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 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE CHESTERFIELD, 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 A COVID-19 Focused Emergency Preparedness Survey was conducted onsite 6/28/22 through 6/29/22. The facility was in substantial compliance with 42 CFR Part 483.73(b)(6) emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 196 certified bed facility was 185 at the time of the survey.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control and a Abbreviated (complaint) Survey were conducted onsite from 6/28/22 through 6/29/22. Corrections are required for compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. In addition, corrections are required for compliance with other sections of 42 CFR Part 483 Federal Long Term Care requirements. The survey sample consisted of 13 residents. Six complaints were investigated during the survey as follows: VA00055227-Substantiated with deficiency VA00055185-Unsubstantiated VA00055144-Substantiated with deficiency VA00055036-Unsubstantiated VA00054785-Substantiated with deficiency VA00054571-Substantiated with deficiency	F 000		

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

S. Jett, LNHA 7-21-22

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. Revised 7/26/2022

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F 000	Continued From page 1 The census in this 196 certified bed facility was 185 at the time of the survey. The survey sample consisted of 13 resident reviews and 10 employee reviews.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff misappropriated Resident funds for one Resident (Resident #11) in a survey sample of 13 Residents. The findings included: For Resident #11, the facility staff used the Resident's personal funds to apply to a facility bill the Resident owed and applied to become representative payee for the Resident's Social Security income, without the Resident's approval or knowledge. On 6/28/22, a closed record review was conducted of Resident #11's medical record. This review revealed the following: * Resident #11 was admitted to the facility on	F 602	**1. Resident #11 was discharged on 9/2/21. Resident #11 will be reimbursed.** **2. All residents with a RFMS account have a potential to be affected by the deficient practice. 100% audit of current residents with RFMS accounts was completed on 7/8/22 by the Regional Business Office Manager. Any discrepancies will be addressed.** **3. Regional Director of Business Office will in-service Business Office Manager and Assistant Business Office Manager on Rep Payee Policy and the process for RFMS accounts/withdraws on 6/30/22.** **4. Regional Director of Business Office or designee will audit RFMS accounts/withdraws for discrepancies with reimbursement if warranted weekly x 4 weeks then monthly x 2 months. Administrator or designee will report the results of the audits to the QAPI committee monthly for 3 months. Audits results/trends will be reviewed at QAPI meeting to ensure Action Plans are effective. Additional action plans will be done as needed.** **5. Date of compliance: 7/29/2022.**	

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F 602	Continued From page 2 7/7/21, and discharged on 9/2/21. * On 7/12/21, Resident #11 was evaluated/seen by a psychiatrist. This note read, "Exam:... Affect is appropriate, full range, and congruent with mood. There are no apparent signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychotic process. Associations are intact, thinking is logical, and intentions are denied. Cognitive functioning was not formally tested today but appears clinically to be unchanged from previous examinations. Vocabulary and fund of knowledge suggest cognitive functioning in the intellectually disabled range..." * On 7/13/21, Resident #11 had a MDS (minimum data set) (an assessment tool) completed by facility staff and was coded as having had a BIMS (brief interview for mental status) score of 15 out of a possible 15, which indicated cognitively intact. * On 8/17/21, another assessment by a mental health nurse practitioner (MHNP) was noted. This assessment read, "...Mental Status Examination. Sensorium: alert, Orientation: person, Speech: coherent, Mood: pleasant, Affect: appropriate, Thought process: organized, Hallucinations: none evident, short-term memory: good, long-term memory: good, concentration: good, insight: good, judgement: good ...fund of knowledge: good..." * A document was scanned into the record that was a letter that was from Social Services dated 7/15/21, that read, "Notice of Patient pay responsibility: July: 0, August-ongoing: $789" meaning Resident #11 was responsible to pay the	F 602		

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F 602	Continued From page 3 facility $789 per month starting in August. * A document was also scanned into the record that were the forms where the facility had applied to become representative payee for Resident #11's social security income. These forms were completed by the attending physician on 8/18/21. * The face sheet noted Resident #11 as her own responsible party. * Progress notes throughout the chart indicated Resident #11 was making decisions in her daily care to include but not limited to: discharge, discharge planning, etc. * Resident #11 had signed her own admission agreement for her admission to the facility. * The progress notes revealed no indication that Resident #11 was aware that the facility was requesting to be made representative payee or the resident had consented to such actions. On 6/29/22 at 9:05 AM, a video call was held with Surveyor G and Employee G, the business office manager and Employee H, the assistant business office manager. Employees G and H were asked if Resident #11 had a trust account when she resided at the facility, Employee H said, "Yes she did". Surveyor G asked if Resident #11 had an outstanding balance due to the facility and they [Employee G and H] responded, "No she doesn't owe us anything". Surveyor G asked Employees G and H, did Resident #11 have any money on admission? Employee H said, "She put in $40 when she opened the account, but cash was deposited later	F 602		

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F 602	Continued From page 4 and misplaced so she was reimbursed for the amount that was misplaced it was $750 and $853, which equaled $1,603". Surveyor G asked the facility staff to submit any supporting documentation regarding this. Surveyor G then stated that it was observed that the facility applied to be representative payee for Resident #11. Employee H said, "That is correct, she wasn't paying us". Employee G added, "Anyone that doesn't pay us for 1 month or has a history of non-payment we apply to be representative payee". Employee H added, "Once we started telling her she had to pay her monthly income she decided to leave. She even had her insurance company call use several times to make sure we were billing her the right amounts". The facility was asked to submit their collections policy that included the step of applying to be representative payee. Surveyor G asked if Resident #11 had authorized her for the money in her trust account to be used to pay her bill and if she was aware the facility was applying to be representative payee. Employee H said, "Yes". The facility staff was asked to submit any evidence they had of those conversations as well. On 6/29/22, during the afternoon the facility submitted documents that included the following: * A receipt dated 7/7/21, that said "locked in safe $1,643.00, -$40.00 RFMS [Resident Fund Management Service/Trust account] = $1,603.00". Resident #11's name was on the receipt and the receipt was signed by Employee H.	F 602		

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F 602	Continued From page 5 * A trust account authorization form dated 7/12/21, signed by Resident #11. This form read, "Resident Fund Management Service Authorization and Agreement to Handle Resident Funds. Check account type: Non-transferring account: (no automatic transfer of deposits to pay for care costs" was selected. * On the Resident Trust Account transaction report there was evidence that on 10/26/21, a deduction from the account in the amount of $829.00 was made and noted "Care cost payment". * On 12/3/21, another trust account withdrawal was made in the amount of $251.67, with the note "Case Cost Payment". The facility submitted no evidence that Resident #11 had agreed to the transfers from her trust account to make payment towards her care at the facility. They also submitted no evidence that Resident #11 was aware nor agreed to the facility becoming representative payee of her social security income. The facility indicated they did not have a collections policy. On 6/29/22, during an end of day meeting the facility Administrator, Director of Nursing and Corporate staff were made aware of the above findings. No further information was provided.	F 602		
F 658	COMPLAINT DEFICIENCY. Services Provided Meet Professional Standards	F 658		

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F 658 SS=D	Continued From page 6 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 clinical record review, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide care and services in accordance with professional standards for 1 resident, Resident #13, in a sample size of 13 residents. The findings included: For Resident #13, facility staff failed to administer medications as ordered by the physician onper physician order 3/24/22. On 6/29/22, Resident #13's clinical record was reviewed and revealed physician orders, schedule times, and actual administration times for medications as follows: *Bisacodyl EC Tablet Delayed Release 5mg, give 2 tablets by mouth one time a day for Constipation--scheduled for 9:00 AM---documented as given at 16:45 PM by RN D *Cetirizine HCl Tablet 10mg, give 1 tablet by mouth one time a day for Seasonal Allergies--scheduled for 9:00 AM---documented as given at 16:45 PM by RN D *Diltiazem CD Capsule Extended Release 24 Hour 120mg, give 1 capsule by mouth one time a	F 658	**1. Residents #13 was discharged on 4/20/22.** **2. All residents have a potential to be affected by the deficient practice. An audit of the EMARs will be conducted by the DON or designee to identify if other residents were not given their medications per physician order.** **3. Staff Development Coordinator or designee will educate licensed nursing staff on medication administration policy.** **4. Unit Managers or designee will audit 20 residents E-MARS weekly x 4 weeks then monthly x 2 months to ensure medications are administered per physician orders at the scheduled times. Unit Managers or designee will report the results of the audits to the QAPI committee monthly for 3 months. Audits results/trends will be reviewed at QAPI meeting to ensure Action Plans are effective. Additional action plans will be done as needed.** **5. Date of compliance: 7/29/2022.**	

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F 658	Continued From page 7 day for A-fib (Atrial Fibrillation)--scheduled for 9:00 AM---documented as given at 16:46 PM by RN D *Ferrous Sulfate Tablet 325mg, give 1 tablet by mouth one time a day for Mineral Supplement--scheduled for 9:00 AM---documented as given at 16:47 PM by RN D *Levothyroxine Sodium Tablet 25mcg, give 1 tablet by mouth one time a day for Hyperthyroidism--scheduled for 9:00 AM---documented as given at 16:47 PM by RN D *Amiodarone HCl Tablet 200mg, give 1 tablet by mouth two times a day for HTN (Hypertension)--scheduled for 9:00 AM and 9:00 PM---morning dose documented as given at 16:45 PM by RN D *Apixaban Tablet 5mg, give 1 tablet by mouth two times a day for DVT Prevention--scheduled for 9:00 AM and 5:00 PM---morning dose documented as given at 16:46 PM by RN D *Lasix Tablet 40mg, give 1 tablet by mouth two times a day for Edema/Defective Kidney Function--scheduled for 9:00 AM and 9:00 PM---morning dose documented as given at 16:47 PM by RN D *Mucinex Tablet Extended Release 12 Hour 600mg, give 1 tablet by mouth every 12 hours for Congestion--scheduled for 9:00 AM and 9:00 PM---morning dose documented as given at 23:07 PM by RN D *Timolol Maleate Solution 0.5%, instill 1 drop in both eyes two times a day for	F 658		

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	495116	A. BUILDING _____ B. WING _____	C 06/29/2022

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F 658	Continued From page 8 Glaucoma--scheduled for 9:00 AM and 5:00 PM--morning dose documented as given at 16:48 PM by RN D *Welchol Tablet 625mg, give 3 tablets by mouth two times a day for Hyperlipidemia--scheduled for 8:00 AM and 5:00 PM---morning dose documented as given at 16:45 PM by RN D Review of nursing progress notes revealed documentation by RN D on 3/25/22 which read, "Medication administration for am [morning] meds on 24th March served at a late time, patient refused due to delayed administration, however refused meds [were] charted inadvertently as being given, unit manager informed of occurrence". Note: RN D was not available for interview. An interview was conducted with the Unit Manager, RN C, however she was unable to recall any details. RN C reviewed Resident #13's progress note on 3/25/22 made by RN D and the morning medication administration times for 3/24/22 and verified that it did not appear the morning medications for 3/24/22 were given as ordered. The Facility Administrator and Director of Nursing (DON) were updated on the findings. The DON stated that the facility's professional nursing standards reference was "Lippincott". A facility policy on medication administration was requested and received. Review of the facility policy entitled, "Administering Medications", revised December 2012, heading "Policy Statement", read, "Medications shall be administered in a safe and	F 658		

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F 658	Continued From page 9 timely manner, and as prescribed". Within the same document, subheading, "Policy Interpretation and Implementation", item 3, read, "Medications must be administered in accordance with the orders, including any required time frame" and item 4 read, "Medications must be administered within one (1) hour of their prescribed time...". According to Lippincott "Nursing Procedures", Seventh Edition, 2016, section entitled, "Oral Drug Administration", steps in the implementation of medication administration included but were not limited to: "Verify the medication is being administered at the proper time ...to reduce the risk of medication errors". No further information was provided.	F 658		
F 883 SS=D	COMPLAINT DEFICIENCY Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883	**1. Residents #17 was offered and received pneumococcal vaccine 7/18/22** **2. All residents have the potential to be affected. An Audit will be conducted by the DON or designee to verify COVID vaccinations were offered, provided education, and administered or declined with documentation in clinical record.** **3. Staff Development Coordinator or designee will educate LPN/RNs regarding Pneumococcal Immunization policy and process for documenting pneumococcal vaccine requirements with offering, education, decline or accepted and**	

			administered with documentation in clinical record. **4. Unit Managers or designee will audit new admissions to verify residents were offered the pneumococcal vaccine with documentation weekly x 4 weeks then monthly x 2 months. Unit Managers or designee will report the results of the audits to the QAPI committee monthly for 3 months. Audits results/trends will be reviewed at QAPI meeting to ensure Action Plans are effective. Additional action plans will be done as needed.** **5. Date of compliance: 7/29/2022.**	

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F 883	Continued From page 10 (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 883		

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F 883	Continued From page 11 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide a pneumococcal vaccine for 1 resident, Resident #17, out of 5 residents reviewed for pneumococcal immunization. The findings included: The facility staff failed to provide pneumococcal immunization for Resident #17. On 6/29/22, a clinical record review was performed for Resident #17 and revealed there was no documentation with regard to pneumococcal immunization, to include the resident's current pneumonia vaccination status, offer to provide immunization against pneumococcal infection, or documentation of resident refusal or medical contraindication. There was a physician's order dated 5/25/22 which read, "May have Pneumovax with consent". On 6/29/22 at 1:45 PM, an interview was conducted with the Infection Preventionist who accessed Resident #17's clinical record, verified the findings, and stated, "This is an oversight, I cannot find any assessment for pneumonia immunization status in [Resident #17's] medical record, I cannot say whether [Resident #17] received vaccination for pneumonia or not". Review of the facility policy revised August 2016 and entitled, "Pneumococcal Vaccine", subheading, "Policy Statement" read, "All residents will be offered the pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections" and item 2 read, "Assessments of pneumococcal vaccination status will be conducted within five (5) working	F 883		

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F 883	Continued From page 12 days of the resident's admission if not conducted prior to admission". The Facility Administrator, Director of Nursing, and Infection Preventionist were all made aware of the findings. No further information was provided.	F 883		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.	F 886	**1. (A) Residents #16, #17, #18, #19, and #20 had no adverse outcomes as result of deficient practice. (B) Employee D was tested on 6/7/22 and has not returned to work. Employee LPN C tested on 6/20/22. C.N.A. F was tested on 7/1/22.** **2. All residents have the potential to be affected. An audit will be conducted by the IP (Infection Preventionist) or designee to verify residents and staff are tested per CDC guidelines and requirements.** **3. Staff Development Coordinator/designee will educate LPN/RNs on current CDC testing guidance for residents and staff.** **4. IP or designee will audit new admissions to verify residents are tested per current CDC guidance and staff are tested per CDC guidelines and requirement weekly x 4 weeks then monthly x 2 months.** **IP or designee will report the results of the audits to the QAPI committee monthly for 3 months. Audits results/trends will be reviewed at QAPI meeting to ensure Action Plans are effective. Additional action plans will be done as needed.** **Date of compliance: 7/29/2022.**	

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	495115	A. BUILDING _____ B. WING _____	C 06/29/2022

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COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE CHESTERFIELD, VA 23834

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F 886	Continued From page 13 §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility documentation review, the facility staff failed to conduct COVID-19 testing in accordance with the Centers for Disease Control and Prevention (CDC) guidance for 4 Residents, Residents #16, #18, #19, and #20 in a sample of	F 886		

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F 886	Continued From page 14 5 Residents reviewed for testing and for 3 staff (Employee D, CNA F, and LPN C) in a sample of 5 employees reviewed for COVID testing. The findings included: 1. For Residents #16, #17, #18, #19, and #20, the facility staff failed to conduct COVID-19 testing upon their admission to the facility. On 6/28/22, a clinical record review was conducted and revealed the following: a. Resident #16 was admitted to the facility on 6/4/22. Resident #16 was not tested for COVID until 6/6/22. b. Resident #18 had been readmitted to the facility on 6/10/22. The first instance of COVID testing for Resident #18 was 6/13/2022. c. Resident #19 was admitted to the facility on 6/24/22. There was no evidence in the clinical chart of Resident #19 that she had been tested for COVID-19 since being admitted to the facility. d. Resident #20 had been admitted to the facility on 6/11/22. The first instance of COVID testing for Resident #20 was 6/13/2022. On 6/28/22 at 3:35 PM, an interview was conducted with the facility Infection Preventionist (IP). The IP stated the facility has an abundance of COVID test kits and have not experienced any difficulty with obtaining COVID test. She was asked about Resident testing and she stated, "Right now because we are in outbreak Residents are tested every Monday and Thursday". When asked to discuss new admissions, the IP said,	F 886		

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F 886	Continued From page 15 "The day of admission or the next day they are tested". When asked about any subsequent testing, she said "They will be tested on our next round of testing and continue with the twice a week testing like everyone else". On 6/29/22 at 10:05 AM, an interview was conducted with RN C, the unit manager. When asked about testing, RN C said, "We are tested twice a week because we are in an outbreak". She was asked to explain who is being tested twice weekly. RN C said, "The staff and Residents". RN C further confirmed that all Resident testing is documented in the progress notes the day testing occurs or the following day. RN C was asked if new admission Residents are tested. RN C said, "Usually they are tested when they come in, if not that night, then the next day if they didn't come with one [a COVID test] already from the hospital". RN C was asked who performs the testing of new admissions. She said, "If on the weekend the admitting nurse should [conduct the COVID test]. If it is Monday-Friday, the IP does". Surveyor G asked, what happens if they are admitted Monday-Friday, after the IP has left for the day. RN C said, "Then it would be the next day". On 6/29/22 at 10:22 AM, an additional interview was conducted with the facility Infection Preventionist. The IP was asked about COVID testing of new admissions. She said, "They are supposed to be tested on admission, if not the next day". The Infection Preventionist was asked by Surveyor G, What happens if they are admitted after you leave for the day? The IP said, "The nurses have access to the test kits and should be testing the Resident. The next day the	F 886		

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F 886	Continued From page 16 unit manager should be reading the notes to ensure they were tested". During the above call, the IP was given Resident #16, #18, #19, and #20's names, date of admission and first occurrence of testing noted by Surveyor G. The IP looked in the clinical chart of two of the Residents and confirmed the findings and then agreed to look and see if she had any additional testing information and let Surveyor G know if she found any. Review of the facility's policy titled, "COVID-19 Testing Plan" was reviewed. This policy read on page 4, "Testing Guidelines for New Admissions: 1. newly admitted residents and residents who have left the facility for >24 hours, regardless of vaccination status, should have a series of two viral tests for SARS-COV-2 infection: immediately and, if negative, again 5-7 days after their admission". Review of the CDC document entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", updated February 2, 2022, and was reviewed. This document read on page 4, "Testing", item 3, "Newly-admitted residents and residents who have left the facility for (greater than) 24 hours, regardless of vaccination status, should have a series of two viral tests for SARS-CoV2 infection; immediately and, if negative, again 5-7 days after their admission". Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html On 6/29/22, during an end of day meeting held at 4:22 PM, the facility Administrator, Director of	F 886		

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F 886	Continued From page 17 Nursing, Regional Clinical Director and Regional Director of operations were made aware of the above findings. The Administrator confirmed the facility "should be" following CDC guidance. No further information was provided. 2. The facility failed to conduct outbreak testing for 3 staff (Employee D, CNA F, and LPN C) in a sample of 5 employees reviewed for COVID testing. On 6/28/22, on survey entrance the facility Administrator reported they were currently in a COVID outbreak. On 6/28/22, the facility staff submitted COVID testing data for the month of June. On 6/29/22, a sample of staff were selected for review of testing occurrences. The following was noted: a. Employee D was tested 6/3/22 and 6/7/22. No other testing occurrences were noted for the month of June with regards to Employee D. Time card records were requested for Employee D but were not received. b. CNA F was tested on 6/1/22, 6/7/22, and 6/14/22. CNA F had not been tested in the past 7 days at the time of survey. Review of payroll records indicated CNA F had continued to work regularly from 6/15-survey dates. c. LPN C had one testing occurrence in June which was 6/7/22. Review of time card reports revealed LPN C had worked 3 days per week	F 886		

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F 886	Continued From page 18 since 6/7/22. On 6/28/22 at 3:10 PM, a video call was conducted with the facility Infection Preventionist (IP). The IP provided the survey team with the COVID line listing which indicated they had been in COVID outbreak for the entire month. The IP confirmed that they started having positive cases the beginning of May and were not able to isolate it so they started doing broad based testing. She confirmed this meant they were testing everyone, Residents and staff, twice weekly. The IP confirmed that they are using rapid COVID test kits and have an abundance of tests and have had no problems accessing COVID test. On 6/29/22 at 10:05 AM, an interview was conducted with RN C, the unit manager. RN C was asked about testing and said, "We are tested twice a week, staff and Residents, because we are in outbreak". On 6/29/22 at 10:22 AM, an interview was conducted with the facility Infection Preventionist (IP). During this call the above findings with regards to Employee D, CNA F, and LPN C were shared with the IP. She was given the staff members name, test dates and Surveyor G noted and that testing occurrences were missing for each of the employees. The IP agreed to look and see if she could find any additional testing occurrences. On 6/29/22 at 2:04 PM, the IP followed up with Surveyor G. During this call she stated, "[Employee D's name redacted] went prn [as needed] and hasn't worked since 6/7/22. [CNA F's name redacted] didn't test. [LPN C's name redacted] went on vacation and was positive for	F 886		

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F 886	Continued From page 19 COVID while out". The IP was asked to give the date that LPN C went on vacation but no further information was received. The CDC: Centers for Disease Prevention and Control gives guidance in their document titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes Nursing Homes & Long-Term Care Facilities, Updated Feb. 2, 2022". This document read, "...New Infection in Healthcare Personnel or Residents: ...Perform testing for all residents and HCP on the affected unit(s), regardless of vaccination status, immediately (but generally not earlier than 24 hours after the exposure, if known) and, if negative, again 5-7 days later...If additional cases are identified, testing should continue on affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of residents who are not up to date with all recommended COVID-19 vaccine doses, until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), should be considered..." Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631031062858 CMS (Centers for Medicare & Medicaid Services) gives guidance regarding testing in their document "QSO-20-38-NH, REVISED 04/27/2021 SUBJECT: Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements and Revised COVID19 Focused Survey Tool". This document read, "Testing of Staff and Residents in Response	F 886		

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F 886	Continued From page 20 to an Outbreak...Upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents, regardless of vaccination status, should be tested immediately, and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result..." On 6/29/22, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the above findings. No further information was provided with regards to the previously noted employees.	F 886		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;	F 887	**1. Resident #19 was offered COVID vaccine on 6/29/22. Resident #20 was offered COVID vaccine on 7/7/22.** **2. All residents have the potential to be affected. An audit of all residents will be conducted by the IP (Infection Preventionist) or designee to verify COVID vaccinations were offered, provided education, and administered or declined with documentation in clinical record.** **3.Staff Development Coordinator or designee will educate LPN/RNs regarding COVID Immunization vaccine requirements with offering, education, decline or accepted and administered with documentation in clinical record.**	

			4. Unit Managers or designee will audit new admissions to verify residents are offered COVID vaccine, education provided and administered if accepted or declined and documented in clinical record weekly x 4 weeks then monthly x 2 months. Unit Managers or designee will report the results of the audits to the QAPI committee monthly for 3 months. Audits results/trends will be reviewed at QAPI meeting to ensure Action Plans are effective. Additional action plans will be done as needed. **5. Date of compliance: 7/29/2022**	

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F 887	Continued From page 21 (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and	F 887		

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F 887	Continued From page 22 related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to offer COVID vaccination(s) to two Residents (Resident #19 & #20), in a sample of 5 Residents reviewed for immunizations. The findings included: 1. The facility staff failed to provide evidence that Resident #19 was offered, educated and provided/or declined COVID vaccination. On 6/28/22, a clinical record review for Resident #19 was conducted. This review revealed the following: Resident #19 was admitted to the facility on 6/24/22. On the immunization tab of the electronic health record (EHR) there was no documentation with regards to the COVID vaccine status of Resident #19. All of the progress notes for Resident #19 were reviewed, which included social work, nursing and medical providers, to include from admission through the date of review. There was no indication of Resident #19 being offered or educated on the benefit of immunization for COVID. Review of the misc. (miscellaneous) tab revealed no evidence of vaccine administration or offering of the COVID vaccine. There was a document scanned into the EHR titled "Admission Alert" that read, "Pt. [patient] vaccination not found in VIIS [Virginia Immunization Information System]".	F 887		

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F 887	Continued From page 23 Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR), revealed no evidence of the COVID immunization being provided to Resident #19. 2. The facility staff failed to provide evidence that Resident #20 was offered, educated and provided/or declined COVID vaccination. On 6/28/22, a clinical record review for Resident #20 was conducted. This review revealed the following: Resident #20 was admitted to the facility on 6/11/22. On the immunization tab of the electronic health record (EHR) there was no documentation with regards to the COVID vaccine status of Resident #20. All of the progress notes for Resident #20 were reviewed, which included social work, nursing and medical providers, to include from admission through the date of review. There was no indication of Resident #20 being offered or educated on the benefit of immunization for COVID. Review of the misc. (miscellaneous) tab revealed a document scanned in that was the immunization record accessed from VIIS [Virginia Immunization Information System]. This document had no information with regards to COVID immunization for Resident #20. Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR), revealed no evidence of the COVID immunization being provided to Resident #20.	F 887		

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F 887	Continued From page 24 On 6/29/22 at 10:05 AM, an interview was conducted with RN C. RN C was asked to explain the process of how she and other nursing staff, find out the COVID immunization status when an admission comes in. RN C said, "Admissions finds out their vaccination status and makes the bed assignment. Their vaccination status should be under the immunization tab in their record". RN C was asked to access the EHR (electronic health record) for Resident #19 and #20 and confirm their immunization status with regards to COVID-19. RN C accessed Resident #19 and said "She doesn't have anything under the immunization tab and I haven't reviewed her entire chart". RN C reviewed the progress notes and other chart contents for Resident #19 and confirmed she didn't see evidence of Resident #19 being offered the vaccine. RN C then accessed Resident #20's EHR and said, "I don't see anything documented". She was asked if she could show Surveyor G where Resident #20 was offered the vaccine and she confirmed she didn't see anything documented. RN C was asked to explain the process if an admission comes in and they are not immunized. She said, "When they come in if they are not vaccinated we offer the vaccine. It would get documented in the progress notes". When asked if there is any type of consent form that is signed, RN C said, "Yes they do". When asked who offers the COVID vaccine to Residents, RN C said "usually the IP [infection preventionist] comes around and they offer it". When asked if the vaccines for COVID-19 are kept in-house/in-stock RN C said, "Usually we do have some in stock".	F 887		

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F 887	Continued From page 25 On 6/29/22 at 10:22 AM, a video call was held with the Infection Preventionist (IP)/Employee C. The IP confirmed that she had Moderna and Pfizer COVID immunizations in stock/on hand and said, "I always keep some on hand because I try to do a vaccine clinic once a week". The IP said, "When a new admit comes in admissions will look up their vaccination status in VIIS, if I don't see it then I will look it up as well, ask the Resident, and call the family to find out their status and I enter it into the immunization tab of their chart". The IP was asked what time frame this occurs and she said, "ASAP [as soon as possible], if admissions doesn't do it I'm the only other person that has access to VIIS and I try to do it the next day". The IP was asked to explain what happens if the Resident is not vaccinated. She said, "We have quite a few admissions that came in my absence, I have to see who needs it and call the RP to verify, I will go ask the Resident if they want it, provide education and immunize them". The IP said she was absent from work 6/9/22-6/27/22. When asked if anyone was doing her responsibilities in her absence she said, "Not that I've seen". The IP then accessed the clinical record for Resident #19 and #20 and confirmed there was no indication that they are immunized for COVID-19, and no evidence that they were offered immunization at the facility. On 6/29/22 at 11:50 AM, an interview was conducted with the Director of Nursing (DON). When asked if they have staff assigned to fill in and assume the responsibility of the IP in her absence, the DON said, "We have designated	F 887		

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F 887	Continued From page 26 testers and as DON, I fill in for the infection preventionist". When asked if they have a system in place in the absence of the IP, the DON said, "We have a system in place to continue as much as possible in her absence". Review of the facility policy titled, "COVID-19 Testing Plan" was conducted. This policy read, "...4. New Admissions...c) Vaccine eligible while resides in facility [sic] the vaccine will be administered if consented to maintain Up to Date status. d) Verification of the vaccination status if Up to date, Not Up to date or COVID infection vs recovery will be identified for bed placement..." The facility policy titled, "COVID-19 Vaccinations for Residents" was reviewed. This policy read, "The facility is committed to ensuring maximum resident protection for all residents as outlined in this policy and in accordance with federal and state regulations. The facility will offer and administer the COVID-19 vaccine to all residents if in agreement and meets the criteria for administration of the vaccine". CDC (Centers for Disease Control and Prevention) provides the following guidance to nursing facilities in their document titled "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes". This document read, "...New Admissions and Residents who Leave the Facility: Create a Plan for Managing New Admissions and Readmissions....In general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine. COVID-19 vaccination should also be offered". Accessed online	F 887		

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F 887	Continued From page 27 4/27/22, at web address: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631030153017 On 6/29/22, during an end of day meeting held at 4:22 PM, the facility Administrator, Director of Nursing, Regional Clinical Director and Regional Director of operations were made aware of concerns regarding COVID immunizations for Resident #19 and #20. They also confirmed that they follow CDC guidance. On 6/29/22 at 5:34 PM, the facility Administrator stated, "[Resident #19's name redacted] RP [responsible party] refused COVID vaccine. She was admitted on 6/24/22. Please review". An additional clinical record review was conducted and revealed a progress note entered into the clinical record on 6/29/22 at 2:05 PM, which indicated Resident #19's RP had declined the pneumonia vaccine, there was no information with regards to being offered COVID immunization. No further information was provided.	F 887		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of	F 888	**1. No residents were affected by deficient practice.** **2.All residents have the potential to be affected. An audit of active employees was conducted by the IP (Infection preventionist) to verify employees have completed the primary series or are within the timeframe to receive and complete the primary series or have an approved exemption form.** **3.Administrator or designee will educate IP Nurse and HR (human resource) on the**	

			process and current CDC guidelines and requirements for COVID vaccinations for the staff. 4. Administrator or designee will audit staff vaccination matrix weekly x 4 weeks then monthly x 2 months to ensure facility staff meet current CDC guidelines on staff COVID vaccination. Administrator or designee will report the results of the audits to the QAPI committee monthly for 3 months. Audits results/trends will be reviewed at QAPI meeting to ensure Action Plans are effective. Additional action plans will be done as needed. 5. Date of compliance: 7/29/2022	

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F 888	Continued From page 28 a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have	F 888		

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F 888	Continued From page 29 received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the	F 888		

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F 888	Continued From page 30 authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and in the course of a complaint investigation, the facility staff failed to ensure 100% compliance for staff primary vaccination against COVID-19.	F 888		

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F 888	Continued From page 31 The findings included; 1. The facility staff vaccination rate for COVID-19 was 86.5%. The total number of staff completely vaccinated was 229. Six staff were granted Non-medical exemption and two staff had a temporary delay per CDC. The total number of all staff was 274. Review of the NHSN website revealed the vaccination rate of the facility during the week ending 6/12/2022 was 87.9 %. On 6/28/2022 during the initial entrance and tour, the staff vaccination matrix was requested and received. On 6/28/2022, during the End of Day meeting with the facility Administrator, Vice President of Operations, Director of Nursing and facility Infection Preventionist, the facility was asked about their expectation with regards to employee immunization for COVID-19. The Administrator stated the expectation is 100%, unless they have a legitimate exemption". On 6/29/2022, Review of the documentation on the matrix revealed conflicting numbers. On 6/29/2022 at 11:34 p.m., an interview was conducted with the Infection Preventionist (Employee C) who stated she had been out for a few days and when she realized some of the numbers were incorrect. Employee C stated the facility did not have a 100% vaccination rate but there were some errors on the form. Employee C stated she was going to review the documentation and resubmit the vaccination matrix.	F 888		

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F 888	Continued From page 32 On 6/29/22 at 4:05 PM, the facility provided the survey team with a final staff vaccination matrix that they indicated was accurate following being notified their previous tracking system was not accurate. Review of this revised matrix revealed the facility had a total of 274 employees. Of the 274 employees, 229 were completely vaccinated and six (6) had been granted religious exemptions. On 6/29/2022 at 4:14 PM, an interview was conducted by Surveyor D and Surveyor G with the Infection Preventionist who stated she was aware of the fact that the facility was supposed to have 100% of its staff vaccinated, however, there had been problems getting some staff members to comply. The Infection Preventionist (Employee C) stated she had been keeping accurate records and offered the vaccine weekly. Employee C stated she let the Administrator know the names of the staff who refused the vaccines. Employee C stated the facility had a new Administrator (of only a couple of weeks). The new Administrator and Director of Nursing had been informed of the current number of staff not fully vaccinated. Employee C stated staff members had been offered the second vaccine but some had refused. Employee C stated it had "been challenging getting them off the schedule until they get vaccinated." She also stated the staff who work PRN (As needed) need to come off the schedule and that number should be decreased." Review of the facility policy revision date 2/17/2022 titled, "Mandatory COVID-19 Vaccinations" was reviewed. This policy read, "The facility is committed to ensuring maximum	F 888		

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F 888	Continued From page 33 resident protection, all staff who interact with other staff or residents in any location beyond the formal clinical setting (such as homes, clinics, other sites of care, administrative offices, off-site meetings, etc.) will be vaccinated. The facility will recognize and respect exemptions for medical conditions and religious beliefs to COVID-19 vaccinations as outlined in accordance with federal and state regulations." The facility Administrator, Director of Nursing,Vice President of Clinical Operations and Vice President of Operations were made aware that based on the information submitted, the facility's staff vaccination rate was 86.5%. No further information was submitted prior to the survey team's exit.	F 888		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility documentation the facility staff failed to maintain adequate pest control for 1 Resident (#14) as well as the facility in general, in a survey sample of 13 Residents. The findings included: On 06/29/22 at approximately 9:15 AM, an interview was conducted with Resident #14 who stated that he has a problem with ants in his room, and in his bed. He stated that he	F 925	**1. Resident #14 had a room change and no other residents were affected.** **2. All residents have the potential to be affected. 100% audit will be conducted to assess current pest status by Maintenance Director/designee.** **3. Staff Development Coordinator /designee will educate all staff on documenting in the pest control book when pest are observed. The Administrator/designee will educate the Maintenance Director and maintenance staff to review the pest control report and any recommendations for repairs will be addressed.** **4. Director of Maintenance or designee will audit pest control reports upon completion. Recommendations for repairs will be addressed weekly x 4 weeks then monthly x 2**	

			months. Director of Maintenance or designee will report the results of the audits to the QAPI committee monthly for 3 months. Audits results/trends will be reviewed at QAPI meeting to ensure Action Plans are effective. Additional action plans will be done as needed. **5. Date of compliance: 7/29/2022**	

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F 925	Continued From page 34 complained to the staff and to his family and they complained "a couple of times" before anything was done. He further stated he sometimes still sees bugs in the facility. On 6/29/22 at approximately 10:00 AM facility provided the requested Maintenance Request Logs from March to May of 2022. A review of the Maintenance Request Logs revealed the following: "3/23/22 - Room 204 - Ongoing ant problem in room, pt reports having ants crawling on her bed. B bed." "3/26/22 - Room 202 - 202 A and B have ants crawling in their beds with them, on their tray tables, by the sink, closets, window and across the floor." "3/30/22 - Room 137 Room needs to be sprayed for bugs (Ants were in the room)." "3/30/22 -Room 137 A. [name redacted] room infested with ants observed in drawers, in bed and on the floor please address." "4/5/22 Room 137 - ANTS" "4/6/22 Room 137 a lot of ants are in room." "4/20/22 Room 212 - Reports of ants in room." [Resident #14's room] "4/24/22 Room 129 Roaches in room." "4/30/22 Room 212 Ant problem has not been resolved and ants are everywhere, floor, sink, bed and closet."	F 925		

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F 925	Continued From page 35 "5/1/22 Room 222 Ants noted crawling near bed." "5/1/22 Room 219 Knats [sic] flying in room." "5/5/22 Room 133 B Bed presents with CNA roaches in room, on bed, on patient." "5/6/22 Room 133 Pests seen in room. "5/6/22 Room 216 Roaches reported in room please address." "5/12/22 Room 215 Gnats, flies, roaches noted in room and belongings of A/B bed patients." "5/26/22 Room 211 Gnats in bathroom." On 6/29/22 a review of the [Company name redacted] "Invoice Customer Service Report" revealed the following: "3/22/22- Service period - Monthly- Conditions found / actions taken: Based on my inspection today the following actions should be taken: Exterior Power Spray, Rooms serviced today 127, 128, 204. Pest activity found during service (YES) Kitchen area interior - The following pests were noted during service Cockroaches noted in room 127 please remove all debris. Ants noted in room 204." "Structural concerns that could cause pest problems (YES) - Kitchen area interior -- hole/gap noted large holes underneath dish was area." "Conditions found / actions taken - Seal to prevent pest entry or harborage. --Hole/gap noted behind line cook., hole / gap behind prep	F 925		

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F 925	Continued From page 36 sink, hole/ gap behind dish machine, floor tiles loose or missing in kitchen area. Please Repair to prevent pest harborage or breeding site." "Sanitation issues that could cause pest problems:" "Kitchen area / Activity room very cluttered, floor drains in need of cleaning. all floor drains need cleaning. food debris found under dish machine area, please clean regularly, Janitorial closets need to be cleaned. Please DEEP clean all three janitor closets Sanitation needs to be improved." The same issues were found on 4/22/22, however the following rooms were mentioned 105, 211, 212, 127 & 137 as being treated for ants. The same structural issues were found holes and gaps as mentioned in the previous report from 3/22/22. Also the report mentioned the sanitation issues with the clutter, drain cleaning and deep cleaning of janitorial closets. On 5/16/22 the pest control report read almost identical. The same structural issues were found holes and gaps as mentioned in the previous report from the previous months. Also the report mentions the sanitation issues with the clutter, drain cleaning and deep cleaning of janitorial closets. On 6/29/22 at approximately 11:09 AM an interview was conducted with the Social Worker who stated that on 4/25/22 Resident #14 had issues with room 212 having ants and was moved from that room so the room could be treated. She indicated she did not have documentation as to why he was moved but remembers they had an issue with ants in that room. She was unsure of who instigated the move family or facility.	F 925		

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	495115	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE CHESTERFIELD, 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 925	Continued From page 37 On 6/29/22 at approximately 11:20 AM observations of the kitchen were made and the area described as having missing tiles in the pest control report was covered with a rubber mat. The dietary manager stated that she has her staff clean under the mat "At least every shift and as often as necessary." She stated a work order had been placed to repair the tiles. On 6/29/22 at approximately 11:45 AM an interview was conducted with the Administrator who was asked for any documents to show repairs, attempts to repair, estimates for repairs or supplies ordered to repair the items suggested by the pest company since 3/22/22. The facility had no such records to provide. On 6/29/22 during the end of day conference the Administrator was made aware of the concerns and no further information was provided. COMPLAINT DEFICIENCY	F 925		