STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495254	A. BUILDING _____ B. WING _____	C 03/15/2023

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COLONNADES HEALTH CARE CENTER	100 COLONNADES HILL DRIVE CHARLOTTESVILLE, VA 22901

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E 000	Initial Comments An unannounced Medicare/Medicaid standard survey was conducted 3/13/2023 through 3/15/2023. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/13/2023 through 3/15/2023. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this thirty-four certified bed facility was twenty-two at the time of the survey. The survey sample consisted of twelve current resident reviews and one closed record review.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/14/2023

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F 657	Continued From page 1	F 657		

the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for one of thirteen residents in the survey sample (Resident #10).

The findings include:

Resident #10's plan of care was not revised after discontinued use of an indwelling catheter, a PICC (peripherally inserted central catheter) and intravenous antibiotics.

Resident #10 was admitted to the facility with diagnoses that included depression, anxiety, urinary tract infection, urine retention, congestive heart failure, hypothyroidism, cognitive communication disorder and osteoporosis. The minimum data set (MDS) dated 1/3/23 assessed Resident #10 with severely impaired cognitive skills.

Resident #10's clinical record documented the resident had a PICC and was treated with intravenous antibiotics in September 2022 for

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F 657	Continued From page 2	F 657		

sepsis related to a urinary tract infection. A nursing noted dated 10/4/22 documented the resident pulled out the PICC. The PICC was not replaced and the order for the intravenous antibiotic was discontinued on 10/4/22.

Resident #10's clinical record documented the resident had an indwelling urinary catheter placed in December 2022 due to retention. The record documented a physician's order dated 12/12/22 to discontinue the indwelling catheter. The resident had a current physician's order for "in and out" catheterization as needed if the resident did not void in 8 hours.

Resident #10's plan of care (revised 1/4/23) listed the resident had a single lumen PICC in the left arm with goals and interventions documented for care of the PICC. The plan of care documented problems, goals, and interventions regarding use of intravenous medications for treatment of urinary tract infection and sepsis. The plan of care documented, "...resident has an indwelling catheter..." due to urine retention and listed goals and interventions for care of the catheter. There was no mention in the care plan regarding the as needed catheter order.

On 3/14/23 at 1:45 p.m., the registered nurse (RN #1) responsible for care plan updates was interviewed about Resident #10. RN #1 stated the PICC and intravenous antibiotics had been discontinued. RN #1 stated, "She no longer gets those (PICC, intravenous medications)." RN #1 stated the PICC and intravenous medication should have been removed from the plan when the interventions were discontinued. RN #1 stated the resident no longer had an indwelling catheter and that should have been deleted from

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F 657	Continued From page 3 the plan. RN #1 stated Resident #10's plan of care was most recently reviewed on 1/4/23 and she did not know why the discontinued care interventions were not deleted from the plan. This finding was reviewed with the director of nursing, executive director, and unit manager during a meeting on 3/14/23 at 4:45 p.m. The administrator was out of the facility during the survey.	F 657		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		

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F 761	Continued From page 4	F 761		

This REQUIREMENT is not met as evidenced by:
Based on a medication pass observation, staff interview, facility document review and clinical record review, the facility staff failed to accurately label a medication for one of thirteen residents in the survey sample (Resident #18).

The findings include:

The pharmacy label for Resident #18's medication bumetanide listed a 3 mg (milligram) daily dose when the resident was currently prescribed a 1 mg dose.

A medication pass was observed on 3/14/23 at 7:35 a.m. with licensed practical nurse (LPN) #1 administering medications to Resident #18. Among medications administered was bumetanide 1 mg (milligram). The pharmacy label for the bumetanide documented the dose as 1 mg with instructions to give three tablets for total dose of 3 mg. There was nothing on the label indicating a dose or order change for the medication. LPN #1 made no comment about the label dosage not matching the current physician's order when preparing and administering the medication.

Resident #18's clinical record documented a current physician's order dated 3/6/23 for bumetanide 1 mg with instructions to give one tablet each day for congestive heart failure. The clinical record documented the previous 3 mg dose was discontinued on 3/6/23.

On 3/14/23 at 8:41 a.m., LPN #1 was interviewed about the pharmacy label not indicating the correct dose of bumetanide for Resident #18.

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F 761	Continued From page 5 LPN #1 stated the resident was previously ordered a daily 3 mg dose. LPN #1 stated the order changed starting on 3/7/23 to a 1 mg daily dose. LPN #1 stated to use existing supply of the medication, a sticker was supposed to be applied to the label indicating there was a dose change. LPN #1 stated the sticker had not been placed on Resident #18's bumetanide. On 3/14/23 at 9:00 a.m., the director of nursing (DON) was interviewed about the bumetanide pharmacy label not matching the physician's order. The DON stated nurses were supposed to apply a sticker to the label indicating there had been a dose or order change until pharmacy corrected the label. The facility's policy titled Reordering, Changing, and Discontinuing Orders (revised 1/1/13) documented, "...If Pharmacy receives a new order that changes the strength or dose of a medication previously ordered, and there is adequate supply on hand...Facility should notify Pharmacy not to send the medication by attaching a 'Change in Directions' sticker to the existing quantity of medications until Pharmacy permanently affixes the new label to the medication package or container..." This finding was reviewed with the director of nursing, executive director, and unit manager during a meeting on 3/14/23 at 3:45 p.m. The administrator was out of the facility during the survey.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		

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F 812	Continued From page 6 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 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, prepare, and serve food in a sanitary manner from the main kitchen. The findings include: Foods beyond the use-by date were stored and available for use in the main kitchen's reach-in refrigerator and walk-in freezer. A bench mounted can opener in the main kitchen's pantry was dirty. Stainless prep pans on the dry rack were stored nested with staff members using paper towels to dry pans prior to use. A maintenance employee was observed in the kitchen during lunch preparation without a hair restraint. On 3/13/23 at 10:55 a.m., the kitchen and food	F 812		

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F 812	Continued From page 7	F 812		

storage areas were inspected accompanied by the dishwasher supervisor (other staff #2). Lunch preparation was in progress during this observation. Stored in a reach-in refrigerator was a container of cranberry sauce labeled with a discard date of 2/8/23. There was a container of diced tomatoes and a container of chopped cucumbers labeled to discard on 3/12/23. A manual, bench mounted can opener in the pantry room was observed with an accumulation of black/brown debris on the blade and metal shavings accumulated behind the blade section. The bracket for the can opener was dirty with dried spills/debris. In the dishwashing room, eight small prep pans and eight medium size prep pans were observed on the rack for drying. The pans were nested and wet with water visible in the pan rims and on the pan surfaces. The dishwasher supervisor stated at this time that she dried the pans with paper towels prior to placing in the kitchen for use. A role of paper towels was attached to the corner of the drying rack.

On 3/13/23 at 11:15 a.m., an employee was observed in the kitchen near the oven and food prep area without a hair restraint. The dishwashing supervisor identified the employee as maintenance and stated that he was in the kitchen working on a repair. The dishwashing supervisor stated all employees in the kitchen were supposed to use hairnets.

On 3/13/23 at 11:20 a.m., a tray of breaded fish (Cod) was stored in the walk-in freezer. The fish was partially uncovered on a stainless pan and exposed to air. There was a pot of soup stored in the freezer covered loosely with aluminum foil that had no label identifying the product or date prepared.

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F 812	Continued From page 8 On 3/13/23 at 3:11 p.m., the sous chef (other staff #1) was interviewed about the observations from the main kitchen. The sous chef stated food items were labeled when prepared and should be discarded after the use-by date. The sous chef stated there was no policy to dry dishware with towels. The sous chef stated pans and dishware were supposed to be air dried and air drying was not possible when the pans were nested. The sous chef stated all employees were supposed put on a hair restraint before entering the kitchen. The sous chef stated the can opener was supposed to be cleaned daily. On 3/14/23 at 9:50 a.m., the certified dietary manager (other staff #3) was interviewed about the observations from the main kitchen. The dietary manager stated the prep pans went through the dishwasher and were placed on racks for drying. The dietary manager stated pots/pans were supposed to air dry and not be wiped with any type of cloth or towel. The dietary manager stated all employees were required to wear a hair restraint when entering the kitchen and food prep areas. The facility's policy titled Food Storage, Preparation and Service (revised 4/11/22) documented, "...A food storage area includes walk-in and reach in refrigerators and freezers..." The action steps in this policy documented, "...Food storage areas are clean and orderly...All food items are labeled, dated and rotated to maintain a system of First In First Out (FIFO)...Expired food is discarded..." The policy titled Kitchen Safety and Sanitation (dated 5/9/22) documented, "...Proper	F 812		

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F 812	Continued From page 9	F 812		

precautions are followed in the kitchen to ensure a safe and sanitary production environment...The Dining Services Coordinator/Director...trains team members on the safe and proper use, maintenance and cleaning of all kitchen equipment..."

The facility's policy titled Personal Appearance and Hygiene (revised 11/2/98) documented, "...An approved hair restraint, such as the following must be worn at all times while working in the kitchen...hair net..."

These findings were reviewed with the director of nursing, executive director, and unit manager during a meeting on 3/14/23 at 3:45 p.m. The administrator was out of the facility during the survey.