided in a manner to prevent infection.

The wound care nurse did not clean her hands between moving from the sacrum to the heel.

The findings included:

Resident #143, was admitted to the facility on 5-5-18 and was readmitted from the hospital on 12-6-18. Diagnoses included: dementia, weight loss, anemia, diabetes and high blood pressure.

Resident #143's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-6-18 was coded as a significant change in status assessment. Resident #143 was coded as having severe memory deficits, and was unable to make own daily life decisions. The Resident was also coded as needing extensive to total assistance of one to staff members to perform activities of daily living, such as bed mobility and eating.

On 2/21/19 at 10:41 AM Wound care observation was conducted by the wound care nurse. The tube feeding was off. The procedure was explained to the resident. Toilet room is now clean. Hand sanitizer used. Soiled clean area designated. Has pants on in bed, not pulled up. Has been medicated for pain. Brief saturated.

F 686

Corrective Action for those residents found to be affected by the alleged deficient practice.
Wound care nurse received education regarding infection control procedures during treatment administration.

Corrective Actions taken for residents with potential to be affected by alleged deficient practice.
Residents admitting into the facility with wounds have the potential to be affected. Director of Nursing completed review on residents with wounds to ensure wound nurse was adhering to infection control practices during wound care treatment observations.

Systemic Changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the Director of Nursing to licensed nursing personnel on ensuring that infection control procedures are maintained during wound care treatment administration.

Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of Nursing will complete wound care observation audits 3x week x 4 weeks and monthly x 2 months to ensure infection control practices are being maintained.

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 02/25/2019

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 686	Continued From page 76 Right buttock dressing off, area clean with granulation tissue. No drainage or odor. Has another small area, open, granulating. Cleansed areas with normal saline. The wound doctor is calling both areas "MASD" -moisture associated skin damage..." Medihoney applied. After completing the sacral wound and the gloves were removed, the hands were not cleaned. The right boot was removed, hard eschar noted to entire heel... Painted with Betadine. The boot reapplied. The left boot was removed. No wounds evident. 02/21/19 01:04 PM Review of the clinical record revealed wounds were present on readmission from hospital 2-12-19. On 2/25/19 at 3:10 PM: The Administrator, DON (director of nursing) and the corporate nurse were present, informed of above findings.	F 686	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. Date of compliance-4/2/19	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688		4/2/19

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 02/25/2019

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 688	Continued From page 77 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review, and facility documentation, the facility staff failed to provide services to provide a left hand roll as ordered by physician to prevent reduction in range of motion for one resident (Resident #29) in a sample size of 59 residents. The findings include: Resident #29, an 85-year old female was admitted to the facility on 05/27/2016. Diagnoses include but not limited to cerebrovascular disease, Alzheimer's disease, aphasia, contracture left hand, and diabetes. Resident # 29's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/07/2018 was coded as an annual assessment. Resident # 29 was not coded with a Brief Interview of Mental Status (BIMS) score but cognitive skills for daily decision-making were coded as severely impaired. Functional status for dressing and toileting were coded as requiring extensive assistance from staff. Functional status for eating and personal hygiene were coded as total dependence on staff. On 02/20/19 at 01:49 PM, Resident #29 was observed dressed and seated in a high back wheelchair. On 02/21/19 at 08:08 AM, Resident #29 was observed lying in bed with her covers pulled up to mid-chest level. Resident was awake and the TV was on.	F 688	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #29 hand roll was immediately placed in the left hand as ordered. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents admitting into the facility with contracture device orders have the potential to be affected. Review completed by Director of Nursing on residents with contracture device orders to ensure they are in place as ordered. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nursing personnel on ensuring that residents with contracture devices are in place per physician order. Monitoring of corrective action to ensure the alleged deficient practice does not recur. Director of Nursing will complete audits residents with contracture devices 3x week x 4 weeks and monthly x 2 months. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary	

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 02/25/2019

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 688	Continued From page 78 On 02/21/2019 at approximately 10:00 AM, the clinical record was reviewed. A current physician's order in the date range of 02/01/2019 through 02/28/2019 documented, "Patient to wear left hand roll at all times except during ADLS (activities of daily living) as tolerated." A care plan intervention initiated on 06/01/2017 and revised on 01/11/2018 documented, "Resting hand splint roll as tolerated (left hand contracture)" under the focus entitled, "ADL (activities of daily living) Self care deficit related to disease process (Dementia/Alzheimer) (sic), physical limitations s/p (status post) CVA (cerebral vascular accident) Refuses showers at times" Another intervention initiated on 04/10/2018 (no revisions) under this same focus documented, "Patient to wear wash cloth roll in left hand at all times except during ADLs as tolerated." On 02/21/19 at 12:50 PM, Resident #29 was observed lying in bed and the TV was on. A left hand roll was not visualized. On 02/22/19 at 12:40 PM, Resident #29 was observed sleeping in her bed. A left hand roll was not visualized. On 02/25/2019 at 2:15 PM, an interview with RN C, the MDS coordinator, was conducted. When asked about the restorative nursing plan for Resident #29, RN C looked for documentation regarding Resident #29 then stated she didn't see any documentation about a restorative program for Resident #29. When asked if Resident #29 had a contracture of left hand, she stated, "Yes."	F 688	additional interventions. Date of compliance-4/2/19	

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 02/25/2019

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 688	Continued From page 79 When asked about the purpose of restorative nursing for Resident #29, she stated, "To prevent further contractures." On 02/25/2019 at approximately 2:25 PM, RN A, RN C, and this surveyor entered Resident #29's room. Upon entrance into Resident #29's room, RN C looked at Resident #29 and stated that her legs are also contracted. Resident #29 did not have a left hand roll in place and her fingers were flexed consistent with contractures. Resident #29 winced as RN A gently extended left fingers. The left palm appeared clean with no open areas. When asked about padding for left hand, RN A stated they use a rolled washcloth in her left hand but "she pulls it out." A washcloth was not seen in the bed and RN A stated she would go "find a washcloth" to place in Resident #29's left hand. On 02/25/2019 at approximately 3:30 PM, RN C presented a document entitled "Restorative Nursing Program Monthly Review July 31, 2016." It contained a list of residents with individualized information regarding restorative care. For Resident #29, it was documented, "Discontinue RNP (restorative nursing program) services due to non-compliance effective 07/18/16." The facility policy entitled "1.2 Restorative Range of Motion Program" was reviewed. Under Process, it was documented, "1. A nursing evaluation will be done on all residents on admission, readmission, after a significant change in condition, annually, or as otherwise indicated." On 02/25/2019 at approximately 6:30 PM, the Administrator and DON were notified of findings and offered no further information or	F 688		

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 02/25/2019

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 688	Continued From page 80 documentation.	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation the facility failed to ensure Residents were free from accidents and hazards for 2 Residents (#212 and #72) in a survey sample of 59 Residents resulting in harm for Resident #212. 1. For Resident #212 the facility failed to adequately supervise and monitor closely for pulling at dialysis port resulting in Resident pulling off the caps of the port and subsequently bleeding out which resulted in death. This is harm. 2. For Resident #72, the facility staff failed to follow physician's orders for "No straws" associated with aspiration risk. Resident #72 was observed drinking water at bedside, unsupervised, through a straw. Also, the discharge diet recommendation from occupational therapy dated 11/26/2018 included supervision.	F 689	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #212 has since been discharged from the facility. Resident #72's physician order and careplan were updated to reflect usage of straws. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents admitting into the facility with dialysis catheters and who are aspiration risk have the potential to be affected. Review completed by Director of Nursing on residents with dialysis catheters to ensure proper supervision and monitoring are in place and residents who are aspiration risk physician orders and careplans are updated to reflect the plan of care. Systemic Changes put into place to ensure the alleged deficient practice does	4/2/19

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 02/25/2019

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 689

Continued From page 81

The findings include:

1. For Resident #212 the facility failed to adequately supervise and monitor closely for pulling at dialysis port resulting in Resident pulling off the caps of the port and subsequently bleeding out which resulted in death. This is harm.

Resident #212 an 87 year old woman admitted to the facility on 4/24/15 with diagnoses of but not limited to (End Stage Renal Disease) ESRD requiring Hemodialysis three (3) days a week, (Resident had Hemodialysis Port in Upper Right Chest) heart failure unspecified, Type 2 Diabetes, anxiety, major depressive disorder, Depression, Psychosis, Dementia and Anemia.

Resident #212's most recent (Minimum Data Set) MDS (screening tool) was a quarterly completed on 10/19/18 and coded Resident as having a (Brief Interview of Mental Status) score of 99 meaning Severe Cognitive Impairment she was also coded under G 0110 as #3 Extensive Assistance- Resident involved in activity, staff provide wt. bearing support and Support was coded as #2 One person physical assist.

On 2/21/19 a clinical record review was conducted.

Resident #212's Care Plan showed the following:

FOCUS:
Resistive/noncompliant with treatment /care/pulling at dialysis port while at dialysis/LTCF, removing oxygen related to cognitive impairment and anxiety [initiated 7/7/16].

F 689

not recur.
Education completed by the Director of Nursing to licensed nursing personnel on ensuring that residents with dialysis catheters are being monitored and documented on and that resident physician orders with aspiration risk accurately reflect the current plan of care.

Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of Nursing will complete audits on residents with dialysis catheters and who are aspiration risk with straw orders 3x week x 4 weeks and monthly x 2 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.

Date of compliance-4/2/19

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 02/25/2019

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 689	Continued From page 82	F 689		

(Dated 7/7/16 no revision until 11/7/19 after resident expired)

INTERVENTIONS:
Allow for flexibility in ADL routine to accommodate mood preferences and customary routine
Ask physician to explain the need for treatment
Elicit family input for best compliance
Provide education about Risks of not complying with therapeutic regimen
Provide non care related conversation proactively before attempting ADL's
Psych consult as needed.
(Dated 7/7/16 no revision until 11/7/19 after resident expired)

On page 23 of the care plan the following was entered on 8/1/16:

FOCUS:
At risk for behavior symptoms related to Dementia with psychosis. Resident has a history of pulling at port, Scratches self.

INTERVENTIONS:
Administer medication per physician order
Attempt psychotropic drug reduction per physician order
Observe for mental status/behavioral changes when new medication is started or with change in dosage
Psych referral as needed
Use consistent approaches when giving care
Wander guard bracelet (canceled on 8/29/17)

According to a progress note dated 10/26/18 @ 11:45 AM the Dialysis Center phoned the facility at 6:20 AM to inform them that Resident #212

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 02/25/2019

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 689		F 689		

Continued From page 83
was "confused and pulled her bandage off."

According to progress notes, a care plan meeting was held on 10/31/18 at 6:27 AM. The note stated the following departments were present. Social Services, Nursing Case Manager, and it stated the Patient Representative was invited but did not attend.

The note goes on to say the topics discussed were Discharge Goal, Advanced Directives, Cognition/Orientation Mood and Behavior, Social Service needs, Medications and Treatments, Continence/ Elimination, Risk for skin breakdown, Communication, Pain management, Nutrition,, ADL function, Risk for Falls,/safety activities.

The summary stated "[Interdisciplinary Care Plan] IDCP team met to review plan of care. Care plans updated as needed. Team to remain available as needed.

On 2/21/19 during clinical record review it was noted that no changes were made to the care plan on 10/31/19 as a result of the care plan meeting or thereafter.

A progress notes dated 11/1/18 at 10:50 AM stated:

Change in condition noted related to removing top from shunt port bleed out and remove scab from upper left leg above knee. This change in condition started on 11/1/18. Since this started she has stayed the same. Other relevant information RP [Responsible Party] RP N states "She has a History of doing this it's not the first time at home you walk in her bedroom and blood

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 02/25/2019

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 689	Continued From page 84 would be everywhere". According to note, the Nurse Practitioner was informed on 11/1/18 at 11:00 AM and gave orders only to clean and redress the right upper chest [port site] and dress (as needed) PRN. Also to clean area to knee and redress daily. The "Behavioral Tracking Sheets" for 9/2018 code Resident and #7 Pulling enteral feeding tube" she is coded as O (indicating number of times pulling at tube) every shift for entire month. For October and November the behavior tracking sheets do not list #7 pulling tubes as a behavior problem in spite of the incident on 11/1/19. A progress notes on 11/6/19 at 05:30 am stated: "Resident last rounded on at 4:05 AM. Dressing to dialysis port dry and intact. Resident acknowledged staff presence by opening eyes while site being checked". Progress note on 11/6/18 at 05:30 am stated: "Change in condition noted related to Resident noted laying in a pool of blood at 0530 when phlebotomist entered to draw blood. Writer entered room noted resident 911 without respirations or pulse. This change in condition started on 11/6/18. Since this started it has stayed the same. Other relevant information 911 called". According to Facility Reported Incident (FRI) dated 11/9/18 Resident #212 had a BIMS of 99 and requires minimal assistance with care. The FRI also stated:	F 689		

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 02/25/2019

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 689	Continued From page 85	F 689		

"Upon investigation and based on the findings per family, dialysis center, and the staff at [Facility Name] the resident had a history of "picking" at dialysis site and removing dressing. [Resident name] removed her dialysis dressing and port caps causing her to bleed excessively. We do not feel evidence supports any other cause that contributed to this unfortunate event of [Resident Name]."

On 2/21/2019 at 5:00pm, an interview with the DON was conducted. The DON stated she was not in the facility when the Resident was there The DON was asked what the expectation for nurses and CNA's for a Cognitively Impaired Resident with a known history of pulling at her dialysis port. The DON stated she wound expect frequent rounding, a bandage might cause her to pick at it more. When asked what is frequent, the DON stated every 2 hours.

On 2/21/19 at 5:10 pm an interview was conducted with the Administrator. The administrator stated that they do not have any other cognitively impaired residents that pull at the dialysis port. She stated she was aware the staff made routine rounds every two hours on all Residents.

On 2/21/29 520 pm, an interview was conducted with RN A. When asked what the facility did about the Resident pulling at the dialysis port, RN A stated, "we used to wrap it in gauze and tape it." When asked if it was a deterrent to the Resident, RN A stated, "Not really it slowed her down but didn't really stop her from doing it." When asked is resident education an appropriate intervention for a Resident with a BIMS of 99, RN

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 02/25/2019

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 689	Continued From page 86	F 689		

A answered, "no we could tell her but she wouldn't understand."

On 2/25/19 the Administrator was made aware of the issue and no further information was provided.

2. For Resident #72, the facility staff failed to follow physician's orders for "No straws" associated with aspiration risk. Resident #72 was observed drinking water at bedside, unsupervised, through a straw. Also, the discharge diet recommendation from occupational therapy dated 11/26/2018 included supervision.

Resident #72, a 74-year old female, had an initial admission date of 03/01/2017. Diagnoses include cerebrovascular disease, cerebral infarction, hemiplegia, dysphagia (oropharyngeal phase), schizophrenia, schizoaffective disorder, and a history of pneumonitis due to inhalation of food and vomit.

Resident #72's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/03/2019 was coded as an annual assessment. Resident #72's Brief Interview for Mental Status (BIMS) was coded as "9" out of possible "15" indicative of moderate cognitive impairment. Functional status for eating was coded as requiring limited assistance from staff. Functional status for dressing, toileting, and personal hygiene were coded as requiring extensive assistance from staff.

On 02/21/2019 at 8:13 AM, Resident #72 was observed seated in front of her tray table in her

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 02/25/2019

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 689	Continued From page 87	F 689		

room. Her breakfast tray and water pitcher (with a straw inserted through the top of it) was on the tray table. A spoon was on the plate and the plate was empty except for some small bits of scrambled eggs and sausage. The milk carton was open and empty on the tray. The apple juice was unopened. Resident #72 was observed picking up her water pitcher and sipping water from it through the straw. There was no staff in the room. The tray card had Resident #72's name on it and under Texture, it was documented, "Mech (mechanically) Altered (NDD2)(National Dysphagia Diet, Level 2) Bread Allowed." Under Special Diets, it was documented, "HCC/CCHO (high calorie consistent carbohydrate)." Under Adaptive Equipment, it was documented, "No straws."

On 02/22/2019 at 8:32 AM, Resident #72 was observed sleeping in her bed, lying on her right side. She was wearing a pink shirt and covered with her blankets. The tray table had her water pitcher on it with a rigid plastic straw inserted through the top of the pitcher.

On 02/22/2019 at 8:35 AM, the physician's orders were reviewed. A current order with a range of 02/02/2019 through 02/28/2019 documented under Diets, "Mech (mechanically) altered (NDD2), HCC/CCHO, thin (liquids), no straws."

On 02/22/2019 at 8:44 AM, CNA B was asked where she finds information about what Resident #72 needs for eating and she stated, "The kardex." Looking at the Kardex together, we saw it was documented, "No straws." When CNA B was asked why Resident #72 could not have straws, she stated, "Because she could aspirate."

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 02/25/2019

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 689 Continued From page 88 F 689

On 02/22/2019 at 9:40 AM, Resident #72 was observed sitting up in front of her tray table. There was bits of French toast and sausage left on the plate. The water pitcher with a straw was also on the tray and the end of the straw had a lipstick stain on the end. There was no staff in the room. An aide entered the room to take the tray away and placed the water pitcher (with the straw inserted through the top) in front of Resident #72.

On 02/22/2019 at 12:47 PM, RN A and this surveyor reviewed the current physician's diet order (including "no straws") together. RN A and this surveyor then entered Resident #72's room. The water pitcher with a straw was on Resident #72's tray table. When asked about the water pitcher, RN A picked up the water pitcher and placed it back on the table and stated, "She can have thin liquids." When asked about the straw, she stated, "oh, the straw." RN A removed it from the water pitcher, and threw it in the trash.

The speech therapy notes were reviewed.
The resident was seen in August 2018 by speech therapy. The referral stated to see if the resident was on the least restrictive diet. At the time the resident was on mechanically altered diet. At the end of speech therapy that ranged from 08/16/2018 to 10/16/2018, the discharge plan dated 10/18/2018 documented, "Discharge planned for this patient. Recommendations discussed with patient and/or caregivers include Regular textured solids and thin liquids. Swallow strategies to include alternate solids/liquids and take small bites/sips."

For speech therapy services with a range of 11/01/2018 through 11/23/2018, a speech therapy note dated 11/01/2018 documented in the

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 02/25/2019

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 689	Continued From page 89 'Reason for Referral' section, "The LTC (long-term care) resident was recently hospitalized for UTI (urinary tract infection) at which time she was also treated for aspiration PNA (pneumonia). Readmitted on mechanically altered diet and thin liquids. Skilled Speech Therapy evaluation is indicated to assess swallowing function and ensure patient is on safest and least restrictive diet." Under Prior Hospitalization, the dates listed were 10/21/2018 to 10/30/2018. In the 'Underlying Impairments' section, it was documented, MBS (modified barium swallow) completed inpatient on 10/30/2018: flash penetration of thin liquid trial by straw, no penetration/aspiration of other trials, thin, nectar, puree, or solid; Rec'd (recommended) mechanically altered diet with thin liquids and no straws. Limited natural dentition." A speech therapy note dated 11/26/2018 documented under 'Discharge Plans & Instructions', "Discharge planned for this patient. Recommendations discussed with patient and/or caregivers include NDD2 mechanically altered solids and thin liquids with supervision for carryover of compensatory swallow strategies." On 02/25/2019 at approximately 10:15 AM, an interview with Employee F, a speech therapist, was conducted. As Employee F looked at Resident #72's electronic medical record, she stated that Resident #72 was seen by speech therapy beginning 08/16/2018 to evaluate if Resident #72 was on the least restrictive diet. Employee F stated that Resident #72 was on a mechanically altered diet at the time. Employee F stated that upon discharge from speech therapy services on 10/16/2018, it was recommended	F 689		

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 02/25/2019

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 689	Continued From page 90 that Resident #72 advance to a diet of regular textured solids and thin liquids. When asked about the physician's diet order that included "no straws", Employee F stated that must be based on the recommendation from the results of the modified barium swallow when (Resident #72) was an inpatient. She also verified that the speech therapy diet recommendation on 11/26/2018 was mechanically altered diet with supervision. The current physician's orders were reviewed. There was no order for diet with supervision. The care plan was reviewed. For the focus of "Imbalanced nutrition and fluid imbalance", an intervention initiated on 05/24/2017 and revised on 01/07/2019 documented, "Provide diet as ordered NDD2/bread allowed HCC/CCHO, thin, NO STRAWS." An intervention initiated on 05/24/2017 documented, "Encourage and assist as needed to consume foods and/or supplements and fluids offered at and between meals." On 02/25/2019 at approximately 6:30 PM, the Administrator and DON were notified of findings and offered no further information or documentation.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(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. This REQUIREMENT is not met as evidenced	F 697		4/2/19

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 02/25/2019

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 697	Continued From page 91 by: Based on Resident interview, staff interview, clinical record review and facility documentation the facility failed ensure adequate pain management for 1 Resident (Resident # 151) in a survey sample of 59 Residents. For Resident #151, the facility failed to address the pain she was experiencing in her mouth and face, in spite of her complaining to facility staff and her Psychiatric Nurse Practitioner (NP). The findings include: Resident #151 a 96 year old woman was admitted to the facility on 10/09/14 with diagnoses of but not limited to Asthenia (Muscle Weakness), Hypertension, Anemia, Dysphagia, Hypothyroidism, Trigeminal Neuralgia, and Dementia. The most recent (Minimum Data Set) MDS was a quarterly dated 2/1/19 and coded the Resident as having a (Brief Interview of Mental Status) BIMS score of 6 indicating severe cognitive impairment. On 2/20/19 at 12:30 PM, during initial tour of the building an interview was conducted with Resident #151. Resident #151 stated, "My teeth hurt and whatever they are giving me don't help". When asked if she had been to the dentist she stated "No I haven't been to a dentist in years and that's just what I need to do." On 2/20/19 at 12:45 am, an interview was conducted with LPN F. LPN F stated that Resident # 151 complains about her teeth hurting but it's really not her teeth she gets treated with medication for Trigeminal Neuralgia.	F 697	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #151 has an appointment with dentist and neurologist for diagnosis management. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents admitting into the facility have the potential to be affected. Review completed by Director of Nursing on residents on a pain regime to ensure that their current pain management plan is sufficient and addressed as applicable. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nursing personnel on ensuring that residents with complaints of pain are provided the necessary pain management interventions per policy and procedure. Monitoring of corrective action to ensure the alleged deficient practice does not recur. Director of Nursing will complete audits of residents with pain management regimes 3x week x 4 weeks and monthly x 2 months. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process	

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 02/25/2019

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 697	Continued From page 92 On 2/20/19 at 12:55 am, an interview was conducted with the Psychiatric Nurse Practitioner who stated " Yes [Resident 151] is one of my patients, and in my opinion she is cognitively aware enough to report accurately that she is in pain and the location of the pain and if it is ongoing." A clinical record review was then initiated and it was found that the Resident has a history of Trigeminal Neuralgia, (A condition which affects the trigeminal facial nerve, is very painful and causes mouth, jaw, ear and facial pain) A Psychiatric Evaluation dated 11/29/18 read, "She reports having no conflict with staff or other residents. Patient was also concerned with trigeminal neuralgia symptoms in her face." "When asked to rate her pain patient was not able to cognitively perform this and was only able to provide a concrete response such as "BAD." A Psychiatric Evaluation dated 1/24/19 stated, "Today patient reports having some dysphoria in the context of facial pain. She states having periodic sadness and anxiety however this is basically linked to her facial pain complaints." Resident #151's care plan was reviewed. The care plan stated Resident #151 was at risk for pain due to Trigeminal Neuralgia. However in spite of repeated complaints of pain the Resident was not taken to a dentist to rule out dental pain. Or to the Neurologist to follow up on Trigeminal Neuralgia pain. The review of the Medication Administration Record shows Resident #151 has an order for	F 697	for tracking/trending and any necessary additional interventions. Date of compliance-4/2/19	

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 02/25/2019

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 697	Continued From page 93 (AS NEEDED) PRN Tylenol and PRN Diclofenac (anti-inflammatory) that was administered only 2 times in the month of January and not at all in February in spite of the complaints of pain. Pain monitoring sheet was coded with all 0 indicating no pain even on the 2 days she received the PRN medication. On 2/21/19 it was requested from facility, any consults Resident #151 has had with a Dentist or Neurologist. On 2/22/19 it was requested again from DON any consults Resident #151 has had with a Dentist or Neurologist. On 2/25/19 an interview was conducted with the DON. The DON stated "I have looked myself and there are no Dental or Neurology consults that I can find in the chart or in the computer system." When asked if she was aware the Resident was having mouth pain, the DON stated, "well she does take medication for her Trigeminal Neuralgia". When asked how she could be sure it was the Trigeminal Neuralgia or a Toothache, the DON stated she could not be sure. When asked if Resident #151 had a routine dental check in the past year, the DON stated that she had not. When asked if she has had a follow up for her Trigeminal Neuralgia in the past year, the DON stated "no." On 2/25/19 at the end of day conference, the Administrator was made aware and no further information was provided.	F 697		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)	F 726		4/2/19

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 02/25/2019

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 726	Continued From page 94 §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation the facility failed to ensure staff have the appropriate competencies and skills sets for 6 of 7 employees, (CNA's B, I, K, M, N AND P).	F 726	Corrective Action for those residents found to be affected by the alleged deficient practice. Employee in-service sheets updated with a date column to reflect proper signing/dating of the employee signature	

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 02/25/2019

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 726	Continued From page 95 CNA B, CNA I, CNA K, CNA M, CNA N, and CNA P were found to have abuse training and other training on dates that they didn't work or were coded as having more inservice hours than they actually worked on the day of the inservice. The findings include: Employee CNA I whose hire date is 2/20/18, was recorded on individual employee education record as attending 7 hours of orientation training on 2/21/18. Review of payroll records indicate CNA I worked 5.75 orientation hours on 2/21. There was no other non-computer based documented training for CNA I for the remainder of the 2018 calendar year other than on 2/20/18-2/21/18. CNA B whose hire date was 12/18/18, was recorded on the individual employee education record as attending 8 hours of education/orientation training on 12/18/18. Review of facility payroll records indicate CNA B had no hours for the date of 12/18/18. For CNA K the facility failed to provide education and training CNA K with a hire date of 11/30/18, was recorded on the individual employee education record as attending 12 hours of education/orientation on 11/30/18 and review of facility payroll records indicate CNA K worked 4.75 hours of orientation time on 11/30/18. CNA M whose hire date is 12/1/03, was recorded on the individual employee education record as attending 12 hours of training on 10/17/18, review of payroll records indicate CNA M worked 7.75 hours that day. She had one hour of training on 9/25/19 and 2 hours of training on 12/18/19.	F 726	while being physically in-serviced at the facility Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Employees hired into the facility have the potential to be affected. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to the facility educator to ensure that staff are signing the in-service education sheet after attending the in-service while in the facility with the dating of their signature. Monitoring of corrective action to ensure the alleged deficient practice does not recur. Director of Nursing will complete audits on in-service sheets and time cards weekly x 4 weeks and monthly x 2 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. Date of compliance-4/2/19	

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 02/25/2019

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 726	Continued From page 96	F 726		

There was no other record of non-computer based training for the remainder of the year.

CNA N whose hire date is 8/7/18, was recorded on the individual employee education record as attending 3 hours of training on 8/9/18 and 2 hours on 8/10/18. Review of payroll records for CNA N indicate no hours worked on 8/9/18 or 8/10/18.

CNA P whose hire date is 3/12/18 was recorded on the individual employee education record as attending 6 hours of training on 3/12/18 and 6 hours which training on 3/13/18. Review of employee payroll records for CNA P indicate no hours worked on 3/12/18 and worked 4 hours on 3/13/18.

Review of employee education attendance records indicate an inservice was provided on "personal care" with 6 employees in attendance. There was no information as to the content of the inservice, objectives, date presented, who presented, or the instructional method.

Review of employee education attendance record indicates as inservice topic on "Identification of changes in condition" was held and 13 staff members attended. There was no information as to the content of the inservice, objectives, date presented, who presented, or the instructional method.

On 2/25/19 15:23 interview with RN D about the training records and hours recorded she stated "these hours on here are wrong then, I can not verify when these people did it." When asked about the signature on the forms as to who signed off that the training is complete RN D

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 02/25/2019

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 726	Continued From page 97 stated "that is my signature." Review of the facility "2018 Annual Education Plan" indicates online and offline training is to be held monthly on a continual basis. The Administrator and DON were made aware of the findings on 2/25/19. No further information was provided.	F 726		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		4/2/19

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 02/25/2019

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 755	Continued From page 98 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to ensure medications were available for administration for one Resident (Resident # 131) in a survey sample of 59 residents. Resident #131 was readmitted to the facility from the hospital on 1/22/2019 for treatment of Infection of PEG (Percutaneous Endoscopic Gastrostomy) tube and Urosepsis. The potassium reducing medication, Kayexalate, was unavailable from the pharmacy on 2/22/2019. Another potassium reducing medication, Veltassa, was ordered. Veltassa was not available until 2/25/2019 until 3:30 PM. The findings included: Resident #131, an 80 year old, was admitted to the facility on 2/13/2018 an readmitted on 1/22/19. Diagnoses included but were not limited to: Urosepsis, Infection of PEG (Percutaneous Endoscopic Gastrostomy) tube, Fluid Retention, Hypertension, Diastolic Heart Failure, Diabetes, Chronic Renal Failure, Anemia, and Lymphocytosis. Resident # 131's most recent Minimum Data Set (MDS) was a Significant Change Assessment	F 755	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #131 medication was obtained and administered. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents admitting into the facility have the potential to be affected. Review completed by the Director of nurses on progress notes to identify any notes that state medications were not available and addressed as applicable. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nurses on ensuring that medications are available as ordered and the procedures for when a medication is not available for pharmacy to include getting an order for an alternate medication as applicable. Monitoring of corrective action to ensure the alleged deficient practice does not recur. Director of Nursing will complete audits on	

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 02/25/2019

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 755 Continued From page 99

with an Assessment Reference Date (ARD) of 1/29/2019. The MDS coded Resident # 131 with a BIMS (Brief Interview for Mental Status) Score of 7 indicating severe cognitive impairment; Resident # 131 was coded as requiring extensive assistance of one staff member of Activities of Daily Living. Resident # 131 had an indwelling urinary catheter and was always incontinent of bowel.

Review of the clinical record was conducted on 2/22/2019 and 2/25/2019.

Review of the Nursing Progress Notes revealed documentation which included:

On 2/22/2019 at 1600 (4:00 PM), "Kayexalate 30 grams in PEG (Percutaneous Endoscopic Gastrostomy) one dose with BMP (Basic Metabolic Profile) on Monday."

On 2/23/2019 at 14:25 (2:25 PM) N.O.(new order) D/C (discontinue) Kayexalate 30 g (grams) via peg. Start Veltassa 8.4 g (grams) via peg for 1 dose. may give when arrives RP (Responsible Party) aware.

On 2/24/2019 14:56 (2:56 PM) New order: D/C BMP on Monday 2/25/19. May draw BMP on Tuesday 2/26/19. MD/RP aware

On 2/24/2019 22:21 (10:21 PM) NP aware of Veltassa. Per NP (Nurse Practitioner) to give when arrive from pharmacy. RP aware.

The 2/22/19 Kayexalate order was included on the February 2019 Medication Administration Record (MAR). The one time dose of Kayexalate was scheduled to start 2/23/19 at 2:00 p.m.

F 755

progress notes 3x a week x4 weeks and monthly x 2 months to ensure timely arrival of medication.

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.

Date of compliance-4/2/19

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 02/25/2019

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 755	Continued From page 100	F 755		

A new order for "Veltassa 8.4 g (grams) via PEG x 1 dose May give when arrives" with an order date of 2/23/19 was included in Resident #131's orders. The new order was included on the February 2019 MAR.

Review of the Laboratory values revealed Potassium levels (Normal range is 3.5-5.3)
2/14/19 Potassium= 5.6 (high) handwritten note: "Noted 2/15/19 no new orders, MD/RP aware" and initials

2/18/19 Potassium= 6.0 (high) handwritten note: "Noted 2/19/20 (sic) no new orders, MD/RP aware" and initials

2/21/19 Potassium= 5.6 (high) handwritten "2120" and initials

On 2/25/2019 at 11:42 AM, Licensed Practical Nurse (LPN) F was overheard talking on the telephone to the Pharmacy. LPN F asked when the medication Veltassa would be delivered to the facility. LPN F stated the medication would come that day on the next delivery from the pharmacy.

Review of the facility Emergency Box contents revealed the Medications Kayexalate and Veltassa were not included in the contents listed.

On 2/25/19 at 3:30 p.m., LPN F was interviewed and asked if Resident # 131 had received the Veltassa dose yet. LPN F stated the pharmacy had "just delivered the medication" and it was going to be administered by the 3-11 nurse. LPN F stated that the pharmacy had been contacted over the weekend about the medication but it was not delivered until 2/25/19 and that the nurse

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 02/25/2019

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 755	Continued From page 101	F 755		

practitioner was made aware of the delay. When asked if she knew why Resident #131's Veltassa was not delivered until 3:30 PM on 2/25/19, LPN F stated that she did not know why it had taken that long.

On 2/25/2019 at 3:32 PM, the 3-11 nurse (LPN G) was observed at her medication cart. An interview was conducted with LPN G who stated she was preparing to administer the medication, Veltassa, "right now."

According to WEBMD, hyperkalemia (high potassium) is defined as "if you have hyperkalemia, you have too much potassium in your blood. The body needs a delicate balance of potassium to help the heart and other muscles work properly. But too much potassium in your blood can lead to dangerous, and possibly deadly, changes in heart rhythm." Also stated "Your body should maintain a specific amount of potassium in the blood, ranging from 3.6 to 5.2 millimoles per liter (mmol/L)."
accessed online at
https://www.webmd.com/a-to-z-guides/hyperkalemia-causes-symptoms-treatments#1on
2/26/2019

On 2/25/19 at 4:32 p.m., the DON was asked why the original Kayexalate order was discontinued. The DON stated that the Kayexalate was not available from the Pharmacy. The doctor was notified and a new order was given. The medication order was changed to Veltassa 8.6 grams via the PEG tube for one dose on 2/23/2019. The medication,Veltassa, did not arrive from the pharmacy until 2/25/2019 at 3:30 PM.

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 02/25/2019

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 755	Continued From page 102 It was reviewed with the DON that Resident #131 did not receive potassium reducing medication until 72 hours after the first medication, Kayexalate, was ordered and 48 hours after the order was changed to Veltassa. At the end of day meeting on 2/25/19, the Administrator, DON and Corporate Nurse were notified of the issue. All three stated it was not acceptable for the medication, Veltassa to be delivered over 48 hours after being ordered by the physician. No further information was provided.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		4/2/19

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 02/25/2019

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 758	Continued From page 103 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation and clinical record review the facility failed to ensure Residents were free from unnecessary psychotropic medications for 3 Residents (#120, #25 and # 212) in a survey sample of 59 Residents. 1. Resident #120's antipsychotic medication (Risperdal) had no GDR (gradual dose reduction), excessive doses; Resident #120 had a diagnosis of dementia (no psychotic disorders).	F 758	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #212 has since been discharged from the facility. Residents' #120/#25 diagnosis updated to reflect validity of usage for anti-psychotic medications and gradual dose reductions evaluated and changed as applicable. Corrective Actions taken for residents with potential to be affected by alleged	

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 02/25/2019

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 758

Continued From page 104

2. Resident #25 has been on the same dosage of Zyprexa (antipsychotic) since 11-22-17 for "mood disorder". She has a diagnosis of dementia with no behaviors warranting the use of an antipsychotic.

3. For Resident # 212 the facility failed to ensure Resident had proper diagnosis for administration of Zyprexa (anti-psychotic medication) and no gradual dose reduction attempted.

The findings included:

1. Resident #120's antipsychotic medication (Risperdal) had no GDR (gradual dose reduction), excessive doses; Resident #120 had a diagnosis of dementia (no psychotic disorders).

Resident #120 was admitted to the facility on 3-31-18. Diagnoses included; dementia, psychosis, diabetes and high blood pressure.

Resident #120's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1-24-19 was coded as a quarterly assessment. Resident #120 was coded as having severe memory deficits, refused care 1-3 during the lookback period, wandered 4-6 days. The Resident was also coded as needing extensive assistance of one to staff members to perform activities of daily living, such as bed mobility and eating. No pressure wounds were documented.

On 2/20/19 at 12:51 PM, Resident #120 was observed leaning over in wheel chair (w/c), her hand was almost on the floor. A CNA (certified

F 758

deficient practice.
Residents on anti-psychotic medications have the potential to be affected. Review completed by the Director of Nurses on residents on anti-psychotic medications for gradual dose reductions/proper diagnosis and assessed as necessary.

Systemic Changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the Director of Nursing to licensed nursing leadership on ensuring that residents on anti-psychotics are evaluated according to policy and procedure for proper diagnosis and/or gradual dose reductions.

Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of Nursing will complete audits psychotropic medications for gradual dose reductions/proper diagnosis weekly x 4 weeks and monthly x 2 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.

Date of compliance-4/2/19

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 02/25/2019

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 758

Continued From page 105

nursing assistant) was attempting to get resident to reposition. TV on in room. The resident continued to lean.

On 2/25/19 at 10:30 AM, Resident #120 was observed in her room, up in w/c. Leaning forward in w/c, almost doubled over. She did not respond to verbal commands.

On 2/25/19 at 12:50 PM, Resident #120 was observed in her room. She continued to have severe leaning and her head resting on her bed.

On 2/25/19 at 1:05 PM, An interview was conducted with LPN (licensed practical nurse-A). She stated the resident requires assistance with meals. She also stated she did not think the leaning was due to lethargy, but was caused by her "dementia."

On 2/25/19 at 1:37 PM: Review of the nurse's notes in September 2018, Resident's had an SBAR (situation, background, assessment, review) done for "lethargy." Seroquel and Ativan were discontinued. The resident continued on Risperdal 2 mg (milligrams) twice daily according to the physician's order sheet (signed by physician), However, the resident is actually receiving 4 mg every 12 hours since 7-29-18.

Review of the resident's psychiatry notes, MD notes, medication administration records and orders since July, 2018 was conducted. In June, the resident had exhibited behaviors that were aggressive to staff and other residents.

The following are the antipsychotic medications changes starting in July, 2018 to present.

F 758

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 02/25/2019

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 758	Continued From page 106	F 758		

7-1-18: Quarterly review of antipsychotic drug monitoring: "Diagnosis- acute delirium psychosis. Seroquel changed from 50 mg to 25 mg twice daily.

7-4-18: Risperdal added at 1 mg every 12 hours x one week, then Risperdal 2 mg every 12 hours.

7-28-18: Risperdal (antipsychotic) increased to 4 mg every 12 hours. The resident was also taking Ativan 1 mg three times daily.

8-11-18: Depakote 250 mg twice daily for one week. The medications was stopped 8-21-18. Seroquel 25 mg twice daily, and Risperdal 4 mg every 12 hours continued.

9-17-18: Ativan as well as the Seroquel was discontinued.

9-20-18: The psychiatric NP (nurse practitioner) noted in his notes that the resident is currently taking Risperdal 2 mg every 12 hours and is doing well on this dose. However, the resident is actually on Risperdal 4 mg every 12 hours.

10-1-19 through current date the resident continues receiving Risperdal 4 mg twice daily.

12-27-18: Psychiatric NP notes document weight loss. Again, it was noted by NP the resident is on Risperdal 2 mg every 12 hours. However, the resident is actually on Risperdal 4 mg every 12 hours.

2-21-19: MD notes documented "reducing meds in schizophrenia most likely to lead to deterioration and poor quality of life." However, the resident's diagnosis is dementia, not

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 02/25/2019

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 758	Continued From page 107 schizophrenia. Review of the care plan dated 12-12-18 revealed the following behaviors: Agitation, yelling/cursing, banging on bathroom, threatening to harm roommate, wandering, packs and unpacks belongings. Interventions included: Administer meds per order, attempt psychoactive medications per physician orders, room change, send to ER, encourage rest periods, hydration. Review of the care plan dated 12-12-18 regarding nutritional status and significant weight loss revealed there have been no new interventions since 10-4-18. Review of Saunders Nursing Drug Handbook, 2011, pages 984- 986 revealed the following information for Risperdal: "Indications for use: management of manifestations of psychotic disorders (e.g. schizophrenia, bipolar disorder. There is a black box warning for elderly patients with dementia related psychosis, "increased risk of mortality in elderly patients with dementia, mainly due to pneumonia, heart failure." Dosage in the elderly: "initially 0.5 mg twice daily, may increase slowly at increments of no more than 0.5 mg twice a day." On 2/25/19 at 3:10 PM: The Administrator, DON (director of nursing) and the corporate nurse were present, informed of above findings. The corporate nurse stated, "We identified we had an issue with psychotropic medications on the mock survey. 2. Resident #25 has been on the same dosage of Zyprexa (antipsychotic) since 11-22-17 for	F 758		

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 02/25/2019

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 758	Continued From page 108	F 758		

"mood disorder". She has a diagnosis of dementia with no behaviors warranting the use of an antipsychotic.

Resident #25 was admitted to the facility on 9-28-12. Diagnoses included; dementia, psychosis, high blood pressure and anemia.

Resident #25's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-6-18 was coded as a quarterly assessment. Resident #25 was coded as having severe memory deficits and no behaviors during the lookback period. The Resident was also coded as needing standby to extensive assistance of one staff member to perform activities of daily living, such as bed mobility and eating.

On 2/25/19 at approximately 10:00 AM, Resident #25 was observed in the activity room. She stated, "I am going to make these."

On 2/25/19, review of the clinical record, psychiatry notes and medication administration records revealed the resident was currently taking Zyprexa for "mood disorder of 2-5 milligrams (mg) at bedtime since 11-22-17.

Review of the quarterly psychotropic drug review dated 12/20/18 read: "Do not attempt to taper/reduce the dose of this drug for the reason: necessary to mange unexpected harmful behavior that cannot be managed without medications." This was signed by the physician.

Review of the care plan dated 1-9-19 read: Mood/behavior: Resident has history of paranoid behavior which will result in agitation. She has history of refusing care/showers/to change her

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 02/25/2019

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 758	Continued From page 109 clothes. She has history of being suspicious of family. Update: Resident noted with increased confusion, pacing, and crying and difficult to redirect. Resident observed with extreme agitation, verbally and physically aggressive to staff. " Review of the psychiatry notes dated 12-27-18 by the psychiatric nurse practitioner (NP) revealed no behavior issues. The NP wrote: "Psychotropic medication dose reduction attempts will most likely cause psychiatric decompensation of patient and decrease psychiatric functioning.". Review of psychiatry notes dated 4-5-18 revealed: "Continue medication as prescribed, the patient is stable at current dose and /or needs more time to see beneficial effects. Dose reduction attempted and or reduction will cause decompensation of patient." No documentation of GDR in past was provided. Review of Saunders Nursing Drug Handbook, 2011, pages 853-855 revealed the following information for Zyprexa: "Indications for use: management of manifestations of psychotic disorders (e.g. schizophrenia, bipolar disorder. There is a black box warning for elderly patients with dementia related psychosis, "increased risk of mortality in elderly patients with dementia, mainly due to cerebrovascular effects." Rationale for Recommendation : The FDA has issued a BOXED WARNING for antipsychotics posing an increased risk of mortality in elderly individuals dementia related psychosis. Additionally the are associated with potentially serious adverse effects including movement disorders metabolic abnormalities and Orthostatic	F 758		

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 02/25/2019

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 758	Continued From page 110	F 758		

Hypotension. Older adults are at increases risk of harm from these medication.

On 2/25/19 at 3:10 PM: The Administrator, DON (director of nursing) and the corporate nurse were present, informed of above findings.

3. For Resident # 212 the facility failed to ensure Resident had proper diagnosis for administration of anti-psychotic medication and (gradual dose reduction) GDR was attempted.

Resident #212 an 87 year old woman admitted to the facility on 4/24/15 with diagnoses of but not limited to(End Stage Renal Disease) ESRD requiring Hemodialysis three (3) days a week, (Resident had Hemodialysis Port in Upper Right Chest) heart failure unspecified, Type 2 Diabetes, anxiety, major depressive disorder, Depression, Psychosis, Dementia and Anemia.

Resident #212's most recent (Minimum Data Set) MDS (screening tool) was a quarterly completed on 10/19/18 and coded Resident as having a (Brief Interview of Mental Status) score of 99 meaning Severe Cognitive Impairment she was also coded under G0110 as #3 Extensive Assistance- Resident involved in activity, staff provide wt. bearing and support was coded as #2 One person physical assist.

On 2/21/19 during a clinical record review, it was noted that according to the (Physicians Order Sheet) POS dated signed 9/1/19 the Resident had an order for Remeron 15 [Milligrams] MG by mouth at bedtime for Depression, and Zyprexa (an antipsychotic) 5 mg by mouth daily for Mood.

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 02/25/2019

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 758	Continued From page 111	F 758		

A review of the Psychiatric Evaluations was conducted and it on 4/19/18 the report states:
Chief Complaint - Depression
History of Present Illness- Patient is an 86 year old Hispanic female currently being treated for dementia and depression and mood disorder.

On 5/31/18 the Psychiatric Evaluation report states:
Chief Complaint - Cognitive Impairment
History of Present Illness- Patient is an 86 year old Hispanic female currently being treated for dementia and depression and mood disorder.

Review of the Quarterly Antipsychotic Drug Monitoring Sheet dated 2/16/18 revealed:

Current Therapy and Dosage - Zyprexa 2.5 mg by mouth daily [Dosage is actually 5 mg. Daily two (2) 2.5 mg tabs]
Diagnosis and or specific behavior that warrant the use of this drug is documented on the clinical record - YES
Diagnosis / Behavior - MOOD D/O [Disorder]
Side Effects - [None selected]
Gradual Dose Reduction:
A gradual dose reduction has been attempted - NO
The date of last attempt [left blank]

Dosage:
Does the current dosage exceed the maximum daily recommended dosage scheduled published by the America Society of Consultant Pharmacies. - NO

Findings:
[Box checked]- Justification of anti-anxiety,

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 02/25/2019

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 758	Continued From page 112 antidepressant or hypnotic. Also dated 2/16/18- Quarterly Anti-Anxiety, Antidepressant and Hypnotic Monitoring Sheet: Current Therapy and Dosage - Remeron 15 mg by mouth at bedtime Diagnosis and or specific behavior that warrant the use of this drug is documented on the clinical record - YES Diagnosis / Behavior - Depression Side Effects -[None selected] Gradual Dose Reduction: A gradual dose reduction has been attempted - NO If a gradual dose reduction is medically contraindicated, the reason stated on the clinical record is: [left blank] Dosage: Does the current dosage exceed the maximum daily recommended dosage scheduled published by the America Society of Consultant Pharmacies. - NO Findings: [box checked]- Justification of anti-anxiety, antidepressant or hypnotic. Review of the Quarterly Antipsychotic Drug Monitoring Sheet dated 5/4/19 revealed: Current Therapy and Dosage Zyprexa 2.5 mg by mouth daily [Dosage is actually 5 mg. Daily two (2) 2.5 mg tabs] Diagnosis and or specific behavior that warrant the use of this drug is documented on the clinical record - YES Diagnosis / Behavior - MOOD D/O [Disorder]	F 758		

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 02/25/2019

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 758	Continued From page 113	F 758		

Side Effects - [None selected]
Gradual Dose Reduction:
A gradual dose reduction has been attempted - NO
The date of last attempt [left blank]

Dosage:
Does the current dosage exceed the maximum daily recommended dosage scheduled published by the America Society of Consultant Pharmacies. - NO

Findings:
[Box checked]- Justification of anti-anxiety, antidepressant or hypnotic.

Quarterly Anti-Anxiety, Antidepressant and Hypnotic Monitoring Sheet dated 5/4/19

Current Therapy and Dosage - Remeron 15 mg by mouth at bedtime
Diagnosis and or specific behavior that warrant the use of this drug is documented on the clinical record - YES
Diagnosis / Behavior - Depression
Side Effects - [None selected]
Gradual Dose Reduction:
A gradual dose reduction has been attempted - NO
If a gradual dose reduction is medically contraindicated, the reason stated on the clinical record is: [left blank]

Dosage:
Does the current dosage exceed the maximum daily recommended dosage scheduled published by the America Society of Consultant

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 02/25/2019

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 758	Continued From page 114 Pharmacies. - NO Findings: [Box checked]- Justification of anti-anxiety, antidepressant or hypnotic. The exact same answers were filled in for 7/20/18 and 10/19/18 The facility submitted Quarterly Psychotropic Drug Review all state the same answers Dated 2/16/18, 5/4/18, 7/20/19, and 10/19/18 Medication and dosage: Zyprexa 5 mg by mouth daily (mood d/o) Remeron 15 mg by mouth at bedtime (depression) Do not attempt to taper/reduce the dose of this drug for the reason: [Box checked] Previous reduction trials have been unsuccessful Review of clinical record could find no record of GDR trial. On 2/25/19 during end of day meeting Administration was made aware of findings and no further information was offered.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on facility documentation review and clinical record review the facility staff failed to	F 760	Corrective Action for those residents found to be affected by the alleged	4/2/19

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 02/25/2019

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 760

Continued From page 115

ensure residents are free of significant medication errors for 2 of 59 residents.

1. For resident # 510 the facility failed to provide insulin as per physician's orders on 4 occasions.

2. For Resident # 131, the facility staff failed to obtain medication prescribed to treat too much potassium in the body.

The findings include:

1. Resident #510, a 72 year old male, was admitted to the facility on 2/9/19. His diagnosis included but are not limited to: chronic pulmonary edema, Muscle weakness, Difficulty in walking, other symptoms and signs involving the musculoskeletal system, cognitive communication deficit, heart failure, type 2 diabetes, sepsis, morbid obesity, hypertension, atherosclerotic heart disease, acute respiratory failure with hypoxia, disorder of kidney and ureter, and shortness of breath.

Resident #510 did not have a complete MDS (minimum data set) (an assessment tool) due to being a new admission.

Review of the resident's Diabetic Flow Sheet on 2/11/19 at 9pm showed resident #510 had a blood sugar level of 249 and no insulin was provided. Per the physician orders he should have received 6 units.

On 2/13/19 at 4:30pm resident #510 had a blood sugar level of 288 and was given 15 units of insulin. He should have been administered 9 units of insulin.

F 760

deficient practice.
Resident #510 has since been discharged from the facility. Resident #131 medication has been obtained and administered.

Corrective Actions taken for residents with potential to be affected by alleged deficient practice.
Residents admitting into the facility have the potential to be affected. Review completed by the Director of Nurses on residents who use insulin for proper administration and documentation and on progress notes to identify an notes relating to medications not being available and both were addressed as applicable.

Systemic Changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the Director of Nursing to licensed nurses on following physician orders for insulin orders and sliding scales and the procedure for obtaining an alternate medication if an ordered medication is not available in a timely fashion.

Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of Nursing will complete audits on resident diabetic flow sheets and progress notes to identify medication availability issues 3x week x 4 weeks and monthly x 2 months.

Plan of correction information and audits

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 02/25/2019

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 760	Continued From page 116 On 2/13/19 at 9pm resident #510 had a blood sugar of 200 and received 6 units of insulin. He should have been given 3 units of insulin. On 2/19/19 at 6:30am resident #510 had a blood sugar of 127 and received 3 units of insulin. He should not have received any insulin. On 2/21/19 review of resident #510's physician orders dated 2/9/19 and signed by the physician on 2/11/19 orders are as follows: accuchecks AC (before meals) & HS (bedtime), notify MD (medical doctor) if BS (Blood sugar)is less than 60 or greater than 400. The same orders also state: Humalog Insulin 100 units/ml injection solution per sliding scale: blood sugar reading of 151-200= 3 units of insulin to be given blood sugar reading of 201-250= 6 units of insulin to be given blood sugar reading of 251-300= 9 units of insulin to be given blood sugar reading of 301-350=12 units of insulin to be given blood sugar reading of 351-400= 15 units of insulin to be given blood sugar reading of 400 or greater= 18 units of insulin to be given and call MD The Administrator and Director of Nursing were informed on 2/25/19 of the failure of the staff to ensure the physician's orders for insulin were carried out as ordered. No further information was provided. 2. For Resident # 131, the facility staff failed to	F 760	will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. Date of compliance-4/2/19	

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 02/25/2019

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 760	Continued From page 117 obtain medication as ordered by a physician to treat too much potassium in the body. Resident #131, an 80 year old, was admitted to the facility on 2/13/2018 an readmitted on 1/22/19. Diagnoses included but were not limited to: Urosepsis, Infection of PEG (Percutaneous Endoscopic Gastrostomy) tube, Fluid Retention, Hypertension, Diastolic Heart Failure, Diabetes, Chronic Renal Failure, Anemia, and Lymphocytosis. Resident # 131's most recent Minimum Data Set (MDS) was a Significant Change Assessment with an Assessment Reference Date (ARD) of 1/29/2019. The MDS coded Resident # 131 with a BIMS (Brief Interview for Mental Status) Score of 7 indicating severe cognitive impairment; Resident # 131 was coded as requiring extensive assistance of one staff member of Activities of Daily Living. Resident # 131 had an indwelling urinary catheter and was always incontinent of bowel. Review of the clinical record was conducted on 2/22/2019 and 2/25/2019. Review of the Nursing Progress Notes revealed documentation which included: On 2/22/2019 at 1600 (4:00 PM), "Kayexalate 30 grams in PEG (Percutaneous Endoscopic Gastrostomy) one dose with BMP (Basic Metabolic Profile) on Monday." On 2/23/2019 at 14:25 (2:25 PM) N.O.(new order) D/C (discontinue) Kayexalate 30 g (grams) via peg. Start Veltassa 8.4 g (grams) via peg for 1 dose. may give when arrives RP (Responsible	F 760		

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 02/25/2019

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 760	Continued From page 118	F 760		

Party) aware.

On 2/24/2019 14:56 (2:56 PM) New order: D/C BMP on Monday 2/25/19. May draw BMP on Tuesday 2/26/19. MD/RP aware

On 2/24/2019 22:21 (10:21 PM) NP aware of Veltassa. Per NP (Nurse Practitioner) to give when arrive from pharmacy. RP aware.

The 2/22/19 Kayexalate order was included on the February 2019 Medication Administration Record (MAR). The one time dose of Kayexalate was scheduled to start 2/23/19 at 2:00 p.m.

A new order for "Veltassa 8.4 g (grams) via PEG x 1 dose May give when arrives" with an order date of 2/23/19 was included in Resident #131's orders. The new order was included on the February 2019 MAR.

Review of the Laboratory values revealed Potassium levels: (Normal range is 3.5-5.3)
2/14/19 Potassium= 5.6 (high) handwritten note: "Noted 2/15/19 no new orders, MD/RP aware" and initials

2/18/19 Potassium= 6.0 (high) handwritten note: "Noted 2/19/20 (sic) no new orders, MD/RP aware" and initials

2/21/19 Potassium= 5.6 (high) handwritten "2120" and initials

On 2/25/2019 at 11:42 AM, Licensed Practical Nurse (LPN) F was overheard talking on the telephone to the Pharmacy. LPN F asked when the medication Veltassa would be delivered to the facility. LPN F stated the medication would come

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 02/25/2019

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 760	Continued From page 119	F 760		

that day on the next delivery from the pharmacy.

Review of the facility Emergency Box contents revealed the Medications Kayexalate and Veltassa were not included in the contents listed.

On 2/25/19 at 3:30 p.m., LPN F was interviewed and asked if Resident # 131 had received the Veltassa dose yet. LPN F stated the pharmacy had "just delivered the medication" and it was going to be administered by the 3-11 nurse. LPN F stated that the pharmacy had been contacted over the weekend about the medication but it was not delivered until 2/25/19 and that the nurse practitioner was made aware of the delay. When asked if she knew why Resident #131's Veltassa was not delivered until 3:30 PM on 2/25/19, LPN F stated that she did not know why it had taken that long.

On 2/25/2019 at 3:32 PM, the 3-11 nurse (LPN G) was observed at her medication cart. An interview was conducted with LPN G who stated she was preparing to administer the medication, Veltassa, "right now."

According to WEBMD, hyperkalemia (high potassium) is defined as "if you have hyperkalemia, you have too much potassium in your blood. The body needs a delicate balance of potassium to help the heart and other muscles work properly. But too much potassium in your blood can lead to dangerous, and possibly deadly, changes in heart rhythm." Also stated "Your body should maintain a specific amount of potassium in the blood, ranging from 3.6 to 5.2 millimoles per liter (mmol/L)."
accessed online at
https://www.webmd.com/a-to-z-guides/hyperkale

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 02/25/2019

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 760	Continued From page 120 mia-causes-symptoms-treatments#1on 2/26/2019 On 2/25/19 at 4:32 p.m., the DON was asked why the original Kayexalate order was discontinued. The DON stated that the Kayexalate was not available from the Pharmacy. The doctor was notified and a new order was given. The medication order was changed to Veltassa 8.6 grams via the PEG tube for one dose on 2/23/2019. The medication,Veltassa, did not arrive from the pharmacy until 2/25/2019 at 3:30 PM. It was reviewed with the DON that Resident #131 did not receive potassium reducing medication until 72 hours after the first medication, Kayexalate, was ordered and 48 hours after the order was changed to Veltassa. At the end of day meeting on 2/25/19, the Administrator, DON and Corporate Nurse were notified of the issue. All three stated it was not acceptable for the potassium reducing medication, Veltassa, to be delivered over 48 hours after being ordered by the physician. No further information was provided.	F 760		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility-	F 790		4/2/19

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 02/25/2019

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 790	Continued From page 121 §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review and facility documentation the facility failed to provide dental care to 1 Resident (Resident # 151) in a survey sample of 59 Residents.	F 790	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #151 has a dental appointment scheduled.	

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 02/25/2019

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 790	Continued From page 122 The findings include: Resident #151 a 96 year old woman admitted to the facility on 10/09/14 with diagnoses of but not limited to Asthenia (Muscle Weakness), Hypertension, Anemia, Dysphagia, Hypothyroidism, Trigeminal Neuralgia, and Dementia. Her most recent (Minimum Data Set) MDS was a quarterly dated 2/1/19 coded Resident as having a (Brief Interview of Mental Status) BIMS score of 6 indicating severe cognitive impairment. On 2/20/19 at 12:30 PM during initial tour of the building an interview was conducted with Resident #151 and she stated "My teeth hurt and whatever they are giving me don't help". When asked if she had been to the dentist she stated "No I haven't been to a dentist in years and that's just what I need to do." On 1/20/19 Interview with Other Employee A who stated " Yes I see [Resident 151] and in my opinion she is cognitively aware enough to report accurately that she is in pain and the location of the pain and if it is ongoing." A clinical record review was then initiated and it was found that the Resident has a history of Trigeminal Neuralgia, (A condition which affects the trigeminal facial nerve and is very painful and causes mouth, jaw, ear and facial pain) On 2/21/19 it was requested from facility, any consults resident has had with Dentist or Neurologist. On 2/22/19 it was requested again from DON any	F 790	Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents admitting into the facility have the potential to be affected. Review completed for residents who may have dental problems and appointments scheduled as necessary. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nurses' leadership to ensure residents with dental issues are scheduled appointments. Monitoring of corrective action to ensure the alleged deficient practice does not recur. Director of Nursing will complete audits on progress notes to identify residents who need dental services weekly x 4 weeks and monthly x 2. 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. Date of compliance-4/2/19	

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 02/25/2019

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 790	Continued From page 123 consults Resident 151 has had with a Dentist or Neurologist. On 2/25/19 in an interview with the DON she stated "I have looked myself and there are no dental or Neurology consults that I can find in the chart or in the computer system." When asked if she was aware the Resident was having mouth pain the DON stated "well she does take medication for her Trigeminal Neuralgia." When asked if she could be sure if it was the Trigeminal Neuralgia or a Toothache the DON stated that she could not. When asked if Resident #151 had a routine dental check in the past year the DON stated that she had not. When asked if the resident has had a follow up for her Trigeminal Neuralgia in the past year the DON stated "no." On 2/25/19 at the end of day conference the Administrator was made aware and no further information was provided.	F 790		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility failed for one resident (Resident #40) in a survey sample of 59 residents, to maintain equipment in a safe operating condition. Resident #40's wheel chair pedals were padded with towels and duct tape.	F 908	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #40 wheelchair was immediately addressed and equipped with the proper wheelchair padding. Corrective Actions taken for residents with potential to be affected by alleged	4/2/19

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 02/25/2019

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 908	Continued From page 124 The findings included: On 2/21/19 at 4:06 PM Resident #40's wheelchair pedals were observed to be padded with towels and duct tape. On 2/22/19 at 12:57 PM Resident #40's wheelchair were observed to have towels and duct tape to pad the w/c pedals. On 2/25/19 at 11:00 AM, the resident was observed in bed and the wheelchair had new cushions on the pedals. Resident #40 stated, "I like it." On 2/25/19 at 3:10 PM, the Administrator, DON (director of nursing) and the corporate nurse were present, informed of above findings.	F 908	deficient practice. Residents who utilize wheelchairs have the potential to be affected. Review completed by the Director of Rehab to ensure wheelchairs are in safe operating condition and addressed as necessary. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Administrator to maintenance staff on wheelchair equipment being in safe working condition and the procedures to take if the wheelchair needs to be addressed. Monitoring of corrective action to ensure the alleged deficient practice does not recur. Director of Maintenance will complete audits wheelchair equipment weekly x 4 weeks and monthly x 2 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. Date of compliance-4/2/19	