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	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Heights Rehabilitation and Nursing Center	831 Ellerslie Ave Chesterfield, VA 23834

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on interview, clinical record review and facility documentation the facility staff failed to consult with the resident's physician, and notify, the resident representative when there is a change in physical, mental or psychosocial status for 1 Resident (#20) in a survey sample of 23 Residents. The findings included: For Resident #20 the facility staff failed to notify the physician and the resident representative of being found engaging in sexual activity with another resident on 2 occasions. Resident #20 was admitted to the facility on [DATE] with diagnoses that included but were not limited to unspecified sequelae of Cerebral Infarction, (unspecified changes brought on by stroke they can vary from physical changes to personality changes), bipolar disorder current episodic hypomanic, alcohol abuse, cocaine use, metabolic encephalopathy, Sexual dysfunction not due to substance or known physiological condition, generalized anxiety disorder, hypertension, major depressive disorder and history of breast cancer (right side). On the morning of 8/1/24 an interview with the DON and Administrator was conducted and they were asked to identify a female Resident noted in another Resident chart, to be engaging in sexual acts on 2 occasions (1/22/23 and 6/14/23). The facility identified the female Resident to be Resident # 20. A review of the clinical record for Resident #20 revealed that Resident #20 is not her own Responsible Party. A review of Resident #20's BIMS (Brief Interview of Mental Status) score at that time was 11 and was conducted on 2/27/23. A BIMS score of 11 / 15 indicates moderate cognitive impairment. A review of the clinical record was conducted and there was no documentation to indicate family or physician notification. The following are excerpts from Resident #20's care plan: FOCUS: Resident has behaviors noted to make sexual advances towards staff, observed with a cigarette in her mouth in facility, noted to have sexual advances towards male resident, speaks inappropriately to staff, and residents. Created on: 12/08/2022 Revision on: 09/11/2023. (continued on next page)

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.

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

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	495115	A. Building B. Wing	08/06/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	INTERVENTIONS Administer medication for behavior as ordered Date Initiated: 01/26/2023 Created on: 01/26/2023 Revision on: 01/26/2023 Educate on smoking policy Date Initiated: 12/30/2022 Created on: 12/30/2022 Physician review of medications as needed Date Initiated: 03/03/2023 Created on: 03/03/2023 Psych services referral as needed Date Initiated: 02/28/2023 Created on: 02/28/2023 Redirect behavior Date Initiated: 12/08/2022 Created on: 12/08/2022 Redirect resident to subjects that matter to them when behaviors occur Date Initiated: 12/08/2022 Created on: 12/08/2022 Separated from other resident Date Initiated: 01/23/2023 Created on: 01/23/2023 On 8/2/24 during the end of day meeting an interview was conducted with the DON, Administrator and Corporate Nurse Consultant who all agreed that physician and the Resident Representative should have been notified, as these behaviors could represent a change in her physical and psychological conditions. The DON and Administrator also agreed that the care plan should have been addressed and updated to reflect any new interventions. **Please note: The Responsible Party for the other Resident involved was notified.** On 8/5/24 during the end of day conference the Administrator was made aware of the concerns and no further information was provided.

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	495115	A. Building B. Wing	08/06/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on interview, clinical record review, and facility documentation, the facility staff failed to implement the abuse policy for 1 Resident, (#20), in a survey sample of 23 Residents. The findings included: For Resident # 20 facility staff failed to notify the Responsible party of discovery that the Resident was allegedly having consensual sexual contact with another Resident (#19). A review of Resident #20's clinical record revealed that Resident #20 was admitted to the facility on [DATE], with diagnoses that included but were not limited to, generalized anxiety disorder, major depressive disorder, bipolar disorder, hx (history) of alcohol abuse, hx of cocaine use, COPD, hx of cerebral infarction and sexual dysfunction not due to a substance or known physiological condition. A review of Resident #20's care plan revealed the following: FOCUS: Resident has behaviors noted to make sexual advances towards staff, observed with a cigarette in her mouth in facility, noted to have sexual advances towards male resident, speaks inappropriately to staff, and residents. Created on: 12/08/2022 Revision on: 09/11/2023 During the course of survey, a review of another Resident clinical record (Resident #19) revealed the following notes: 1/22/23 at 7:44 - Resident was observed in a female resident room on the [NAME] wing, with his pants down to his knees having a sexual encounter. Non-pharmacological intervention: [none entered] Effect: [none entered] PRN Medication: [none entered] Outcome: Resident pulled his pants up and came out of room when nurse and aide entered. 6/14/23 -10:30 p.m. - Client was in bed with brief undone and female resident had her hand around his penis using a up and down movement. She was asked to stop and to leave his room. RP notified and stated, I know he has some dirty ways and to do what we have to do with him non-pharmacological intervention: [none entered] Effect: [none entered] PRN Medication [none entered] (continued on next page)

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	495115	A. Building B. Wing	08/06/2024

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the morning of 8/1/24 an interview with the DON and Administrator was conducted and they were asked who was the Female Resident noted in the chart, they gave Resident #20's name. A review of the clinical record for Resident #20 revealed that Resident #20 is not her own Responsible Party. A review of Resident #20's BIMS (Brief Interview of Mental Status) score at that time was 11 and was conducted on 2/27/23. A BIMS score of 11 / 15 indicates moderate cognitive impairment. A review of the clinical record was conducted and there was no documentation to indicate family or physician notification. On the morning of 8/2/24 an interview was attempted with Resident #20 who's current BIMS score conducted on 3/23/24 is 5/15 indicating severe cognitive impairment, the interview was unsuccessful as the Resident was not able answer interview questions. The Resident did not appear fearful or frightened, the Resident did not recall the incident and was unable to stay on topic. On 8/2/24 at approximately 11:00 AM Employee G was what action if any would the facility take if 2 Residents are found engaging in sexual activity? Employee G stated that it would depend on the cognitive level and ability of the Residents to give consent. When asked should anyone be notified, she stated that would depend on if they are their own Responsible party or not, however the physician should be notified. She stated she would also notify the Administrator so that an investigation could be started to ensure the encounter was not abusive in nature. When asked how staff would ascertain the interaction was not abusive, she stated that once it was investigated by staff, they would interview both parties to ensure it was by mutual agreement. Resident #19's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/25/24 scores Resident #19 as maximum assistance with all aspects of care including moving in the bed. He uses a wheelchair with assistance from staff. He is unable to stand or walk. He is currently on Hospice and not getting up much, when he does get up it is with maximum assistance. At the time of the incidents Resident #19's BIMS score was 9-10 indicating moderate cognitive impairment. Resident # 19's clinical record indicated his family and physician were notified. On 8/1/24 a review of the abuse policy revealed the following excerpt: Policy Name: Abuse Neglect and Misappropriation Paragraph 1. 4. Any and all suspected or witnessed incidents of patient / patient abuse, neglect, theft and/or exploitation or any reasonable suspicion of a crime against a patient /patient Center brought to the attention of the Center's Administration will result in internal investigation, appropriate and timely reporting to the State Survey Agency and other legally designated agencies, as well as staff corrective action, suspension, and or termination as necessary. 5. Failure by employee to report any suspected or witnessed incident of mistreatment, abuse, neglect theft or exploitation or reasonable suspected crime against a patient will result in corrective action. On 8/5/24 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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	495115	A. Building B. Wing	08/06/2024

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49916 Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to complete a 48-hour baseline Care Plan for one Resident (Resident #18) in a survey sample of 23 Residents. The findings include: For Resident #18, the facility staff failed to develop and implement a 48-hour baseline care plan to include guidance for effective person-centered care. For Resident #18, the facility staff failed to provide focus, goals, and interventions regarding urinary retention, and self-catheterization. Resident #18 was admitted to the facility on [DATE], with diagnoses including but not limited to; urinary tract infection, urine retention, benign prostate hyperplasia (BPH), type 2 diabetes, hemiplegia and hemiparesis following a cerebral infarction affecting the left dominant side, muscle weakness, and personal history of transient cerebral infarct (TIA). Resident #18's MDS review included the MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 07/20/2024 which was an admission assessment. The MDS coded Resident #18 as dependent for dressing, toileting, hygiene, and bathing. The Resident was also coded as 14 of 15 possible points on a brief interview for mental status (BIMS), indicating no cognitive impairment. The Resident was coded as always incontinent of bladder and in-frequently incontinent bowel. On 07/31/204, at 12:20 p.m., during an afternoon tour, Resident #18 was observed sitting in his wheelchair in his room, He asked if this surveyor could help. Resident #18 stated he self-catheterizes 3 times a day, but that he was told on 07/30/24 that the facility did not have any straight catheters but that some were ordered for him. Resident #18 went on to say that he had last self -straight catharized the day before on 07/30/24 in the morning, that he was uncomfortable and does not like being wet in his briefs. 07/31/204 at 12:30 p.m., Licensed Practical Nurse (LPN) #H was asked if she was aware that Resident #18 self-catheterizes and states he does not have any 14 French (F) straight catheters and that he was told the facility does not have any. LPN#H stated she was not aware, but that she would go and check the supply room and with the Central Supply Coodinator. On 07/31/24 at 12:45 p.m., during an interview with the Central Supply Coordinator and LPN #H. The Central supply Coordinator stated that they do not have any of the 14 French(F) catheters that the resident uses but that he expects them to come in the facility order today, and Resident #18's home order to be received on 08/01/2024. LPN#H stated that she had a Foley 14F that she could use as a straight catheter to assist Resident #18. (continued on next page)

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	495115	A. Building B. Wing	08/06/2024

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/31/24 at approximately 1:15, LPN #H met with Resident #18 and explained, that she could assist him with straight catheterization using the Foley 14 French catheter that is used for indwelling catheters, and Resident #18 agreed. LPN #H went on to straight catheterize Resident #18 and, 275ml's (Militer's), of urine were obtained. On 07/31/24 at approximately 3:30 PM, an interview was conducted with the Facility Administrator and Regional Clinical Nurse (RCN), and the Director of Nursing (DON) which included a review of Resident #18's clinical record. The RCN verified there was no evidence that Resident #18's Care Plan addressed his care regarding, Aute UTI, Urinary Retention, Voiding How the resident voids (self- catheterization), The DON states that she expects all residents to be assessed head to toe on admission and a Person-Centered Comprehensive Care Plan to be implemented within 48 hours of admission. Review of the clinical record revealed a Comprehensive Care Plan for Resident #18, however there was no documentation indicating that Resident #18 straight catheterizes 3-4 times a day and may require assistance, and an intervention to record input and output. On 7/31/2024, during the end of day meeting, the Administrator and Corporate Nurse Consultants, DON and Assistant Director of Nursing (ADON) were made aware of the findings. No further information was provided prior to survey exit.

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	495115	A. Building B. Wing	08/06/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to follow standards of practice affecting 7 residents (Resident # 4, #12. #14, # 2, #21, #18, & #9) in a survey sample of 23 residents. The findings included: 1. For Resident # 4, the facility staff failed to take blood pressures prior to the administration of the medication Midodrine Resident # 4 was admitted to the facility on [DATE] with diagnoses that included but were not limited to: Chronic Obstructive Pulmonary Disease, Emphysema, Diabetes and Rhabdomyolisis. The most recent MDS (Minimum Data Set) assessment was coded as a quarterly assessment with an ARD (Assessment Reference Date) of 6/15/2024. The BIMS (brief interview for mental status) was coded as 12 out of possible 15 indicating moderate cognitive impairment. Review of the clinical record was conducted on 7/30/2024 to 8/6/2024. Midodrine HCl Tablet 10 MG (milligrams) Give 1 tablet by mouth three times a day for hypotension HOLD FOR SBP (Systolic Blood Pressure) 120 or > -Order Date- 01/13/2024 0118 -D/C Date- 08/01/2024 1311 Review of the Medication Administration Records for June 2024 revealed no blood pressures were documented prior to administration of the medication, Midodrine. Every day, the Review of blood pressures documented in the vital signs every shift section of the MAR revealed systolic blood pressures were 120 or greater 80 out of 90 times during the month of June 2024. There were 18 times that nurses held the medication due to the blood pressures being out of the parameters. On 8/1/2024 during the end of day debriefing, the Facility Administrator, Director of Nursing, Assistant Director of Nursing and two Regional Nurse Consultants were informed of the findings. On 8/5/2024, an interview was conducted with the Assistant Director of Nursing who stated blood pressures should be taken prior to the administration of the medication as ordered. The Assistant Director of Nursing stated the professional guidance used by the facility was [NAME]. She stated they also use [NAME]-[NAME]. (continued on next page)

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	495115	A. Building B. Wing	08/06/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PROFESSIONAL GUIDANCE- According to [NAME], there are 8 rights of Medication Administration: Number 7 specifically instructs nurses to confirm the rationale for the ordered medication Rights of Medication Administration 1. Right patient Check the name on the order and the patient. Use 2 identifiers. Ask patient to identify himself/herself. When available, use technology (for example, bar-code system). 2. Right medication Check the medication label. Check the order. 3. Right dose Check the order. Confirm appropriateness of the dose using a current drug reference. If necessary, calculate the dose and have another nurse calculate the dose as well. 4. Right route Again, check the order and appropriateness of the route ordered. Confirm that the patient can take or receive the medication by the ordered route. 5. Right time Check the frequency of the ordered medication. Double-check that you are giving the ordered dose at the correct time. Confirm when the last dose was given. 6. Right documentation Document administration AFTER giving the ordered medication. (continued on next page)

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	495115	A. Building B. Wing	08/06/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug. 7. Right reason Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication? Revisit the reasons for long-term medication use. 8. Right response Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant? Be sure to document your monitoring of the patient and any other nursing interventions that are applicable. Reference: Nursing2012 Drug Handbook. (2012). [NAME] & [NAME]: Philadelphia, Pennsylvania On 8/4/2024 at 3:45 p.m., an interview was conducted with the Unit Manager, Licensed Practical Nurse-L who stated she thought possibly the nurses did not understand the greater than sign. She stated nurses should follow physicians orders. No further information was provided. 2. For Resident # 12, the facility staff failed to identify a severe yeast rash on the buttocks and thigh that was identified by the nurse practitioner. The staff did not assess and monitor Resident # 12's skin and failed to provide incontinence care to meet the needs of Resident # 12. Review of documentation of incontinence care revealed missing documentation of care being provided. Resident # 12 was admitted to the facility on [DATE] and discharged to home with family on 7/26/2024. Resident # 12 was admitted to the facility on [DATE] with diagnoses that included but were not limited to COPD (Chronic Obstructive Pulmonary Disease), Diabetes, Hypertension, Pulmonary Embolism, and VRE (Vancomycin Resistant Enterococcus) of urine. Resident # 12 was discharged to home with family on 7/26/2024. The most recent MDS (Minimum Data Set) assessment was coded as a quarterly assessment with an ARD (Assessment Reference Date) of 7/20/2024. The BIMS (brief interview for mental status) was coded as 15 out of possible 15 indicating no cognitive impairment. Review of the clinical record was conducted 7/31/2024 - 8/6/2024. (continued on next page)

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	495115	A. Building B. Wing	08/06/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record revealed Resident # 12 was admitted with bilateral excoriation under her breasts and in pelvic area. There were no wounds present. 5/28/2024 Nurse Practitioner wrote a note that stated: Skin : Red bottom. Will have wound care team follow. Pt has had this in the past but will be worse if she continues to lay in waste for hours. Instructed pt to advocate for herself by talking to DON (Director of Nursing) regarding how long she is laying in her own waste. Date of Service : 2024-06-06 Visit Type : Progress Note Details : Chief Complaint : f/u Cough HPI: Patient seen today for complaint of cough and shortness of breath .When the provider approached the room patient was having her briefs changed and provider noticed significant yeast rash to posterior buttocks down the back of her legs. Patient will need treatment with oral antifungal. Patient denies that she has felt febrile . Review of documentation of incontinence care revealed missing documentation of care being provided. Interviews were conducted with LPN-B on 7/30/2024 at 2:08 p.m., LPN-D on 7/30/2024 at 2:10 p.m., LPN-H on 7/30/2024 at 2:52 p.m., and Registered Nurse Supervisor (RN)-B on 7/30/2024 at 3:10 p.m. They all stated they make rounds to ensure the residents' needs were met. They stated any problems with providing care should be reported to the nurses. The three Unit Managers were interviewed. LPN-E was interviewed on 7/30/2024 at 2:20 p.m., LPN-G was interviewed on 7/30/2024 at 2:45 p.m. and LPN-L was interviewed 7/30/2024 at 3:00 p.m. The Unit Managers each stated they monitor the care being provided to the residents. They stated the staff should assess and monitor the residents' skin during incontinence care and during assessments. During the end of day debriefing on 8/5/2024, the facility Administrator, Director of Nursing and Assistant Director of Nursing were informed of the findings. No further information was provided. 3. For Resident # 14, the facility staff failed to ensure the medication, Trulicity, was available for administration as per physician orders. Resident # 14 was admitted to the facility in 2018 with diagnoses that included but were not limited to: Diabetes, Cerebral Palsy, Dysphagia, Contracture and Hypertension. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent MDS (Minimum Data Set) assessment was coded as an annual assessment with an ARD (Assessment Reference Date) of 6/14/2024. The BIMS (brief interview for mental status) was coded as 15 out of possible 15 indicating no cognitive impairment. Resident # 14's clinical record was reviewed 7/31/2024-8/6/2024. Review of the Physicians Orders revealed a Physician's order for the medication: Trulicity 0.5 milliliters subcutaneously one time a day every Saturday The time of scheduled administration of the medication, Trulicity 0.5 milliliters subcutaneously one time a day every Saturday was documented on the MAR (Medication Administration Record) to be administered at 9:00 a.m. on every Saturday. Review of Resident # 14's medication administration record (MAR) revealed the nursing staff failed to administer the medication as ordered by the physician on the following dates: May 3, 2024-9:00 a.m. May 11, 2024-9:00 a.m. May 18, 2024 -9:00 a.m.

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	495115	A. Building B. Wing	08/06/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on staff interview, facility document review, clinical record review, the facility staff failed to ensure incontinence care was provided timely for 1 resident (Resident # 12) in a survey sample of 24 residents. The Findings Included: For Resident #12, the facility staff did not provide timely incontinence care. For Resident # 12, the facility staff failed to identify a severe yeast rash on the buttocks and thigh that was identified by the nurse practitioner and failed to provide incontinence care to meet the needs of Resident # 12. Resident # 12 was admitted to the facility on [DATE] with diagnoses that included but were not limited to COPD (Chronic Obstructive Pulmonary Disease), Diabetes, Hypertension, Pulmonary Embolism, and VRE (Vancomycin Resistant Enterococcus) of urine. Resident # 12 was discharged to home with family on 7/26/2024. The most recent MDS (Minimum Data Set) assessment was coded as a quarterly assessment with an ARD (Assessment Reference Date) of 7/20/2024. The BIMS (brief interview for mental status) was coded as 15 out of possible 15 indicating no cognitive impairment. Review of the clinical record was conducted 7/31/2024 - 8/6/2024. Review of the Admission Progress Notes revealed Resident # 12 was admitted with bilateral excoriation under her breasts and in pelvic area. On 5/28/2024, the NP (Nurse Practitioner) wrote a note: Skin : Red bottom. Will have wound care team follow. Pt has had this in the past but will be worse if she continues to lay in waste for hours. Instructed pt to advocate for herself by talking to DON (Director of Nursing) regarding how long she is laying in her own waste. Another Progress note was written on 6/6/2024: Date of Service : 2024-06-06 -Visit Type : Progress Note Details : Chief Complaint : f/u (follow up) Cough HPI : Patient seen today for complaint of cough and shortness of breath. Previous chest X-ray normal.When the provider approached the room patient was having her briefs changed and provider noticed significant yeast rash to posterior buttocks down the back of her legs. Patient will need treatment with oral antifungal. Patient denies that she has felt febrile. Patient with history of COPD. (continued on next page)

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	495115	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Heights Rehabilitation and Nursing Center	831 Ellerslie Ave Chesterfield, VA 23834

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Nursing Progress Notes revealed no documentation of a rash on the buttocks and down the back of the thighs. The provider discussed the condition of the skin during each of the visits with Resident # 12. Further review of the Progress Notes revealed no documentation about the skin being monitored by the licensed nurses. There was no documentation of the rash being noted on the buttocks and thighs prior to the Nurse Practitioner observing it during briefs being changed. Review of the documentation by the Certified Nursing Assistants revealed missing documentation of care being provided. Review of the clinical record revealed Resident # 12 was admitted with bilateral excoriation under her breasts and in pelvic area. There were no wounds present. 5/28/2024 Nurse Practitioner wrote a note that stated: Skin : Red bottom. Will have wound care team follow. Pt has had this in the past but will be worse if she continues to lay in waste for hours. Instructed pt to advocate for herself by talking to DON (Director of Nursing) regarding how long she is laying in her own waste. Date of Service : 2024-06-06 Visit Type : Progress Note Details : Chief Complaint : f/u Cough HPI: Patient seen today for complaint of cough and shortness of breath .When the provider approached the room patient was having her briefs changed and provider noticed significant yeast rash to posterior buttocks down the back of her legs. Patient will need treatment with oral antifungal. Review of documentation of incontinence care revealed missing documentation of the care being provided. During the initial tour of the facility on 7/30/2024 and throughout the survey, interviews were conducted with staff members about expectations regarding incontinence care. Interviews were conducted with 5 CNAs (Nursing Assistants) who stated incontinence care should be provided at least every two hours and more often if needed and documented in the record. They all stated the expectation was for the Certified Nursing Assistants to report any changes in the condition of the skin to the nurse. The CNAs interviewed were CNA-B on 7/30/2024 at 2:10 p.m., CNA-C on 7/30/2024 at 2:12 p.m., CNA-F on 7/30/2024 at 2:23 p.m., CNA-D on 7/30/2024 at 2:50 p.m. and CNA-E on 7/30/2024 at 2:52 p.m. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interviews were conducted with Licensed Nurses who each stated the expectation was for residents to receive incontinence care to meet their needs but at least every two hours staff should check the residents. Interviews were conducted with LPN-B on 7/30/2024 at 2:08 p.m., LPN-D on 7/30/2024 at 2:10 p.m., LPN-H on 7/30/2024 at 2:52 p.m., and Registered Nurse Supervisor(RN)-B on 7/30/2024 at 3:10 p.m. They all stated they make rounds to ensure the residents' needs were met. They stated any problems with providing care should be reported to the nurses. The three Unit Managers were interviewed. LPN-E was interviewed on 7/30/2024 at 2:20 p.m., LPN-G was interviewed on 7/30/2024 at 2:45 p.m. and LPN-L was interviewed 7/30/2024 at 3:00 p.m. The Unit Managers (LPN-E, LPN-G and LPN-L) each stated they monitor the care being provided to the residents. They stated the staff should assess and monitor the residents' skin during incontinence care and during assessments. During the end of day debriefing on 8/5/2024, the facility Administrator, Director of Nursing and Assistant Director of Nursing were informed of the finding. No further information was provided.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 34894 Based on staff interview, facility documentation review and clinical record review, the facility staff failed to ensure three Residents (Resident #14, #4 and #21) of 23 residents in the survey sample were free of significant medication errors. The findings included: 1. For Resident # 14, the facility staff failed to ensure the medication, Trulicity, was available for administration as per physician orders. Resident # 14 was admitted to the facility in 2018 with diagnoses that included but were not limited to: Diabetes, Cerebral Palsy, Dysphagia, Contracture and Hypertension. The most recent MDS (Minimum Data Set) assessment was coded as an annual assessment with an ARD (Assessment Reference Date) of 6/14/2024. The BIMS (brief interview for mental status) was coded as 15 out of possible 15 indicating no cognitive impairment. Resident # 14's clinical record was reviewed 7/31/2024-8/6/2024. Review of the Physicians Orders revealed a Physician's order for the medication: Trulicity 0.5 milliliters subcutaneously one time a day every Saturday The time of scheduled administration of the medication, Trulicity 0.5 milliliters subcutaneously one time a day every Saturday was documented on the MAR (Medication Administration Record) to be administered at 9:00 a.m. on every Saturday. Review of Resident # 14's medication administration record (MAR) revealed the nursing staff failed to administer the medication as ordered by the physician on the following dates: May 3, 2024-9:00 a.m. May 11, 2024-9:00 a.m. May 18, 2024 -9:00 a.m. Review of the blood sugars via accuchecks from May 2024 to August 2024 revealed values ranging from 120 to 389.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49916 Based on staff interview, facility documentation, and clinical record review, the facility staff failed to obtain laboratory specimens as ordered and notify the physician of the delay in obtaining the specimens for 1 Resident (#9) in a survey sample of 23 residents. The findings included: Resident #9 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, diabetes, cognitive communicative deficit, Dementia, Alzheimer's, Aphasia, and History of falling. Resident #9 was discharged home on 06/03/2024. Resident #9's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 06/03/2024 was a discharge assessment. The MDS coded Resident #9 with a BIMS (Brief Interview for Mental Status) score of 3 out of 15 possible points, indicating server cognitive impairment. On 07/30/2024, at approximately 2:00 pm, an interview was conducted with Regional Nurse Consultant and the Director of Nursing (DON). The DON was asked what is expected when labs are ordered by the physician. She stated are expected to be completed as ordered, and if there is a delay or the order is unable to be completed, the physician should be notified, and it should be documented in the progress notes. A review of the facility policy revealed: Policy Number: 1702 Laboratory Tracking 11/01/19 Policy: A licensed nurse will monitor and track all physician or physician extender ordered laboratory test; ensure the lab tests are drawn as ordered and communicate the results to the physician in a timely manner. Policy Number: 1703 Specimen Collection 11/01/19 Policy: A licensed nurse will obtain a specimen as ordered by the physician. Procedure: Section I Urine, clean voided 1. Cleanse urethra. (instructions for female and males) 2. Assist patient to bedpan/bedside commode/bathroom 3. Collect specimen mid-stream if possible (at least 30-60 cc). 4. Label Specimen container with name, date, time of collection and physician. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Refrigerate until pick-up. Document any unusual findings and follow up interventions. (notification of physician and responsible party) in nursing narrative notes. On 08/05/24, a review of Resident #9's clinical record with the Regional Nurse Consultant revealed: -On 05/06/2024 a Urinalysis was ordered. There was documentation that specimen was collected. -On 05/22/24-05/24/24 a Urinalysis with micro reflex urine culture was ordered. The lab collected, but on 05/24/2024 the urine specimen was rejected. -On 05/31/2024 a Urinalysis was ordered with micro reflex urine culture. It was collected on 06/01/2024. -06/03/2024, Progress Note: Patient is seen today for skilled visit. Patient is up in the wheelchair and ready to be discharged to home today. Family states 'were out of insurance money'. Patient will be discharged to home with home health care to continue therapy services. UA results finally returned, and patient is positive for UTI. Patient will be discharged with oral antibiotics. Pain is currently well-managed with tramadol 100 mg 3 times a day given with Tylenol. She has no c/o pain at this time. She remains pleasantly confused. Pt has no c/o dysuria or lower abdominal pain today. On 8/02/2024 during the end of day meeting the Administrator, Regional Nurse Consultant, DON, and ADON (Assistant Director of Nursing) were notified of the findings. No further information was provided.