STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE , CHESTERFIELD, Virginia, 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
F0000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard (complaint) survey was conducted 1/6/26 through 1/8/26. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Six complaints and three incidents were investigated during the survey. Complaint 2699922 was substantiated with deficiency. Complaint 252617 was substantiated with deficiency. Complaint 252622 was substantiated with deficiency. Complaint 252607 was substantiated with deficiency. Complaint 252620 was substantiated with deficiency. Complaint 2696224 was unsubstantiated. Incident 2670461 was substantiated with deficiency. Incident 252592 was substantiated with deficiency, which was previously cited. Related deficiencies were identified. Incident 252623 was substantiated with no deficient practice. The census in this 196 certified bed facility was 139 at the time of the survey. The survey sample consisted of ten resident reviews.	F0000		01/20/2026
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F0607	F607: Develop implement Abuse/Neglect Policies. A copy of the FRI's Resident #1 that was completed on 9/12/2025, 11/2/2025 initial and 11/7/2025 final was submitted on 1/24/2026 to the ombudsman and Adult protective services. A copy of the e fax was obtained for verification the FRI was submitted. All residents in the center had the potential to be affected. An audit by the Administrator or designee was	02/03/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE , CHESTERFIELD, Virginia, 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
F0607 SS = D	Continued from page 1 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to implement their abuse policy with regards to allegations of abuse involving one resident (Resident #1-R1) in a sample of ten residents. The findings included: For R1, who was involved in several resident-to-resident altercations, the facility staff failed to report the incidents of/allegations of abuse to the Ombudsman in accordance with their abuse policy. On 1/7/26-1/8/26 a clinical record review was conducted of R1's chart. This review revealed a progress note dated 11/2/25 that read, "Resident was witnessed telling another resident to move from in front of his door holding a butter knife. Resident yelled, 'move her from in front of my door.' Removed resident and attempted to take butterknife and resident refused to	F0607	Continued from page 1 conducted on residents to verify allegations of abuse/neglect had abuse policy implemented and reported within the timeframe of 2 hours or within 24 hours based on type of abuse with or without injury with state agencies Ombudsman and APS as applicable and final completed and submitted within 5 working days. Findings will be corrected and sent to the Ombudsman, APS and state agencies. The VPO will educate the Administrator and DON in-serviced on timely reporting and submission of FRI according to the abuse/Neglect policy- within 2 hours for initial FRI and 5 days for the investigation summary to APS, Ombudsman and OLC. Administrator/Designee will audit weekly X 4 weeks and then monthly X 2 to verify that all FRI are submitted timely to OLC, APS and Ombudsman. All findings will be reported to the QA Committee, and the action plan will be revised as needed. The results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines whether the problems no longer exist and are sustained, the review will be conducted. Date of Compliance: 02/03/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE , CHESTERFIELD, Virginia, 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
F0607 SS = D	Continued from page 2 give to write [sic]…" On 1/7/26, a review of facility documentation revealed that the facility failed to send the investigation summary to the ombudsman and Adult protective services. Further review of facility documentation revealed a facility investigation summary dated 9/12/25 that described an incident where R1 was "… struck from behind and that he responded by striking her back…" The facility had no credible evidence that the incident was reported to the Ombudsman in accordance with their abuse policy. On 1/7/26 at 4:12 PM, an interview was conducted with R1. R1 was difficult to keep focused on the questions asked when the surveyor inquired about the above incidents. R1 did report that he "gets along with everyone" and wasn't able to give any details about the incidents. The facility's policy titled, "Reporting Requirements/Investigations" with an effective date of 02/05/2023, was reviewed. The policy read in part, "1. Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. A. Notify the Adult Protective Services Agency, the local Ombudsman, and the appropriate local law enforcement authorities (police, sheriff's office, and/or medical examiner as deemed appropriate) for any incident of patient abuse, mistreatment, neglect, or misappropriation of personal property or other reasonable suspicion of a crime…" On 1/7/26 at 4:55 PM, during an end of day meeting with the facility administrator, director of nursing, and regional director of clinical services the above findings were reviewed. On 1/8/26 at 8:23 AM, the facility administrator met	F0607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE , CHESTERFIELD, Virginia, 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
F0607 SS = D	Continued from page 3 with the surveyor and reported that she had come to the facility from another state and was not aware that incidents of abuse were reported to/sent to the Ombudsman. The administrator went on to state that she had received communication recently from the Ombudsman's office and was made aware of this requirement. The administrator stated she is now aware and would be reporting as required going forward. On 1/8/26 at 12:04 PM, during another meeting with the facility administrator, director of nursing and regional director of clinical services, the above findings were again reviewed.	F0607		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to report incidents/allegations	F0609	F609: Report of Alleged Violations A copy of the FRI's Resident #1 that was completed on 9/12/2025, 11/2/2025 initial and 11/7/2025 final was submitted on 1/24/2026 to the ombudsman and Adult protective services. A copy of the e fax was obtained for verification the FRI was submitted All residents in the center had the potential to be affected. An audit by the Administrator or designee was conducted on residents to verify allegations of abuse/neglect had abuse policy implemented and reported within the timeframe of 2 hours or within 24 hours based on type of abuse with or without injury with state agencies and APS as applicable and final completed and submitted within 5 working days. Findings will be corrected. The VPO will educate Administrator and DON in-serviced on timely reporting and submission of FRI according to the abuse/Neglect policy- within 2 hours for initial FRI and 5 days for the investigation summary to APS, Ombudsman and OLC . Administrator/Designee will audit weekly X 4 weeks and then monthly X 2 to verify that all FRI are submitted timely to VDH, APS and Ombudsman. All findings will be reported to the QA Committee, and the action plan will be revised as needed. The results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines whether the problems no longer exist and are sustained, the review will be conducted. 5. Date of Compliance: 02/03/2026	02/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE , CHESTERFIELD, Virginia, 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
F0609 SS = D	Continued from page 4 of abuse to the required agencies involving one resident (Resident #1-R1) in a survey sample of ten residents. The findings included: For R1, who was involved in several resident-to-resident altercations, the facility staff failed to report the incidents of/allegations of abuse to each of the required agencies and make reports of incidents of abuse within the required timeframes. On 1/7/26-1/8/26 a clinical record review was conducted of R1's chart. This review revealed a progress note dated 11/2/25 that read, "Resident was witnessed telling another resident to move from in front of his door holding a butter knife. Resident yelled, 'move her from in front of my door.' Removed resident and attempted to take butterknife and resident refused to give to write [sic]…" On 1/7/26, a review of facility documentation revealed that the facility failed to have credible evidence that the facility investigation summary was sent to Adult Protective services. Further review of facility documentation revealed a facility investigation summary dated 9/12/25 that described an incident where R1 was "… struck from behind and that he responded by striking her back…" The facility had no credible evidence that the incident was initially reported to the state survey agency or adult protective services when it occurred. On 1/7/26 at 4:12 PM, an interview was conducted with R1. R1 was difficult to keep focused on the questions asked when the surveyor inquired about the above incidents. R1 did report that he "gets along with everyone" and wasn't able to give any details about the incidents. The facility's policy titled, "Reporting Requirements/Investigations" with an effective date of 02/05/2023, was reviewed. The policy read in part, "1. Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE , CHESTERFIELD, Virginia, 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
F0609 SS = D	Continued from page 5 Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. A. Notify the Adult Protective Services Agency, the local Ombudsman, and the appropriate local law enforcement authorities (police, sheriff's office, and/or medical examiner as deemed appropriate) for any incident of patient abuse, mistreatment, neglect, or misappropriation of personal property or other reasonable suspicion of a crime…" On 1/7/26 at 4:55 PM, during an end of day meeting with the facility administrator, director of nursing, and regional director of clinical services the above findings were reviewed. On 1/8/26 at 8:23 AM, the facility administrator met with the surveyor and reported that she had come to the facility from another state and was not aware that incidents of abuse were reported to/sent to adult protective services in addition to the state survey agency. The administrator stated she is now aware and would be reporting as required going forward. On 1/8/26 at 12:04 PM, during another meeting with the facility administrator, director of nursing and regional director of clinical services, the above findings were again reviewed. No additional information was provided.	F0609		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by:	F0684	F684: Quality of care Resident #8 no longer resides in the facility. All residents have the potential to be affected. The DON or designee conducted a review of all clinical records on 01/16/2026 for residents who did not receive their medication per the physicians' order that the physician notification is in the clinical records. The SDC or designee will educate licensed nurses on the policy and procedure for medication unavailability to include provider notification in the medical record.	02/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE , CHESTERFIELD, Virginia, 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
F0684 SS = D	Continued from page 6 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to administer medications in accordance with physician orders and failed to notify the doctor when medications were not available for administration affecting one resident (Resident #8-R8) in a survey sample of ten residents. The findings included: For R8 the facility failed to administer medications in accordance with physician orders and failed to notify the doctor when medications were not available for administration. On 1/6/26, during a closed record review of R8's clinical record. Review of the medication administration record (MAR) for R8 revealed that on 5/4/25, Hydralazine HCL (used to treat blood pressure) was not administered. According to the nursing progress note it read, "medication unavailable awaiting refill from pharmacy." According to the facility's Omnicell (medication dispensing/storage machine/supply maintained on-site) content listing the medication would have been available to facility staff to administer. On 5/30/25, R8 was not administered the physician ordered dose of diltiazem HCl ER beads (Cardizem, used to treat hypertension, high blood pressure, chest pain and other heart rhythm disorders). There were no associated nursing progress notes to indicate the provider was made aware of the medication not being given. On R8's June 2025 medication administration record, there was no documentation regarding the administration of pantoprazole sodium oral tablet (Protonix- a proton pump inhibitor, used to reduce stomach acid production), on 6/15/25. There were no progress note entries in R8's chart to explain why the medication was not administered nor any evidence that the doctor was notified. According to R8's physician orders, each of the above noted medications had an active physician order.	F0684	Continued from page 6 The DON or designee will audit residents who did not receive their medication per physician order for provider notification in the clinical records weekly x 4 weeks and monthly x 2 months. All findings will be reported to the QA Committee, and the action plan will be revised as needed. The results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines whether the problems no longer exist and are sustained, the review will be conducted. 5. Date of compliance 02/3/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE , CHESTERFIELD, Virginia, 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
F0684 SS = D	Continued from page 7 On 1/7/26 at 3:28 PM, an interview was conducted with licensed practical nurse #3 (LPN #3). LPN #3 explained the protocol when medications are not available for administration. LPN #3 stated that she checks to see if the medication has been ordered, if it had not been ordered, she would order it. LPN #3 went on to report she would check the Omnicell [medication dispensing/storage machine/supply maintained on-site]. When asked what LPN #3 would do if the medication is not available in the Omnicell, LPN #3 said, “I would call the pharmacy, if it is not STAT [medical term meaning immediately/without delay] you don’t have to get it, you just wait for it to come in through the pharmacy. I make a note in the chart and let the nurse coming in to relieve me know and the administrator.” When asked why it is important for residents to receive their medications, LPN #3 said, “A lot of the medications they receive help with different co-morbidities they have.” On 1/7/26 at 3:52 PM, an additional nurse was interviewed, LPN #4. LPN #4 explained when medications are not available how she responds. LPN #4 said, “First I check the Omnicell and then I call the provider if it is not available and document the intervention the provider suggests.” When asked why it is important for residents to receive their medications, LPN #4 said, “for the continuation of care, medication compliance and to maintain therapeutic levels.” On 1/7/26 at 3:57 PM, an interview was conducted with the assistant director of nursing (ADON), who was a registered nurse (RN #1). RN #1 explained that if a medication is not available, the staff “let us know and let the doctor know. We get an order to actually put it on hold until we get the medication, we call the pharmacy to see when we will get it, if it is not in the Omnicell. We don’t have a big problem, usually we have the medications in the Omnicell.” On 1/7/26 at 4:55 PM, during an end of day meeting with the facility’s administrator, director of nursing (DON), and regional director of clinical services (RDCS), the above findings were discussed. The DON explained that during medication administration if a medication is not available, they [the staff] are to check the Omnicell and “if it is not available contact the provider to initiate an alternative medication.”	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE , CHESTERFIELD, Virginia, 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
F0684 SS = D	Continued from page 8 Review of the facility policy titled, “General Guidelines for Medication Administration” with an effective date of 09-2018, was conducted. The policy read in part, “… 11. If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g. other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit…” No further information was provided.	F0684		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to conduct post fall assessment and monitoring following a fall with a head injury for one resident (Resident #9-R9) in a survey sample of ten residents. The findings included: For R9 who fell and sustained a laceration and hematoma to the back of the head and complained of pain, the facility staff failed to provide ongoing assessment and monitoring of the resident through neuro checks (neurological assessment/observations). On 1/6/26, a closed record review was conducted of R9’s clinical record. According to a “Fall Note” dated 11/3/25 at 5:28 AM, it noted, “During routine rounds, CNA found the resident on the floor and immediately notified the nurse. Upon arrival to the resident's	F0689	F689 Free of Accident Hazards/Supervision/Devices 1.Resident #9 no longer resides in the facility. 2.All residents have the potential to be affected. The DON or designee will conduct a review of all falls for the past 2 weeks to ensure the residents requiring neurological checks are present in the medical record. 3. The SDC or designee will educate licensed nurses on fall management policy to include assessing and monitoring any injury and to include types of falls that require neurological checks to be completed. 4. The DON or designee will audit residents with falls to ensure post fall documentation is completed and completion of neuro checks if applicable weekly x 4 weeks and monthly x 2 months. All findings will be reported to the QA Committee, and the action plan will be revised as needed. All findings will be reported to the QA Committee, and the action plan will be revised as needed. The results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines whether the problems no longer exist and are sustained, the review will be conducted. 5. Date of compliance 02/3/2026	02/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE , CHESTERFIELD, Virginia, 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
F0689 SS = D	Continued from page 9 room, writer observed the resident sitting on the floor on the side of the bed closest to door with both legs extended. Upon assessment, writer noted a hematoma with a small laceration to the occipital area with a small amount of blood present; no active bleeding observed. A small amount of blood was also noted on the floor and on the back of the resident's head. Vital signs obtained. Resident was assisted back to bed safely. Gauze applied to the site to maintain cleanliness and protect the area. Resident verbalized, 'I fell bad and my head hurt' and also reported bilateral leg pain. Resident was uncooperative with skin assessment… What new Interventions were implemented in response to the fall?: Neuro check initiated. head wound cleansed and gauze applied. Increased monitoring and safely checks implemented Was the Provider/resident and RP notified at the time of the fall?: Yes, NP notified; stated to monitor resident." A review of the "Neurological Checklist" in R9's chart dated 11/3/25, was conducted. It revealed that the first neurological check was initiated on 11/3/25 at 4:10 AM. The Resident reported a pain score of 8 on a sale of 1-10. The next three neuro checks were to be done in 15-minute intervals and were documented as done at 4:25 AM, 4:40 AM, and 4:55 AM. Following the 15-minute interval there were to be neuro checks done every 30 minutes for four occurrences. They were documented as having been done at 7:30 AM, 8AM, 8:30 AM and 9 AM. There was no documentation or evidence that R9 was assessed, monitored or evaluated from 4:55 AM until 7:30 AM. There was a nursing note entered into R9's chart on 11/3/25 at 7:08 AM, that read, "Resident observed sitting upright on the bed, alert and in stable condition. No acute distress noted. Resident touched the back of her head and stated, " the area feels sore". Report passed on 7-3pm nurse for continued monitoring. Writer followed with NP, who stated " she will assess the resident upon arrival to the building this morning". DON notified on resident fall. RP contacted and no response." There was no documentation of an assessment of the resident at that encounter. On 11/3/25 at 17:27 (5:27 PM) the director of nursing made an entry in R9's chart that read, "…During a follow-up assessment this afternoon, a laceration was noted on the occipital. The wound measured approximately 3 cm in length and 0.5 cm in width. The laceration appeared open, with visible tissue edges and	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE , CHESTERFIELD, Virginia, 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
F0689 SS = D	Continued from page 10 minimal bleeding observed. The surrounding skin showed mild redness, but no signs of infection or swelling were noted. Given the depth and appearance of the wound, it was determined that the resident would require sutures for proper closure. The NP was notified and gave an order for the resident to be sent to the Emergency Room for evaluation and possible stitching…." According to a progress note entry dated 11/4/25, the facility staff received a call from the hospital which reported that R9 was being admitted to the hospital for a "Sub-Dural [sic] hematoma brain bleed." On 1/6/26 at 3:45 PM, during an end of day meeting, the facility administrator and director of nursing were asked to provide the facility policy regarding post-fall response and neurological evaluations. On 1/7/26 at 9:04 AM, an interview was conducted with the nurse practitioner (NP) for R9. The NP reported that R9 was one of her routine patients and she (NP) had seen R9 the day of the fall. The NP reported that R9 was ambulating and appeared to be at baseline. The NP went on to report that when a resident falls and hit their head or is suspected to have hit their head she will have them do neuro checks to make sure they don't have any changes from their baseline and to continue those and notify if there are any changes. The NP explained that neuro checks are important to monitor for changes and is the first indication that something is going on that "we can't see." On 1/7/26 at 10:38 AM, an interview was conducted with licensed practical nurse #5 (LPN #5), who was the unit manager where R9 resided. LPN #5 explained that she went to see R9 when she arrived and another nurse identified as LPN #6 was in the room. The unit manager/LPN #5 explained the protocol for neuro checks and explained if a resident hit their head or had an unwitnessed fall they do neuro checks. Neuro checks are done every 15 min for first 4, then every 30 min for hour, then hour after that for four hours. The unit manager said neuro checks are important, "because they can have change in level of consciousness, a total decline, blood pressure issues, and we want to keep an eye on that so we can send them out if something were to change." On 1/7/26 at 10:52 AM, an interview was conducted with	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE , CHESTERFIELD, Virginia, 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
F0689 SS = D	Continued from page 11 LPN #6. LPN #6 stated she was the nurse that relieved the nurse assigned to R9 when the fall occurred. LPN #6 reported that her shift began at 7 AM and upon her arrival she was told that she needed to continue the neuro checks which she reported she did. LPN #6 explained that neuro checks are done every 15 minutes for four occasions, every 30 minutes for four occasions, every hour for four hours and then every shift. LPN #6 explained that neuro checks involve vital signs, pupil reaction, grip and range of motion. When asked why neuro checks are important, LPN #6 said, “It is important because if there is a change in pupil reaction it can indicate a closed head injury.” LPN #6 was asked about the gap in R9’s neuro checks from 4:55 AM until 7:30 AM. LPN #6 said her shift started at 7AM and during report she was told to continue them, which she did and can’t answer why they were not done prior to her shift starting. On 1/7/25 at 4:55 PM, during an end of day meeting with the facility administrator, director of nursing and regional director of clinical services the above findings were reviewed with regards to R9’s lack of evaluation and neuro checks from 4:55 AM until 7:30 AM. On 1/8/26 at 6:01 AM, an interview was conducted with LPN #7, who was working when R9 fell on 11/3/25. LPN #7 confirmed that R9 did fall in the early morning hours, hit her head, had bleeding and a bandage was applied. LPN #7 reported she did the neuro checks but said, it was in the middle of me passing medications and doing my other stuff… I don’t know if I didn’t finish putting them in there [the computer/clinical record].” On 1/8/26 at 11:24 AM, an interview was conducted with the director of nursing (DON). The DON confirmed that there was a “gap” in evidence of R9 being monitored and assessed the day of the incident from 4:55 AM until 7:30 AM. The DON went on to report that R9’s vital signs were stable and “for me, I didn’t have a major concern until later when I saw the opening. I did the measurements, and I felt it needed sutures…” According to the facility policy titled, “Neurological Assessment” with an effective date of 1/29/2024, it read, “A neurological assessment will be completed by a licensed nurse in order to detect potential early signs of brain injury.” The procedure went on to state: “1. Explain to the resident why neurological assessment is being performed. 2. Complete the Neurological Checklist	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE , CHESTERFIELD, Virginia, 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
F0689 SS = D	Continued from page 12 Assessment in the medical record. Assess: a. vital signs, b. orientation, c. level of consciousness, d. pupillary response, e. verbal responses, f. pain, g. movement and sensation of extremities. 3. Complete assessment every 15 minutes for the first hour, every 30 minutes for the next two hours, and every hour for the next four hours. 4. Notify provider and responsible party of any abnormal findings. Document in the medical record and follow provider recommendations." No additional information was provided.	F0689		
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by:	F0755	F755 Pharmacy Services/Procedures/Pharmacist/Records 1. Resident #8 no longer resides in the facility. 2. All residents have the potential to be affected. The DON or designee conducted a review of all clinical records on 01/16/2026 for residents who did not receive their medication per the physicians' order that the physician notification is in the clinical records. 3. The SDC or designee will educate licensed nurses on the policy and procedure for medication unavailability to include provider notification in the medical record. 4. The DON or designee will audit residents who did not receive their medication per physician order for provider notification in the clinical records weekly x 4 weeks and monthly x 2 months. All findings will be reported to the QA Committee, and the action plan will be revised as needed. The results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines whether the problems no longer exist and are sustained, the review will be conducted. 5. Date of compliance 02/3/2026	02/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE , CHESTERFIELD, Virginia, 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
F0755 SS = E	Continued from page 13 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to have five medications available for administration for one resident (Resident #8-R8) in a survey sample of ten residents. The findings included: For R8 the facility failed to have give medications available to administer in accordance with physician orders on 5/4/25. On 1/6/26, during a closed record review of R8's clinical record it was noted on the census tab that R8 had discharged from the facility on 10/15/25. Review of the medication administration record (MAR) for May 2025 revealed that on 5/4/25, the following medications had a code 9- entered on the MAR. According to the "chart codes" (legend) at the bottom of the MAR, code 9 indicated "other/see nurse notes." The medications with that code were: Fluticasone Propionate Nasal Suspension (Flonase nasal spray- used for allergic rhinitis), Vitron-C (a vitamin with Vitamin C and iron), Budesonide-Formoterol Fumarate inhaler (a corticosteroid used to treat inflammation in the lungs), Buspirone HCL (Buspar- used to treat anxiety) for two doses, and Hydralazine HCL (used to treat blood pressure). According to the MAR, R8's blood pressure on 5/4/25 was recorded as 197/103, which was elevated and the medication used to treat elevated blood pressure was not administered. According to R8's physician orders, each of the above noted medications had an active physician order on 5/4/25. According to the nursing progress note entries dated 5/4/25 regarding each of the medications not given, the entry read, "medication not available." On 1/7/26 at 3:28 PM, an interview was conducted with licensed practical nurse #3 (LPN #3). LPN #3 explained the protocol when medications are not available for administration. LPN #3 stated that she checks to see if the medication has been ordered, if it had not been ordered, she would order it. LPN #3 went on to report she would check the Omnicell [medication dispensing/storage machine/supply maintained on-site]. When asked what LPN #3 would do if the medication is	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE , CHESTERFIELD, Virginia, 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
F0755 SS = E	Continued from page 14 not available in the Omnicell, LPN #3 said, “I would call the pharmacy, if it is not STAT [medical term meaning immediately/without delay] you don’t have to get it, you just wait for it to come in through the pharmacy. I make a note in the chart and let the nurse coming in to relieve me know and the administrator.” When asked why it is important for residents to receive their medications, LPN #3 said, “A lot of the medications they receive help with different co-morbidities they have.” On 1/7/26 at 3:52 PM, an additional nurse was interviewed, LPN #4. LPN #4 explained when medications are not available how she responds. LPN #4 said, “First I check the Omnicell and then I call the provider if it is not available and document the intervention the provider suggests.” When asked why it is important for residents to receive their medications, LPN #4 said, “for the continuation of care, medication compliance and to maintain therapeutic levels.” On 1/7/26 at 3:57 PM, an interview was conducted with the assistant director of nursing (ADON), who was a registered nurse (RN #1). RN #1 explained that if a medication is not available, the staff “let us know and let the doctor know. We get an order to actually put it on hold until we get the medication, we call the pharmacy to see when we will get it, if it is not in the Omnicell. We don’t have a big problem, usually we have the medications in the Omnicell.” Review of the Omnicell contents listing provided by the facility revealed that of the five medications not administered to R8 on 5/4/25, only one was available in the Omnicell, which was Hydralazine 25 mg tablet. On 1/7/26 at 4:55 PM, during an end of day meeting with the facility’s administrator, director of nursing (DON), and regional director of clinical services (RDCS), the above findings were discussed. The DON explained that during medication administration if a medication is not available, they [the staff] are to check the Omnicell and “if it is not available contact the provider to initiate an alternative medication.” Review of the facility policy titled, “General Guidelines for Medication Administration” with an effective date of 09-2018, was conducted. The policy read in part, “… 11. If a medication with a current,	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE , CHESTERFIELD, Virginia, 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
F0755 SS = E	Continued from page 15 active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g. other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit…" No further information was provided.	F0755		