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 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Abbreviated survey was conducted 3/11/2020 through 3/12/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The census in this 196 certified bed facility was 180 at the time of the survey. The survey sample consisted of 3 Residents.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		4/10/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/03/2020

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F 580	Continued From page 1 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, facility documentation, clinical record review, and in the course of an investigation, the facility staff failed to notify the Physician that the entire course of antibiotics was not administered as ordered for one Resident (Resident # 1) in a survey sample of 3 residents. The findings include: For Resident # 1, the facility staff failed to notify/consult the Physician that the entire course of antibiotics was not administered as ordered and discuss a possible need to alter or extend treatment. There were 2 missed doses.	F 580	The filing of the plan of correction does not constitute an admission that the alleged deficiencies did, in fact, exist. This plan of corrections is filed as evidence to comply with requirements of participation and continue to provide high quality resident centered care. F580 Notify of Changes (Injury/Decline/Room etc.) 1)Resident # 1 has discharged from the facility on 1/30/2020	

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F 580	Continued From page 2 Resident #1 was admitted to the facility on January 1, 2020. Diagnoses included but were not limited to Pneumonia, Chronic Diastolic Congestive Heart Failure, Pleural Effusion, Morbid Obesity, Atrial Fibrillation, and Hypertension. Resident # 1's most recent MDS (Minimum Data Set) was an Admission Assessment with an ARD (Assessment Reference Date) of 1/5/2020. Resident # 1 was coded as having a Brief Interview for Mental Status of 13 out of 15 indicating no cognitive impairment. Resident # 1 was coded as requiring extensive assistance of one to two staff persons for ADLs (activities of daily living), such as bathing. Review of the closed clinical record was conducted on 3/11/2020 and 3/12/2020. Review of the Physician Orders revealed an order written on 1/24/2020 for Vancomycin 250 milligrams by mouth four times a day for C-Diff for 10 Days. Review of the January 2020 Medication Administration Record (MAR) revealed documentation that the antibiotic Vancomycin 250 milligrams by mouth four times a day for C-Diff was not administered as ordered by the Physician. The scheduled times for administration were 9 AM., 1 PM, 5 PM and 9 PM for ten days. Review revealed blanks for 1/27/2020 at 1 PM and 1/28/2020 at 1:PM. All other scheduled doses had checkmarks and initials indicating the medication had been administered and	F 580	2)Audits of current resident's EMAR (electronic medication administration record) documentation and nurses notes will be reviewed to verify Physician or Nurse Practitioner(NP)have been notified if antibiotic was not administered as ordered , the Physician or NP will be notified with documentation. 3)In-services for the Licensed Nurses will be completed by the Facility Educator or designee from Nursing Management on the policy and process for notification of Physician or NP for antibiotics not administered as ordered and the process for EMAR documentation and nurse notes in PCC (point click care) to support reason not given and Physician or NP notified. 4)The Unit Manager or designee from nursing management will complete audits to review EMAR documentation and nurses notes in PCC to verify administration of antibiotics as ordered , if not , the physician or NP will be notified with supporting documentation 3 x weekly x 4 weeks then monthly x 3 months .The audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and revisions as needed x 3 months 5)Date of compliance- 4/10/2020	

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F 580	Continued From page 3	F 580		

documented as such,

Review of the Medication Administration Audit report revealed the actual times of administration:

On Page 5 of 6, Vancomycin 250 milligrams by mouth four times a day for C-Diff due 1/27/2020 at 13:00 (1:00 PM) blank -not administered and no documented reason.

On Page 4 of 6, Vancomycin 250 milligrams by mouth four times a day for C-Diff due 1/28/2020 at 9 PM, administered at 11:19 PM, documented at 11:20 PM. (2 hours late).

On Page 2 of 6, Vancomycin 250 milligrams by mouth four times a day for C-Diff due 1/27/2020 at 5 PM, administered at 9:55 PM, documented at 9:55 PM (4 hours and 55 minutes late)

On Page 3 of 6, Vancomycin 250 milligrams by mouth four times a day for C-Diff due 1/28/2020 at 5 PM, administered at 11:19 PM, documented at 11:20 PM (over 6 hours late).

On Page 6 of 6, Vancomycin 250 milligrams by mouth four times a day for C-Diff due 1/28/2020 at 13: (1 PM) blank, not administered and no documented reason.

According to the MAR (medication administration record) the 1/27/2020 1:00 PM and 1/28/2020 1:00 PM doses were blank. The doses were not signed off as being administered.

Review of the clinical record including the Nurses Notes revealed there was no documentation that the facility staff notified the physician of the missing administration of the antibiotic,

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F 580	Continued From page 4 Vancomycin. On 3/12/2020 at 11:15 AM, an interview was conducted with LPN (Licensed Practical Nurse) B who stated the nurses administer medications as ordered by the physician. LPN B stated that the nurse should document on the Medication Administration Record immediately after administering medications. LPN B stated if a medication was not administered, it should be documented as omitted and the reason why. On 3/12/2020 at 2 PM, an interview was conducted with the Director of Nursing who stated medications should be administered as ordered by the physician. The Director of Nursing stated it was important for the full course of antibiotics to be administered as ordered to effectively treat the infection for which the antibiotic was prescribed. The DON stated the nurse should notify the physician of any missed doses and ask if the physician would like to extend the amount of time it was ordered to make up for the missing doses. During the end of day debriefing on 3/12/2020, the facility Administrator, Corporate Nurse Consultant and Director of Nursing were informed of the findings. The Director of Nursing stated the physician should be informed of incomplete courses of antibiotics. No further information was provided.	F 580		
F 658 SS=D	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,	F 658		4/10/20

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F 658	Continued From page 5 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, facility documentation clinical record review and in the course of an investigation, the facility staff failed to follow professional standards regarding treatments for one Resident (Resident # 1) in a survey sample of 3 residents. The findings include: For Resident # 1, treatments were not administered on 1/16/2020. Resident #1 was admitted to the facility on January 1, 2020. Diagnoses included but were not limited to Pneumonia, Chronic Diastolic Congestive Heart Failure, Pleural Effusion, Morbid Obesity, Atrial Fibrillation, and Hypertension. Resident # 1's most recent MDS (Minimum Data Set) was an Admission Assessment with an ARD (Assessment Reference Date) of 1/5/2020. Resident # 1 was coded as having a Brief Interview for Mental Status of 13 out of 15 indicating no cognitive impairment. Resident # 1 was coded as requiring extensive assistance of one to two staff persons for ADLs (activities of daily living), such as bathing. Review of the closed clinical record was conducted on 3/11/2020 and 3/12/2020. Review of the January 2020 Treatment Administration Record revealed missing treatments on 1/16/2020.	F 658	Tag 0658 - 483.21(b)(3)(i) Services Provided Meet Professional Standards (LONG TERM CARE FACILITIES) 1)Resident # 1 has discharged from the facility on 1/30/2020 2)Audits on current resident's E-TAR (electronic treatment administration record) documentation and nurses notes in PCC (point click care) will be reviewed to verify treatment was performed as per physician ordered. 3)In-services for the Licensed Nurses will be completed by the Facility Educator or designee from the Nursing Management on the process and procedure for performing and documenting treatments as per physician order and on the process and procedure for documentation for treatments not performed and notification to Physician or NP (Nurse practitioner). 4)The Unit Manager or designee from the nursing management will complete audits to review E-TAR documentation and nurses notes in PCC to verify treatment was performed , if not , the physician or NP will be notified with supporting documentation 3 x weekly x 4 weeks then monthly x 3 months .The audits will be reviewed in the quality assurance and performance improvement process for	

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F 658	Continued From page 6 Cleanse open area to right buttock with Normal Saline, apply skin prep and hydrocolloid dressing,. Change twice a week, every day shift every Tuesday and Thursday for Promote wound healing. Start date: 1/7/2020, D/C (Discontinue) Date: 1/21/2020. There was nothing that evidenced the treatment was perform on the Day shift on 1/16/2020. Dressing PICC (Peripherally Inserted Central Catheter)/Midline/Tunneled & Non Tunneled: 24 hours after insertion then weekly and PRN (as needed). Change needleless connector with weekly dressing change and after blood draw. If securement device is used, change at time of dressing change. every day shift every 7 days for IV protocol weekly Start Date 1/2/2020 D/C Date 1/27/2020. There was nothing that evidenced the treatment was perform on the Day shift on 1/16/2020. Valid Physician's Orders were evident for the treatments. On 3/12/2020 at approximately 1:00 PM, the Director of Nursing (DON) was asked about the medications and treatments that were not documented as having been administered. The DON said "if they are not documented they are not done." The Director of Nursing cited Lippincott as its Nursing Professional guidance used by the facility.	F 658	tracking/trending and revisions as needed x 3 months 5)Date of compliance- 4/10/2020	

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F 658	Continued From page 7 "Fundamentals of Nursing, by Lippincott", stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients." During the end of day debriefing on 3/12/2020, the facility Administrator, Corporate Nurse Consultant and Director of Nursing were informed of the findings. The Director of Nursing stated Nurses should follow the Professional Standards of Nursing to ensure residents receive treatments as ordered by the physician. No further information was provided.	F 658		
F 760 SS=E	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 interview, facility documentation clinical record review and in the course of an investigation, the facility staff failed to ensure one Resident (Resident # 1) in a survey sample of 3 residents was free from significant medication errors. There were multiple errors. The findings include: For Resident # 1, the facility staff failed to administer the antibiotic, Vancomycin, as ordered by the physician. There were missed doses and doses administered late (some doses administered over 6 hours late).	F 760	483.45(f)(2) Residents are Free of Significant Med Errors (LONG TERM CARE FACILITIES 1.Resident # 1 has discharged from the facility on 1/30/2020 2.Audits of the E-MAR (electronic medication administration) record ,nurses notes in PCC (point click care), Medication Administration Audit Report in PCC on current residents with physician or NP (Nurse Practitioner) orders for antibiotics to verify antibiotics have been administered and if not, Physician or NP	4/10/20

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F 760	Continued From page 8 Resident #1 was admitted to the facility on January 1, 2020. Diagnoses included but were not limited to Pneumonia, Chronic Diastolic Congestive Heart Failure, Pleural Effusion, Morbid Obesity, Atrial Fibrillation, and Hypertension. Resident # 1's most recent MDS (Minimum Data Set) was an Admission Assessment with an ARD (Assessment Reference Date) of 1/5/2020. Resident # 1 was coded as having a Brief Interview for Mental Status of 13 out of 15 indicating no cognitive impairment. Resident # 1 was coded as requiring extensive assistance of one to two staff persons for ADLs (activities of daily living), such as bathing. Review of the closed clinical record was conducted on 3/11/2020 and 3/12/2020. Review of the Physicians Orders revealed an order written on 1/24/2020 for Vancomycin 250 milligrams by mouth four times a day for C-Diff for 10 Days. Review of the January 2020 Medication Administration Record revealed documentation that the antibiotic Vancomycin 250 milligrams by mouth four times a day for C-Diff was not administered as ordered by the Physician. The scheduled times for administration were 9 AM., 1 PM, 5 PM and 9 PM for ten days. Review revealed blanks for 1/27/2020 at 1 PM and 1/28/2020 at 1:PM. All other scheduled doses had checkmarks and initials indicating the medication had been administered and documented as such,	F 760	have been notified to consider continue or extend with documentation to support. 3.In-service Licensed Nurses by Facility Educator or designee from the nursing management on the process and procedure for medication administration of antibiotic with documentation ,missed doses ,medication errors, and documentation in E-MAR and nurses note to support reason antibiotic not given with Physician and NP notification with consideration to continue or extend antibiotic for missed doses. 4.Weekly audits by Unit Managers or designee from nursing management to review E-MAR (electronic medication administration) record ,nurses notes in PCC (point click care), Medication Administration Audit Report to verify antibiotics administered as ordered 3 x weekly x 4 weeks the monthly x 3 months .Findings will be reviewed, discussed and revised as indicated in QAPI meetings x 3 months. 5.Date of compliance: 4/10/2020	

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F 760	Continued From page 9	F 760		

Review of the Medication Administration Audit report revealed the actual times of administration:

On Page 5 of 6, Vancomycin 250 milligrams by mouth four times a day for C-Diff due 1/27/2020 at 13:00 (1:00 PM) blank -not administered and no documented reason.

On Page 4 of 6, Vancomycin 250 milligrams by mouth four times a day for C-Diff due 1/28/2020 at 9 PM, administered at 11:19 PM, documented at 11:20 PM. (2 hours late).

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On Page 6 of 6, Vancomycin 250 milligrams by mouth four times a day for C-Diff due 1/28/2020 at 13: (1 PM) blank, not administered and no documented reason.

On 3/12/2020 at 11:15 AM, an interview was conducted with LPN (Licensed Practical Nurse) B who stated the nurses administer medications as ordered by the physician.

On 3/12/2020 at 2 PM, an interview was conducted with the Director of Nursing who stated medications should be administered as ordered by the physician.

During the end of day debriefing on 3/12/2020,

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F 760	Continued From page 10 the facility Administrator, Corporate Nurse Consultant and Director of Nursing were informed of the findings. The Director of Nursing stated residents should be free of significant medication errors. No further information was provided.	F 760		