STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. BUILDING _____ B. WING _____	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEALTH & REHAB CENTER, LLC	1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454

(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 revisit to the Federal Monitoring survey conducted 8/10/21 through 8/19/21, was conducted 10/19/21 through 10/21/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. No complaints were investigated during the survey. The census in this 90 certified bed facility was 52 at the time of the survey. The survey sample consisted of 24 Resident reviews (Residents 101 through 124).	{F 000}		
✓ F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, and staff interviews, the facility staff failed to ensure the call bell was within reach at all times for 1 of 25 residents (Resident #118), in the survey sample. The findings included: Resident #118 was originally admitted to the facility 5/5/15 and readmitted 5/7/20 after an acute care hospital stay. The current diagnoses included; Alzheimer's disease, coronary artery disease, heart failure and high blood pressure.	F 558	**F 558 Reasonable Accommodations Needs/Preferences** **1. Resident # 118 had call bell placed in reach. .** **2. Current residents have the potential to be affected this deficient practice. Audit was completed of current residents to ensure call bell was accessible to resident.** **3. Administrator/designee educated current staff on call bell policy, to include call bell in place and functioning. Agency and new facility staff educated during orientation.** **4. Administrator/designee will audit 10 residents weekly for 12 weeks for call bell placement. Results of audits will be taken to QAPI meeting monthly X 3 months** **5. Date of compliance** 11/4/2021	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashlei Z. Pease, LNHA	Administrator	11/16/2021

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.

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F 558	Continued From page 1 The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/24/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #118's cognitive abilities for daily decision making were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing and toileting, extensive assistance of one person with bed mobility and dressing, and supervision after set-up with eating. On 10/19/21 at approximately 4:10 p.m., Resident #118 was observed in bed with the call bell beneath the bed. On 10/20/21 at approximately 11:45 a.m., prior to observation Resident #118 wound the resident was observed attempting to sit on the side of the bed but she didn't possess enough upper body strength to manage the task therefore; she asked the surveyor to help her to reposition. The resident was asked to use the nurse call system to get assistance but; she was unable to locate the call system. Observation was made of the call bell beneath the bed, stretched to the opposite side of the bed. Resident #118's roommate asked would she like for her to call the nurse for her. On 10/20/21 at approximately 11:55 a.m. an observation of Resident #118's left buttock wound was made with Registered Nurse (RN) #1. Afterward the observation RN #1 assisted the resident to reposition in bed but she didn't provide her with the call bell. The call bell remained beneath the bed. On 10/21/21 at approximately 12:05 p.m., Resident #118 was again observed in	F 558		

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F 558	Continued From page 2 bed with the call bell beneath the bed. On 10/21/21 at approximately 12:05 p.m., an interview was conducted with Certified Nursing Assistant (CNA) #1 and Licensed Practical Nurse #1 regarding Resident #118's call bell. They both stated they were unaware the call bell wasn't within reach and CNA #1 stated I will take care of it immediately. CNA #1 was observed obtaining the call bell from beneath the bed and putting it within reach of the resident. On 10/21/21 at approximately 2.00 p.m., the above findings were shared with the Administrator, Director of Nursing and two Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 558		
✓{F 563} SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's	{F 563}	**F 563-Right to receive/deny visits.** **1. Resident #125's family was made aware of ability to visit following CMS guidelines.** **2. Current residents have the potential to be affected by this deficient practice. Notification of indoor visitation following CMS guidelines was sent to families of current residents.** **3. Administrator, DON, Social Worker educated by Divisional Clinical specialist on visitation guidelines and notifications. .** **4. Administrator/designee will interview 5 residents/families randomly weekly for any concerns with visitation. Results of audits will be taken to QAPI monthly for 3 months for review and revision as needed.** **5. Date of Compliance** 11/4/2021	

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{F 563}	Continued From page 3 right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on observation, family interviews, and staff interviews, the facility staff failed to afford resident/family visits of their choosing for 1 of 25 residents (Resident #125), in the survey sample. The findings included: Resident #125 was originally admitted to the facility 1/29/18 and readmitted 10/11/21 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Alzheimer's disease, stroke, right hemiparesis, aphasia and deep vein thrombosis. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/15/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This	{F 563}		

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{F 563}	Continued From page 4	{F 563}		

indicated Resident #125's cognitive abilities for daily decision making were severely impaired.

On 10/20/21 Resident #125 was observed in a wheel chair propelled by her son to her room. She was also accompanied by her daughter-in-law.

On 10/20/21 at approximately 12:10 p.m., an interview was conducted with Resident #125's son who stated his father and mother were residents of this community but his father had passed on and he realized with his mother's advanced age (94), she may be nearing the end of her life span. The son further stated he desired to spend more time with his mother for currently he had a standing in-person visit on Wednesdays at 10:30 a.m., and a standing zoom visit on Fridays. The son also stated pre-pandemic they visited daily and it was their desire to resume that practice since Resident #125 was vaccinated and they were vaccinated.

Resident #125's daughter-in-law stated from time to time they received updates from the facility regarding the COVID-19 status in the facility but there hadn't been any recent updates therefore; as far as they knew the visitation status was still one in-person visit per week and one zoom visit each week, since no one had told them anything different.

On 10/20/21 at approximately 1:15 p.m., an interview was conducted with the Administrator and Director of Nursing. The Administrator stated there were no visitation restrictions at that time for the facility but she had not personally conveyed the information to the family of Resident #125.

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{F 563}	Continued From page 5 The Administrator further stated the Activity Director sends out communication to residents, representatives and families and their last COVID-19 positive case diagnosed in a resident was 7/16/21 and at that time indoor visits were suspended. The Administrator didn't say when the suspension was lifted and when the current visitation procedure was instituted. The Administrator stated there had been three positive staff occurrences beginning in August 2021 and the last in September 2021. An interview was conducted with the Activity Director on 10/21/21 at approximately 1:21 p.m. The Activity Directory stated Resident #125's family visits with the resident twice each week; one day in-person and one day by zoom but; they had the option to call and make an appointment for any days they would like to visit but she never shared that information with the family in person or by letter. On 10/21/21 at approximately 2.00 p.m., the above findings were shared with the Administrator, Director of Nursing and two Corporate Consultant. The Administrator stated they had updated resident contact information to ensure all residents, representatives and families contact information was current and letters were sent to all explaining the current visitation status for the community.	{F 563}		
{F 677} SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	{F 677}		

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✓ {F 677}	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to provide personal care to include showers for one resident in the survey sample (Resident #101) who was unable to independently carry out activities of daily living (ADL's). The findings included: The facility staff failed to ensure Resident #101 was offered and received a scheduled twice-weekly shower to maintain good personal hygiene. Resident #101 was originally admitted to the nursing facility on 12/09/20. Diagnosis for Resident #101 included but are not limited to Congestive Heart Failure (CHF), muscle weakness and need for assistance with personal care. Resident #101's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 08/29/21 coded Resident #101 with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no impaired cognitive skills for daily decision-making. The MDS coded Resident #101 total dependence of two with transfer, total dependence of one with dressing, hygiene, bathing and toilet use, extensive assistance of one with bed mobility and supervision of one with eating for ADL care. Resident #101's comprehensive care plan with a revision date 09/29/21 documented the resident is resistive to care. The goal set for the resident by the staff the resident will cooperate with care. Some of the approaches to manage goal is to	{F 677}	**F 677-ADL Care provided for dependent residents.** 1. **Resident # 101 was provided with shower.** 2. **Current residents have the potential to be affected by this deficient practice.** 3. **Education to clinical staff on shower process and importance of documenting received by DON/designee. New hires and agency are educated during orientation.** 4. **5 residents audited 5 times a week to ensure showers given by administrator/designee. Results of audits taken to QAPI committee monthly X 3 for review and revision as needed.** 5. **Date of compliance** 11/4/2021	

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{F 677}	Continued From page 7 give clear explanation of all care activities prior to an as they occur during each interaction and if the resident resist with ADL's, staff is to reassure the resident, leave and return 5-10 minutes later and try again. An interview was conducted with Resident #101 on 10/20/21 at approximately 12:05 p.m. Resident #101 stated, "I have only received one shower since I've been here and if they have documented something else, it's not true." When asked if he wanted showers, he stated, "Of course I want showers, who doesn't." Resident #101 said, I would be willing to take a shower every day, if possible. Resident #101's showers were scheduled to be given every Tuesday and Friday (3p-11p). Review of Resident 101's Certified Nursing Assistant (CNA tracking form) revealed showers were not provided on the following shower days for October 2021: 10/01, 10/05, 10/08 and 10/12/21. An interview was conducted with the Administrator and Director of Nursing (DON) on 10/21/21 at approximately 9:45 a.m. The DON said the Charge Nurse or Unit Manager (UM) should have made sure that Resident #101 received his shower on the scheduled shower days. The DON said she expect for the staff to signed off showers as given unless they refuse then the refusal should be document in the resident's clinical record. She if the resident refused his/her shower, the CNA is to report the refusal the Charge Nurse or UM. The Unit Manager or Charge Nurse will speak with the resident and if the resisent still refuses, the refusal is documented in the resident's clinical	{F 677}		

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{F 677}	Continued From page 8 record. Review of Resident #101's clinical record did not reveal evidence that the resident had refused his showers. The Administrator, Director of Nursing and Corporate support nurses were informed of the finding during a debriefing on 10/21/21 at approximately 1:40 p.m. The facility staff did not present any further information about the findings. The facility policy titled ADL Documentation Policy with a revision date of 08/12/20 including the following information: provision of ADL care will be documented each shift by staff providing the care. This shall include, but not limited to, documentation of bathing, dressing, and transferring. Procedure: In facilities still using paper records, ADL's will be documented in the ADL Flow Record and the nurse will review the ADL Flow Record or Plan of Care (POC) before the end of the shift to ensure completion before staff depart.	{F 677}		
√{F 812} SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	{F 812}	**F 812-Food Procurement Store/Prepare/Serve-Sanitary** 1. **Expired and non-dated food were discarded during survey.** 2. **Current Residents have the potential to be affected by this deficient practice.** 3. **Education to dietary department by Regional Dietician/designee on proper food storage. Agency and new hires will be educated on orientation.** 4. **Dietary Manager/designee will audit kitchen 5 times a week for 12 weeks for any non-labeled/expired foods. Results of audits will be taken to QAPI committee monthly X 3 months for review and revision as needed.** 5. **Date of compliance** 11/4/2021	

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{F 812}	Continued From page 9 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility staff failed to store food in accordance with professional standards for food service safety. The findings included: The food service staff failed to ensure foods stored in the freezer were labeled and dated when open. On 10/19/21 at 2:45 p.m., during the inspection of the kitchen with the Dietary Manager and Regional Dietitian, the following were observed: Inside the walk-in-freezer was a bag of French Toast, 1 bag of blueberries, 1 bag of strawberries, 1 bag of vegetable blend, 1 bag of broccoli and 1 bag green of peas were open; not labeled and dated. An interview was conducted with the Dietary Manager and the Regional Director on 10/19/21 at approximatley 3:15 p.m. The Dietary Manager stated, "Most of our staff are new hires and we have a lot of coaching issues." He said the open bags of frozen food located inside the walk-in-freezer should have been labeled and	{F 812}		

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{F 812}	Continued From page 10 dated once open. On the same day at approximately 1019/21 at approximately 3:35 p.m., the Dietary Manager provided an in-service document titled Food Nutritional Service (FNS). The document was signed by the five (5) dietary staff members who currently working in the kitchen. The document included the following information: Topic: educate on importance of proper food/spices and seasoning - sealing, labeling and dating and dis items past use by date with review of policy, expectations of compliance to policy. All items must be resealed and labeled immediately after use. The Administrator, Director of Nursing and Corporate support nurses were informed of the finding during a debriefing on 10/21/21 at approximately 1:40 p.m. The facility staff did not present any further information about the findings. The facility policy titled Storage of Frozen Foods Policy. Frozen foods will be stored at appropriate temperatures and methods which promote food quality and food safety. Procedure: 11. Food stored in the freezer shall be covered, labeled and dated.	{F 812}		