STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025

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 0558

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Reasonably accommodate the needs and preferences of each resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to accommodate resident needs for four(4) of 33 residents in the survey sample, Resident #8, #19, #5 and #12.

The findings include:

1. For Resident #8 (R8), the facility staff failed to maintain the call light in a position where they could access it.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/14/24, the resident was assessed as being severely impaired for making daily decisions. Section GG documented R8 having impairment one side of the upper extremity.

On 12/19/24 at 8:54 a.m., an observation was made of R8 in their room. R8 was observed out of bed sitting in a wheelchair at the end of the bed between the footboard of the bed and the closet. The call bell was observed to be wrapped around the grab bar at the head of the bed out of R8's reach.

On 12/20/24 at 8:26 a.m., an observation was made of R8 in their room. R8 was observed in the wheelchair in the same location as documented above. The call bell was observed beside the mattress at the head of the bed out of R8's reach.

Additional observation was made on 12/20/24 at 10:20 a.m. of R8 in the wheelchair at the foot of the bed with the call bell located on the mattress near the head of the bed out of reach.

The comprehensive care plan for R8 documented in part, Resident has had actual falls & is at risk for falls related to cognitive impairment, muscle weakness, poor balance, unsteady gait recent, poor safety awareness, dementia, Prostate CA (cancer), incontinence, impaired mobility, cognitive impairment, dementia, communication impairment, metabolic encephalopathy, OA (osteoarthritis), nonambulatory, psychotropic med use, depression, malnutrition, HTN (hypertension). Created on: 04/05/2023. Revision on: 03/19/2024. Under Interventions/Tasks it documented in part, .remind the resident to use their call light to ask for assistance with ADLS (activities of daily living). Date Initiated: 04/05/2023 .

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/20/24 at 11:50 a.m., an interview was conducted with LPN (licensed practical nurse) #27 who stated that the call bell should be in the residents reach at all times, so they were able to call for assistance when needed. On 12/20/24 at approximately 12:07 p.m., an observation was made with LPN #27 of R8 sitting in their room at the end of the bed in the wheelchair with the call bell located on the grab bar at the head of the bed. LPN #27 stated that the call bell was not in R8's reach and that they were able to use it. On 12/20/24 at 12:54 p.m., an interview was conducted with CNA (certified nursing assistant) #25 who stated that call bells should be placed across the resident's stomach so they could reach it. She stated that it was placed there so the resident could press the button to let them know if they needed something. The facility provided policy, Nursing Care & Services effective 1/29/24 documented in part, .The center will utilize Mosby's Textbook for Long-Term Care Assistants by Kostelnick and/or Clinical Nursing Skills & Techniques by [NAME], [NAME], and Ostendorff, as a reference for nursing services and skills not otherwise provided in the Policies and Procedures Manuals. According to Mosby's Textbook for Long-Term Care Nursing Assistants 7th edition, Unit IV Assisting with activities of daily living pg. 242 documented in part, .When in their rooms, using the toilet, or in the bathing area, residents must be able to contact the staff at the nurses' station. The call system lets the person signal for help. The call light is at the end of a long cord. In resident units, it attaches to the bed or chair .Always keep the call light within the person's reach- in the room, bathroom, and shower or tub room . On 12/20/24 at 4:00 p.m., ASM (administrative staff member) #14, interim administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, ASM #5, regional director of clinical services, ASM #11, regional vice president of operations, ASM #15, regional director of clinical services, and ASM #12, administrator from sister facility were made aware of the findings. No further information was presented prior to exit. 2. For Resident #19 (R19), the facility staff failed to maintain the call light in a position where they could access it. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/21/24, the resident was assessed as scoring five out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were severely impaired for making daily decisions. Section GG documented R19 having no impairments to the upper extremities. On 12/19/24 at 8:16 a.m., an observation was made of R19 in their room. R19 was observed in bed eating breakfast. The call bell was observed on the right side of the bed on the floor. Additional observation was made on 12/19/24 at 9:01 a.m. of R19's call bell located on the floor on the right side of the bed. At that time R19's the breakfast tray was no longer in front of the resident. On 12/20/24 at 8:26 a.m., R19 was observed in bed with the call bell clipped to the sheet at the back of the mattress out of the resident's reach. When asked if they were able to reach the call bell, R19 did not answer appropriately. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan for R19 documented in part, [Name of R19] had an actual fall and remains at risk/Actual falls related to cognitive impairment, muscle weakness, poor balance, psychoactive medications, unsteady gait, poor trunk control. Created on: 08/22/2024. Revision on: 11/19/2024. Under Interventions/Tasks it documented in part, .remind the resident to use their call light to ask for assistance with ADLS (activities of daily living). Date Initiated: 08/22/2024 . On 12/20/24 at 11:50 a.m., an interview was conducted with LPN (licensed practical nurse) #27 who stated that the call bell should be in the residents reach at all times, so they were able to call for assistance when needed. On 12/20/24 at 12:54 p.m., an interview was conducted with CNA (certified nursing assistant) #25 who stated that call bells should be placed across the resident's stomach so they could reach it. She stated that it was placed there so the resident could press the button to let them know if they needed something. On 12/20/24 at 4:00 p.m., ASM (administrative staff member) #14, interim administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, ASM #5, regional director of clinical services, ASM #11, regional vice president of operations, ASM #15, regional director of clinical services, and ASM #12, administrator from sister facility were made aware of the findings. No further information was presented prior to exit. 3. For Resident #5 (R5), the facility staff failed to ensure that the resident went to a follow-up doctor appointment as scheduled on 11/27/23. R5 was admitted to the facility with diagnoses that included but were not limited to fracture of right femur, fracture of lumbosacral spine and pelvis, fracture of tibia and right fibula, ribs and wedge compression fracture of thoracic vertebra. R5 no longer resided at the facility at the time of the survey. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/26/24, the resident was assessed as scoring 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. On 12/19/24 at 10:56 a.m. R5 was interviewed via telephone. R5 stated that they missed their scheduled follow-up appointment on 11/27/23 due to the facility not having any transportation to get them to the doctor's office. R5 stated that they were not able to get another appointment until February of 2024 because they missed the appointment. A service concern report for R5 dated 11/20/23 documented a concern reported regarding a missed neurophysiology appointment on 11/27/23. Under the action taken section, it documented the appointment rescheduled for 2/12/24 at 3:00 p.m. The service concern failed to evidence documentation regarding why the appointment was missed and documented action taken on 12/7/23 by the former assistant director of nursing. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The progress notes for R5 failed to evidence documentation of an appointment scheduled on 11/27/23, the resident missing the appointment on 11/27/23 or the appointment being rescheduled for 2/12/24. On 12/20/24 at 12:54 p.m., an interview was conducted with CNA (certified nursing assistant) #25 who stated that they set up appointments and transportation for residents at the facility. She stated that she set up appointments based on resident and family requests if the physician approved them and when the physician requested them. CNA #25 stated that transportation was set up depending on the insurance and usually was arranged through the insurance. She stated that she did have problems with transportation not showing up and the appointments having to be rescheduled due to this. She stated that when this happened, she filed a grievance though the insurance and asked them not to be put on the list of transportation in the future. She stated that it was an ongoing issue, and she could not say why R5 missed the 11/27/23 appointment for sure because she did not work with them. On 1/3/25 at 12:09 p.m., ASM #1, the interim administrator, ASM #2, the assistant administrator, ASM #3, the director of nursing, ASM #4, the regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit.4. For Resident #12, the facility staff failed to ensure the call bell was within reach and answered in a timely manner. Resident #12 was admitted to the facility on [DATE] with diagnosis of End Stage Renal Disease, Difficulty in Walking, Hypertension, Hypothyroidism, Congestive Heart Failure, Respiratory Failure, Hypoxia, Depression, Fracture of Fifth Metatarsal Bone (Foot), and Dependence on Renal Dialysis. Resident #12 Minimum Data Set (MDS) dated [DATE], the resident was coded as needing extensive assistance for bed mobility and transfer (how the resident moves between surface including to or from: bed, chair, wheelchair, standing position). An interview was conducted with Resident #12 on 12/19/2024 at 10:55 AM. Resident #12 expressed to the surveyor she wanted to be discharged from the facility as soon as possible and was dissatisfied with the nursing staff. Resident #12 told the surveyor she is transported three times a week from the facility for dialysis treatment. Resident stated on several occasions after returning to the facility from treatment, the nursing staff would not be available for assistance. Resident #12 stated the transportation driver would push her call bell prior to leaving and sometimes she waited for assistance for approximately 45 minutes to an hour. Resident #12 said the driver would just leave her in the room sitting in the chair. An interview was conducted on 12/19/2024 at 4:00 PM with the Director of Nurse, Regional Nurse, and the facility Administrator regarding the findings. No additional information was provided to the surveyor regarding this matter.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to implement the requirements for a resident room change for four (4) of 33 residents in the survey sample, Resident #25 (R25), R26, R27, and R28. The findings include: 1. For R25, the facility staff failed to provide the resident with written notification of a room change, the opportunity to see the new location and meet the new roommate, when the R25 was transferred to a different room on 12/22/2024 and on 12/26/2024. On 12/31/2024 at approximately 8:55 a.m., an interview was conducted with R25. When asked why he had a room change R25 stated that he was told by the facility staff that it was for consolidating residents. When asked how long it was from being informed of the room change until he was moved R25 stated the first move was within two hours of being told and the other move R25 stated the staff came into his room told him he was being moved and immediately move him. When asked if he was given the opportunity to visit either of the rooms he was being moved, meet the roommate, was provided written notification to his responsible party or himself of the two room changes, R25 stated, No. A review of R25's clinical record revealed the resident was transferred to a different room on 12/22/2024, due to medical management. Further review of clinical record failed to evidence R25, R25's representative was provided with written notification of a room change, provided R25 the opportunity to see the new location and meet the new roommate. On 12/31/2024 at approximately 9:25 a.m., an interview was conducted with OSM (other staff member) #33, social worker/discharge planner. When asked to describe the procedure for changing a resident's room initiated by the facility, she stated a resident's room would be changed if there was a roommate conflict, extensive room repairs and medical needs. If the resident was their own responsible party OSM #33 stated she would explain to the resident, why they were being moved and if the resident was not their own responsible party, she would contact the resident's responsible party about the room change and document it. OSM #33 stated that she would complete a Room Change Assessment and notify housekeeping and nursing of the room change. When asked about the room change for R25, OSM #33 stated that the corporate COO (chief operating officer) informed us to clear the facility's back hall (the third hall on the [NAME] Unit) to consolidate residents due to a drop in the facility census. When asked if she provided R25 with a written notification of the room changes, allowed R25 to visit the new roommates and visit the new rooms, OSM #33 stated no. The facility's policy Room to Room Transfer documented in part, Procedure: 2. The social Services Department will initiate appropriate documents, notify patient(s) and/or responsible partners, and obtain signatures as indicated. 7. Introduce patients to new roommate, if applicable. The facility's Resident Rights documented in part, Right to be Fully Informed of .Advance plans of a change in rooms or roommates. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/03/2025 at approximately 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. 2. For R26, the facility staff failed to provide the resident and/or R26's responsible party with written notification of a room change, the opportunity to see the new location and meet the new roommate, when the R26 was transferred to a different room on 12/26/2024. A review of R25's clinical record revealed the resident was transferred to a different room on 12/22/2024, due to medical management. Further review of clinical record failed to evidence R25, R25's representative was provided with written notification of a room change, provided R25 the opportunity to see the new location and meet the new roommate. On 12/31/2024 at approximately 9:25 a.m., an interview was conducted with OSM (other staff member) #33, social worker/discharge planner. When asked about the room change for R26, OSM #33 stated that the corporate COO (chief operating officer) informed us to clear the facility's back hall (the third hall on the [NAME] Unit) to consolidate residents due to a drop in the facility census. When asked if she provided R26 and R26's responsible party with a written notification of the room changes, allowed R26 to visit the new roommates and visit the new room, OSM #33 stated no. On 01/03/2025 at approximately 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. 3. For Resident #27 (R27), the facility staff failed to implement the requirements for transferring the resident's room on 12/22/24. On the most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date if 10/20/24, the resident scored an eight out of ten on the BIMS (brief interview for mental status) score, indicating the resident is moderately cognitively impaired for making daily decisions. An interview was conducted with R27 on 12/31/24 at approximately 9:15 a.m. The resident stated the staff just went and moved me with no explanation. When asked if he got anything in writing regarding the move, he stated no. The Room Change Notification dated 12/22/24 at 5:12 p.m. documented in part, Date and time of notification: 12/22/24 at 5:12 p.m . Family/Resident's Representative Notified/Consented: Unable to reach RP (responsible party) phone is disconnected .Reason for Change: Medical management (i.e. isolation, acuity, treatments, symptoms mgmt [management], etc.) .Comments: clinical need. Resident and/or RP were provided with copy of notification: yes. Roommate notified: yes. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The progress note dated, 12/22/24 at 5:12 p.m. documented, (R27) notified of room change on 12/22/24 at 5:12 a.m. (sic) Family/Responsible party notification not applicable. Unable to reach RP, phone is disconnected. Notified on 12/22/24. Reason for change: Medical management (i.e. isolation, acuity, treatments, symptoms mgmt [management], etc.). Clinical need. On 12/31/2024 at approximately 9:25 a.m., an interview was conducted with OSM (other staff member) #33, a social worker. When asked to describe the procedure for changing a resident's room initiated by the facility, she stated a resident's room would be changed if there was a roommate conflict, extensive room repairs and medical needs. If the resident was their own re-sponsible party OSM #33 stated she would explain to the resident, why they were being moved and if the resident was not their own responsible party, she would contact the resident's responsible party about the room change and document it. OSM #33 stated that she would complete a Room Change Assessment and notify housekeeping and nursing of the room change. When asked about the room change for R27 OSM #33 stated that the corporate COO (chief operating officer) informed us to clear the facility's back hall (the third hall on the [NAME] Unit) to consolidate residents due to a drop in the facility census. When asked if she follows-up with resident following a room change OSM #33 stated sometimes it is done the same day or when room rounds are conducted by the staff. When asked if the follow-ups are documented she stated no, further stating that there is no evidence of follow-up with the resident regarding their room change. A second interview was conducted with OSM #33 on 12/31/24 at 1:30 p.m. OSM #33 stated she told R27 of the room change and asked if he wanted to see the room. She further stated she failed to document that she had mailed out a notice to the resident's responsible party regarding the room change. OSM #33 stated unless the resident is hesitant about the room change, she doesn't offer them to see the new room or meet the new roommate. OSM #33 stated she does not give the resident and/or responsible party anything in writing related to the room changes. ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit. 4. For Resident #28 (R28), the facility staff failed to implement the requirements for transferring the resident's room on 12/26/24. On the most recent MDS assessment, an admission assessment, with an assessment reference date of 12/8/24, the resident scored a 15 out of 15 on the BIMS score indicating the resident was not cognitively impaired for making daily decisions. An interview was conducted with R28 on 12/31/24 at 9:20 a.m. R28 stated she was not given an explanation for changing rooms. She did not receive anything in writing related to the room. She did not have the opportunity to see the new room or meet the new roommate. R28 stated no one has followed up with her to see if she liked her room and/or roommate. she stated she was not allowed to ask questions about the move and wondered why she was being moved. The facility staff told her there wasn't going to be any residents down her hallway anymore. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Room Change Notification dated, 12/26/24, documented, Family/Responsible party (RP) notified and consent obtained: yes. Name of Family Resident's Representative Notified/Consented: Resident is own RP. Date of notification: 12/26/24. Reason for change: Medical management (i.e. isolation, acuity, treatments, symptoms mgmt, etc.). Resident and/or RP were provided with copy of notification: Yes. Roommate notified: yes. The progress note dated 12/26/25, documented, (R28) notified of room change on 12/26/24 at 8:00 a.m. Family/Responsible party notified of change. Resident is own RP notified on 12/26/24. Reason for change: Medical management (i.e. isolation, acuity, treatments, symptoms mgmt, etc.). On 12/31/2024 at approximately 9:25 a.m., an interview was conducted with OSM (other staff member) #33, a social worker. When asked to describe the procedure for changing a resident's room initiated by the facility, she stated a resident's room would be changed if there was a roommate conflict, extensive room repairs and medical needs. If the resident was their own re-sponsible party OSM #33 stated she would explain to the resident, why they were being moved and if the resident was not their own responsible party, she would contact the resident's responsible party about the room change and document it. OSM #33 stated that she would complete a Room Change Assessment and notify housekeeping and nursing of the room change. When asked about the room change for R27 OSM #33 stated that the corporate COO (chief operating officer) informed us to clear the facility's back hall (the third hall on the [NAME] Unit) to consolidate residents due to a drop in the facility census. When asked if she follows-up with resident following a room change OSM #33 stated sometimes it is done the same day or when room rounds are conducted by the staff. When asked if the follow-ups are documented she stated no, further stating that there is no evidence of follow-up with the resident regarding their room change. A second interview was conducted with OSM #33 on 12/31/24 at 1:32 p.m. OSM #33 stated she told R28 that she was moving to a new room to consolidate the residents. OSM #33 stated unless the resident is hesitant about the room change, she doesn't offer them to see the new room or meet the new roommate. OSM #33 stated she does not give the resident and/or responsible party anything in writing related to the room changes. When asked if the residents would have to change rooms if the census continues to drop, OSM #33 stated, that was her understanding. ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to notify the physician and/or responsible party of a change in condition for four of 33 residents in the survey sample, Resident #8, #16, #1 and #4. The findings include: 1. For Resident #8 (R8), the facility staff failed to notify the physician of medications not administered on 9/24/24, 9/28/24, 11/17/24, and 11/23/24. Review of the eMAR (electronic medication administration record) dated 9/1/24-9/30/24 for R8 documented the resident not receiving Aricept 10mg 2 tablets at 4:00 p.m. and Atorvastatin 20mg at 8:00 p.m. on 9/24/24, and Memantine 10mg at 5:00 p.m. on 9/28/24. The eMAR documented a chart code of Other/See Progress Notes. Review of the eMAR dated 11/1/24-11/30/24 for R8 documented the resident not receiving Glucosamine 1500 and Namenda 10mg at 9:00 a.m. on 11/17/24. The chart codes documented Hold/See Nurses Notes. The eMAR further documented R8 not receiving Sertraline 100mg and Namenda 10mg at 9:00 a.m. on 11/23/24. The chart code of Other/See Progress Notes. The eMAR's failed to evidence notification of the physician of the medications not administered as documented above. The progress notes for R8 documented in part, - 09/24/2024 18:49 (6:49 p.m.) Note Text: This nurse contacted residents daughter [Name of daughter] to make her aware that since we are now uusing [sic] a differenr [sic] pharmacy that some of the scheduled evening medications were missing. Family member was upset and stated that the medications that were in the cart from [Name of pharmacy] had just beed [sic] paid for by her and she wanted to know why they were not being used. This nurse advised [Name of daughter] to call back in the am when she could get more direct answers to her questions. - 09/24/2024 19:33 (7:33 p.m.) Note Text: Aricept Tablet 10 MG Give 2 tablet by mouth one time a day for dementia. not available from new pharmacy. - 09/24/2024 19:34 (7:34 p.m.) Note Text: Atorvastatin Calcium Oral Tablet 20 MG Give 1 tablet by mouth one time a day for Hyperlipidemia. not available [NAME] [sic] new pharmacy. - 09/28/2024 16:06 (4:06 p.m.) Note Text: Memantine HCl Tablet 10 MG Give 1 tablet by mouth two times a day for Memory May cause drowsiness. Avoid alcohol. not available not to reorder from pharmscript per family. - 11/17/2024 09:09 a.m. Note Text: Glucosamine 1500 Complex Oral Capsule Give 1 tablet by mouth one time a day for supplement. not available. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER Colonial Heights Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	- 11/17/2024 09:10 a.m. Note Text: Namenda Tablet 10 MG Give 1 tablet by mouth two times a day related to Unspecified Dementia, Unspecified Severity, With Agitation (F03.911). not available. - 11/23/2024 09:25 a.m. Note Text: Namenda Tablet 10 MG Give 1 tablet by mouth two times a day related to Unspecified Dementia, Unspecified Severity, With Agitation (F03.911). NOT AVAILABLE, DO NOT REORDER PER FAMILY. - 11/23/2024 09:25 a.m. Note Text: Sertraline HCl Oral Tablet 100 MG Give 1 tablet by mouth one time a day for Depression. NOT AVAILABLE DO NOT REORDER PER FAMILY. The progress notes failed to evidence physician notification of the medications not administered on the dates above. On 1/2/25 at 10:10 a.m., an interview was conducted with LPN (licensed practical nurse) #1 who stated that if medications were not available, they checked the in-house stocked medications to see if they were available and if not, they called the physician to put the medication on hold or find an alternative. LPN #1 stated that R8's family got their medication from an outside pharmacy, and it caused some confusion with the medications when they first switched the pharmacies, but she did not know the specific. She stated that they should notify the physician about a resident missing doses of their medication even if it was the family's request not to reorder them. The facility policy, Medication Unavailability documented in part, 1. A licensed nurse will notify the provider of the unavailability of medication and discuss an alternative order, if necessary. 2. If alternate medication is ordered and is not available, the licensed nurse will activate the backup pharmacy process and procedures. 3. A licensed nurse will document notification of the provider of the unavailability in the medical record. A licensed nurse will notify the responsible party of any new orders and document notification in the medical record. On 1/3/25 at 12:09 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the assistant administrator, ASM #3, the director of nursing, ASM #4, the regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit. 2a. For R16, the facility staff failed to notify the physician and responsible party of the laboratory (lab) tests of CBC (complete blood count) (1), BMP (basic metabolic panel) (2) and CRP (C-Reactive protein) (3) on 10/07/2024, 10/14/2024, 10/21/2024 and 10/28/2024; a CBC on 11/21/2024; and a CBC and CMP (comprehensive metabolic panel) (4) ordered on 12/05/2024 for two days. R16 was admitted to the facility with diagnoses that included but were not limited to osteomyelitis (5) of vertebra (bone of the spine), sacral (bottom of the spine) and sacrococcygeal region (base of the spine) and sepsis (6). On the most recent comprehensive MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 10/10/2024, R16 scored 13 out of 15 on the BIMS (brief interview for mental status), indicating R16 was cognitively intact for making daily decisions. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The POS (physician's order sheet) dated 10/01/2024 for R16 documented in part, CBC, BMP, CRP every night shift every Mon (Monday) for monitoring. Start Date: 08/05/2024. The POS dated 11/01/2024 for R16 documented in part, CBC, CMP, CRP one time only until 11/22/2024. Order Date: 11/21/2024. Start Date: 11/21/2024. End Date: 11/22/2024. The POS dated 12/01/2024 for R16 documented in part, CBC, CMP one time only for 2 (two days. Order Date: 12/05/2024. Start Date: 12/06/2024. End Date: 12/07/2024. The comprehensive care plan for R16 dated 08/05/2024 documented in part, Focus. CARDIAC: the resident is at risk for cardiac complications secondary to hypotension, anemia and sepsis. Created on: 08/05/2024. Under Interventions it documented in part, Labs as ordered. Date Initiated: 08/05/2024. Review of the facility's nursing progress notes dated 10/01/2024 through 10/31/2024, 11/13/2024 through 11/30/2024 and 12/01/2024 through 12/15/2024 failed to evidence of notification to the physician and responsible party for the CMP, BMP, CRP and CMP labs not obtained on the dates listed above. On 01/03/2025 at approximately 9:38 a.m., an interview was conducted with LPN (licensed practical nurse) #27 regarding when labs are not obtained. She stated the physician resident, and responsible party should be notified and documented. The facility's policy Laboratory/Diagnostic Testing documented in part, Procedure: 5. The licensed nurse will document the dates of the notification or critical results, the method of notification as well as any other necessary information related to the lab, radiology, or other diagnostic testing results in the patient's medical record. On 01/03/2025 at approximately 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References: (1) is a group of blood tests that measure the number and size of the different cells in your blood. Obtained from the website: Complete Blood Count (CBC): MedlinePlus Medical Test (2) measures eight different substances in your blood. It provides important information about your body's fluid balance, your metabolism (the process your body uses to make energy from food you eat), and how well your kidneys are working. Obtained from the website: Basic Metabolic Panel (BMP): MedlinePlus Medical Test (3) measures the level of c-reactive protein (CRP) in a sample of your blood. CRP is a protein that your liver makes. Obtained from the website: C-Reactive Protein (CRP) Test: MedlinePlus Medical Test (continued on next page)

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F 0580

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

(4) a routine blood test that measures 14 different substances in a sample of your blood. Obtained from the website: Comprehensive Metabolic Panel (CMP): MedlinePlus Medical Test

(5) Bone infection. Obtained from the website: Osteomyelitis: MedlinePlus Medical Encyclopedia

(6) your body's overactive and extreme response to an infection. Sepsis is a life-threatening medical emergency. Without quick treatment, it can lead to tissue damage, organ failure, and even death. Obtained from the website: Sepsis: MedlinePlus

2b. For R16, the facility staff failed to notify the physician and responsible party of Piperacillin (1) not administered at 6:00 a.m. on 09/02/2024, 09/14/2024, 09/16/2024, 09/19/2024, 09/22/2024 and 09/31/2024; at 2:00 p.m. on 09/16/2024 and at 10:00 p.m. on 09/17/2024 and Tigecycline (2) not administered on 11/15/2024 at 5:00 p.m.

The POS (physician's order sheet) dated 09/01/2024 through 09/30/2024 documented in part, Piperacillin Sod (sodium)-Tazobactam So (sodium) Solution Reconstitute 3-0.375 GM (grams).

Use 3.373 gram intravenously (3) every 8 (eight) hours for wound infection until 09/06/2024. Order Date: 08/01/2024. Start Date: 08/01/2024. End Date: 09/06/2024.

The POS dated 11/01/2024 through 11/30/2024 documented in part, Tigecycline Intravenous Solution Reconstituted 50 MG (Tigecycline) Use 50 mg intravenously two times a day for sacral wound/ osteomylitis (4) until 11/30/2024. Order Date: 11/08/2024. Start Date: 11/09/2024. End Date: 11/30/2024.

The eMAR (electronic medication administration record) dated September 2024 for R16 documented the physician's order as stated above for the administration of Piperacillin. Further review if the eMAR revealed blanks at 6:00 a.m. on 09/02/2024, 09/06/2024, 09/14/2024, 09/16/2024, 09/19/2024, 09/22/2024 and 09/31/2024; at 2:00 p.m. on 09/16/2024 and at 10:00 p.m. on 09/17/2024.

The eMAR dated November 2024 for R16 documented the physician's order as stated above for the administration of Tigecycline. Further review if the eMAR revealed a blank on 11/15/2024 at 5:00 p.m.

The facility's nursing progress notes for R16 dated 11/15/2024 failed to evidence the administration of Tigecycline on 11/15/2024 at 5:00 p.m. Further review of the nurse's notes failed to evidence notification to the physician, R16 and R16's responsible party of Tigecycline not being administered on the above date and time.

The facility's nursing progress notes for R16 dated 09/01/2024 failed to evidence the administration of Piperacillin at 6:00 a.m. on 09/02/2024, 09/14/2024, 09/16/2024, 09/19/2024, 09/22/2024 and 09/31/2024; at 2:00 p.m. on 09/16/2024 and at 10:00 p.m. on 09/17/2024. Further review of the nurse's notes failed to evidence notification to the physician, R16 and R16's responsible party of Piperacillin not being administered on the above dates and times.

On 01/03/2025 at approximately 9:38 a.m., an interview was conducted with LPN (licensed practical nurse) #27 regarding physician ordered medications not administered. She stated the physician, resident and responsible party should be notified and documented.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/03/2025 at approximately 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References: (1) used to treat pneumonia and skin, gynecological, and abdominal (stomach area) infections caused by bacteria. Obtained from the website: Piperacillin and Tazobactam Injection: MedlinePlus Drug Information. (2) Used to treat certain serious infections including community acquired pneumonia (a lung infection that developed in a person who was not in the hospital), skin infections, and infections of the abdomen (area between the chest and the waist). Obtained from the website: Tigecycline Injection: MedlinePlus Drug Information. (3) Occurring within or entering by way of a vein. Obtained from the website: Intravenous Definition & Meaning - Merriam-Webster (4) Bone infection. Obtained from the website: Osteomyelitis: MedlinePlus Medical Encyclopedia 3.a. For Resident #1 (R1), the facility staff failed to notify the physician and the responsible party of a medication, Paxlovid, not being available for administration. The physician order dated 8/30/24, documented, Paxlovid (150/100) oral tablet therapy pack 10 x 150 MG (milligrams) & 10 x 100 MG; give 1 tablet by mouth one time a day for antiviral for 10 days use as directed. The pharmacy delivery manifest documented the Paxlovid was delivered on 9/6/24 at 6:18 a.m. The September 2024 MAR (medication administration record) documented the above order. On 9/3/24 and 9/5/24, there was a 9 documented. A 9 indicated, Other/See Progress note. The progress note dated, 9/3/24 at 2:13 p.m. documented, Awaiting pharmacy. The progress note dated, 9/5/24 at 1:51 p.m. documented, Medication not available. An interview was conducted with LPN (licensed practical nurse) #1 on 1/2/25 at 10:10 a.m. LPN #1 stated that if a medication is not available the nurse should check the Omnicell (back up pharmacy machine in the building). If the medication is not available in the Omnicell you call the doctor to put the medication on hold or find an alternative. It is documented in a progress note that the medication is not available, and that you contacted the doctor. ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. (continued on next page)

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	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 - Some	No further information was provided prior to exit. References: (1) Paxlovid - The combination of nirmatrelvir and ritonavir is used to treat coronavirus disease 2019 (COVID-19 infection) caused by the SARS-CoV-2 virus in adults who have mild to moderate symptoms and are at risk of severe disease that could result in hospitalization or death. This information was retreived from the following website: https://medlineplus.gov/druginfo/meds/a622005.html. 3.b. For Resident #1, the facility staff failed to notify the responsible party of an order for an x-ray and for the results of the x-ray. The resident's face sheet documented the resident was not her own responsible party, her sister-in-law was documented as the responsible party. The most recent MDS (minimum data set) assessment, prior to the fracture in April 2024, with an assessment reference date of 3/28/24, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section GG, Functional Abilities and Goals, the resident was coded as being dependent for sit to standing and for chair/bed-to chair transfers. In Section GG0115 - Functional Limitation in Range of Motion, R1 was coded as having limitations in range of motion on one upper extremity (arms) and both lower extremities (legs). The nurse practitioner note dated, 4/17/24 at 3:39 p.m. documented in part, Pt (patient) seen today for c/o (complaint of) left ankle pain and swelling x 1-2 weeks. Would like some Tylenol. Wears TED (anti-embolism stockings) hose daily for support. Ankle feels stiff. Denies numbness and tingling. The nurses' note dated, 4/18/24 at 5:43 p.m. documented, Received call from (name of radiology company), reporting that she (R1) has a fractured distal fibular (sic). Left message for NP (nurse practitioner). Resident denied pain when asked. The nurse's note dated 4/18/24 at 6:31 p.m. documented, Received fax report of resident's results for x-ray taken earlier today. Report indicates fracture to left distal fibular. Updated NP with results. Spoke with resident and asked if she experienced a fall recently. Resident stated that she has not fallen, but approximately two weeks ago there were two aids getting her up to her power chair, her foot somehow got caught on or beneath the power chair at the moment the aids pulled her upward to sit her in the chair. She remembers this because she states this particular incident hurt left ankle and this is the only incident that has occurred that caused significant pain to that body part. Resident did not recall the names of the aides that were assisting her but stated that they are not the regular staff that works with her. The x-ray report dated, 4/18/24 documented in part, Findings: A fracture of the distal fibula is identified. The fracture does not involve the articular surface (1). No callus formation is noted. The ankle mortise (2) is intact. The surrounding soft tissues are normal. Further review of the clinical record failed to evidence notification of the responsible party related to the order for the x-ray or the results of the x-ray. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025

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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 - Some	The nurse's note dated, 4/22/24 at 4:38 p.m. documented, (First name) , pt (patient) RP (responsible party) notified of appt (appointment) and time and MD being seen. An interview was conducted with LPN (licensed practical nurse) #1 on 1/2/25 at 10:10 a.m. LPN #1 stated if a resident has an injury of unknown origin, they contact the doctor, the responsible party and let the unit manager know. A complete assessment of the resident is performed and findings reported to the MD and RP. ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit. 4. For Resident #4 (R4), the facility staff failed to notify the physician and the responsible party of a medication, Lyrica, not being available for administration. The physician order dated 3/1/24 documented, Lyrica Capsule 100 MG; Give 1 capsule by mouth three times a day for Pain. May cause dizziness or drowsiness. Avoid alcohol. The pharmacy delivery manifest documented the Lyrica was delivered to the facility on 3/7/24 at 8:34 p.m. The March 2024 MAR documented the above order. The medication was ordered for 6:00 a.m., 2:00 p.m. and 10:00 p.m. On the following dates and times, a 5 was documented. A 5 indicates, Hold/see nurse note. 3/1/24 at 10:27 p.m. - nurse's note - awaiting arrival. 3/2/24 at 6:46 a.m. - no nurse's note documented. 3/2/24 at 1:15 p.m. - no nurse's note documented. 3/3/24 at 6:41 a.m. - no nurse's note documented. 3/4/24 at 6:00 a.m. - no nurse's note documented. 3/7/24 at 6:20 a.m. - no nurse's note documented. On the following dates and times, a 9 was documented. A 9 indicates, Other/See progress notes. 3/2/24 at 9:51 p.m. - nurse's note - Medication not available. 3/4/24 at 1:09 p.m. - nurse's note - medication being ordered, called pharmacy to do a follow up on order. 3/4/24 at 9:16 p.m. - no nurse's note documented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/5/24 at 6:55 a.m. - nurse's note - awaiting delivery from pharmacy. 3/5/24 at 3:30 p.m. - nurse's note - resident oof (out of facility) to ER. 3/5/24 at 9:08 p.m. - no nurse's note documented. 3/6/24 at 5:17 a.m. - awaiting delivery from pharmacy. 3/6/24 at 3:06 p.m. - waiting on delivery. An interview was conducted with LPN (licensed practical nurse) #1 on 1/2/25 at 10:10 a.m. LPN #1 stated that if a medication is not available the nurse should check the Omnicell (back up pharmacy machine in the building). If the medication is not available in the Omnicell you call the doctor to put the medication on hold or find an alternative. It should be documented in a progress note that the medication is not available, and you contact the doctor. ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and clinical record reviews, the facility staff failed to ensure a clean comfortable homelike environment on two of three facility units, [NAME] and [NAME]. The findings include: 1. For one of four hallways on the [NAME] unit, the facility staff failed to maintain a homelike environment. On 12/19/24 at 8:16 a.m., an observation of the [NAME] unit was conducted. Observation of the 114-124 hallway revealed a strong, musty odor lingering in the hallway between rooms 119-124. Additional observations on 12/19/24 at 9:01 a.m., 11:09 a.m., and 12:10 p.m. revealed the findings above. On 12/19/24 at 12:45 p.m., an interview was conducted with OSM (other staff member) #10, the director of environmental services. OSM #10 stated that they had two housekeepers who worked on the [NAME] unit. She stated that the resident rooms were cleaned daily and to control odors they used a spray air freshener product that pulled odors out of the air and cleaned the mattresses when the CNA (certified nursing assistant) staff stripped the beds. OSM #10 stated that there were a few rooms where it was harder to control the odors in due to behaviors of the residents. She stated that in those rooms they cleaned them twice a day, sprayed the curtains and washed them monthly or when soiled. When asked if the odor was homelike, OSM #10 stated, It's very hard. On 12/19/24 at 12:51 p.m., an observation was made with OSM #10 of the hallway with rooms 114-124 on the [NAME] unit with the strong, musty odor lingering in the hallway. OSM #10 stated that it did not smell that bad to her and they cleaned twice a day down there, sprayed with air freshener and one of the residents had behaviors that was probably the cause. The facility policy Property Management effective 1/23/20 documented in part, The Administrator is responsible for assuring that the internal and external property of the Health and Rehabilitation Center is efficiently and safely maintained, and that the property resembles that of a high-quality establishment at all times . On 12/20/24 at 4:00 p.m., ASM (administrative staff member) #14, interim administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, ASM #5, regional director of clinical services, ASM #11, regional vice president of operations, ASM #15, regional director of clinical services, and ASM #12, administrator from sister facility were made aware of the findings. No further information was presented prior to exit. 2. For R7, who resided on the [NAME] Unit, the facility staff failed to maintain the resident's room free of cigarette smoke. R7 was admitted to the facility with diagnoses that included but were not limited to heart disease. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 05/11/2023, R7 scored 14 out of 15 on the BIMS (brief interview for mental status), indicating R7 was cognitively intact for making daily decisions. The facility's census form documented R7's room number indicating the room was next to the facility's designated smoking area for residents. On 12/19/2024 at approximately 1:40 p.m., an observation of R7's room by two surveyors revealed the room looked out onto a patio where residents were designated to smoke. Further observation of the room revealed that an odor of cigarette smoke throughout the room. The facility's policy Patient Smoking documented in part, 3. The designated area(s) on the grounds for smoking must: b. not allow passive smoke to re-circulate into the building. On 01/03/2025 at approximately 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. 3. Based observation and staff interview the facility failed to maintain a clean, comfortable, and homelike environment on the [NAME] Unit. Surveyor was conducting a medication pass on 12/18/2024 at 9:24 AM with Nurse #5. Surveyor escorted Nurse #5 into Resident's room [ROOM NUMBER] to administer medications. The surveyor observed several paper cups and napkins that appeared to be used located underneath the resident's bed. Surveyor observed no housekeeping staff working on the [NAME] unit from 08:50AM to 12:00PM. An interview was conducted on 12/19/2024 at 12:32PM with the Director of Environmental Services (DOE #1). DOE #1 stated the facility usually has approximately 6 to 7 housekeepers working each day throughout the facility. She said there are 3 housekeepers allocated to the skill nursing units, and 4 housekeepers allocated to the long-term nursing units. DOE #1 stated that all the housekeepers are given a checklist each day of duties to complete on the units. The surveyor discussed with the DOE #1 the observations made on 12/18/2024. DOE #1 said there were 7 housekeepers scheduled on that day. She was concerned this happened because staff should have been someone available. DOE #1 provided the surveyor with a copy of the housekeeper's checklist duties sheet. An interview was conducted on 12/19/2024 at 4:00PM with the Director of Nursing, Regional Nurse, and the facility Administrator regarding the findings. No additional information was provided to the surveyor regarding this matter. 4. On 12/23/24 at 10:15 a.m., during general observations on the [NAME] Unit and [NAME] Unit, six random rooms were inspected on each unit and revealed the following environmental issues that did not support a clean, comfortable environment for the facility residents: (continued on next page)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. [NAME] Unit (The hallways and rooms inspected in the [NAME] Unit possessed a strong bleach odor). -room [ROOM NUMBER], 118, 128, 132, 136, 137-The floor exhibited an accumulation of adhered dark substance along the perimeter of the room, including the corners and behind the resident entry door and floor surfaces under the room sink and heating, ventilation, and air conditioning units (HVAC). Debris and food were identified on the floor and most pronounced under the nightstands and HVAC heating, ventilation, and air conditioning units. The Cove Base Molding did not fully adhere to the wall and floor transition. It was clearly visible that dirt and debris were trapped in the areas of trim that were not flush against the wall. The Cove Base Molding was looser, fanned outward, or nonexistent under the HVAC units. The sinks in these rooms had dark stains on the bowls and along the sides. The soap dispensers leaked streaks of soap under them, and that settled on the floor. The privacy curtains for the resident in the B bed did not fully allow for complete visual privacy. rooms [ROOM NUMBERS]'s privacy curtains had smears of dark substances. The bathrooms of the aforementioned rooms were shared with an adjacent room. All the bathroom walls were discolored with dark streaks, and the floors exhibited an adhered dark substance along the perimeter and corners of the bathroom. Sporadic dark stains were observed on the toilet seat and sides of the toilet, and the caulking around the base of the toilets was stained with a black substance. During the lunch meal on 12/23/24, room [ROOM NUMBER]'s B bed Cove Base Molding was observed from the hallway to have fallen entirely from the wall and floor transition with prominent crumbled sheetrock on the floor along the entire length of the Cove Base Molding. The resident in the B bed (R#26) sat in a wheelchair, eating lunch next to the outside back wall with the dismantled sheetrock to his right side and in the pathway of his wheelchair. Resident #26 did not respond verbally when asked what he thought about the condition of the wall he was sitting next to; he just smiled and placed his hands in the air. An unidentified light brown bug approximately three inches long with too numerous to count legs on each side and long tentacles was observed crawling on the crumbled sheetrock. Resident #26 was admitted on [DATE] with a significant diagnosis of right-sided weakness. The Brief Interview for Mental Status (BIMS) coded the resident a 10 out of a possible score of 15, indicating he was moderately impaired in his cognitive skills for daily decision-making. During the continued observation of the [NAME] Unit, Resident #29, the resident in room [ROOM NUMBER] A bed, voluntarily stated, That wall has been like that for a while, and no one has bothered to fix it. He (referring to R#26) doesn't talk much about anything but has to see it. When asked if he had ever seen a centepede crawling along the edges of the room, he stated, Not only that but plenty of roaches too. Resident #29 said, Before you leave please take a long look at my bathroom. It is nasty-looking, and there is a hole in the wall. I hate going in there to use it. I see the housekeeping slopping water on the floor, but it never seems to change how it looks. The toilet needs to be replaced with all that dark stuff all over it. It probably can't get clean. The resident also highlighted the dark substance on the roommate's privacy curtain and stated he sees it every time the nursing staff pulls it, but they seem like they don't see it, I guess. These are the newer curtains, too. Resident #29 added that he can see his roommate when it is pulled. The privacy curtain was validated as short when pulled, allowing visualization of the roommate. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #23 resided in room [ROOM NUMBER] B. She highlighted issues in the room that were clearly observed: dirty floors, stained with a black adhered substance throughout, accumulated in the corners, and under the room's sink. She stated, The soap dispensers leak soap down the walls and build up on the floor, and the housekeeping staff never wipes up the soap or replaces the dispensers. They do not clean my room; they just mop in the middle and leave. I have brought these things to their attention, but they tell me there is not enough staff to get to everything. They push it off on me, saying I have too much stuff in my room. I don't think that should stop them from adequately cleaning my room. The resident also brought attention to her disdain for the condition of the shared bathroom, They may have to tear everything out; replace floors, toilets, and sinks. B. [NAME] Unit (The hallways and rooms inspected in the [NAME] Unit possessed a strong bleach odor). Licensed Practical Nurse (LPN) #38 exited room [ROOM NUMBER] and said, Why so bleachy today, it is beginning to give me a headache. Some of the residents on this unit asked that they not be specifically mentioned so they would not be singled out have attention brought to me and I get the worse nurse. -room [ROOM NUMBER], 204, 205, 223, 233, and 235-The floor exhibited an accumulation of adhered dark substance along the perimeter of the room, including the corners and behind the resident entry door and floor surfaces under the room sink and heating, ventilation, and air conditioning units (HVAC). Debris and food were identified on the floor and most pronounced under the nightstands and HVAC heating, ventilation, and air conditioning units. The Cove Base Molding did not fully adhere to the wall and floor transition. It was clearly visible that dirt and debris were trapped in the areas of trim that were not flush against the wall. The Cove Base Molding was looser, fanned outward, or nonexistent under the HVAC units. The sinks in these rooms had dark stains on the bowls and along the sides. The soap dispensers leaked streaks of soap under them, and that settled on the floor. The privacy curtains for the resident in the B bed did not fully allow for complete visual privacy. The bathrooms of the aforementioned rooms were shared with an adjacent room. All the bathroom walls were discolored with dark streaks, and the floors exhibited an adhered dark substance along the perimeter and corners of the bathroom. Sporadic dark stains were observed on the toilet seat and sides of the toilet, and the caulking around the base of the toilets was stained with a black substance. On 12/23/24 at approximately 12:30 p.m., a housekeeper was observed in room [ROOM NUMBER] wet mopping the floor that exhibited food particles. Resident #25 stated that it was par for the course that the housekeeping staff did not sweep the floors before mopping them. The resident said, It probably saves them time, but the food is just pushed around the floor and under furniture. Resident #25 was admitted to the facility on [DATE] with a primary diagnosis of hip fracture and cerebral palsy. The resident scored a 14 out of a possible score of 15, which indicated that cognitive skills were intact for daily decision-making. Old, worn, wide brown, and maroon duct tape was observed on the threshold floor of every resident room in the [NAME] and [NAME] units. The edges of the hallway flooring were exposed through portions of the duct tape. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/23/24 at approximately 12:45 A.M., this writer was joined by Administrative Staff Member #12 (ASM #12), who identified himself as an Administrator from another sister facility. ASM #12 was shown the condition of the resident rooms and bathrooms, as well as duct tape on the floor at the entrance of every room of [NAME] and [NAME] Units. In passing room [ROOM NUMBER], the previously observed brown bug was again identified as crawling on the baseboard of the entranceway of the resident's room. ASM #12 was asked to retrieve it, and he started using a long-handled dustpan and broom. When it appeared the bug was recessing into the gap between the baseboard and wall, this writer hollered to kill it. ASM #12 stepped on the bug and said, I have never seen anything like that; it looks like a centipede, but we got it. Shortly after this observation, the [NAME] President of Operations (VPO) ASM #11 was shown the condition of some of the rooms and the duct tape on the floor to the entrance of the resident's rooms. He was shown the Cove Base Molding that fell away from the wall with crumbled sheetrock and the centipede's sighting. ASM #12 lightheartedly responded that the bug had a couple of legs on each side, and the crumbling wall and detached Cove Base Molding in room [ROOM NUMBER] probably just happened because the Administration/Leadership conducts daily room rounds. On 12/23/24 at approximately 1:15 P.M., ASM #12 was asked why he minimized the appearance of the centipede; there was no response, as he retreated down the hallway where the administrative offices were located. On 12/23/24, at approximately 1:38 PM, the ASM#11 emailed this surveyor indicating that 12/30/24 the duct tape would be removed, and transition strips would be placed on the floors. At approximately 2:30 PM, ASM#11 said the facility had all stored supplies ready to start renovation on both [NAME] and [NAME] units. When requested to see the Capital Improvement Plan, ASM #11 stated he had one and would email it to this writer. On 12/31/24 at 1:01 p.m., ASM#11 emailed the Capital Improvement Plan for the facility. It was previously shared on 12/23/24 that the supplies for a complete facility renovation were stored onsite. The emailed details of the Capital Improvement Plan were as follows: 1. Floor transitions in doorways were started on 12/29 to replace the previous duct tape that was in place throughout the building. *Still awaiting some to be glued down. 2. room [ROOM NUMBER] was taken offline (residents moved) and will be repaired by the maintenance team by 1/31 to include wall and baseboard repair. 3. The remaining floors and building repairs will be a continual focus to get all room remodels completed by 12/2025. We can complete 2 rooms per week as long as there are no setbacks. We anticipate some setbacks along the way. This includes floors, toilets, sinks, and paint. This will bring the building up to par with the remodel that has been started. The Capital Improvement Plan failed to list contractors and their agreements or maintenance staff that would be involved in any parts of the renovations. There was no itemization of what fixtures would be replaced in the resident's room (toilets, sinks, soap dispensers, etc.), considering their worn or dysfunctional disposition. The plan did not identify the start of the renovation nor the unit or give any guarantees of what will be done and when it will be done with the expectation of setbacks. The plan did not explain what may cause anticipated setbacks during the renovation project. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/2/25 at approximately 10:30 A.M., upon this writer's return to the facility, it was shared that the previously housed residents in the [NAME] Unit had been moved to the [NAME] Unit to consolidate residents to provide care due to inadequate nursing staff. room [ROOM NUMBER] had been dismantled completely, and the room was scheduled for a complete renovation. The crumbling wall appeared to have been repaired, and the Cove Base Molding was replaced; although uneven and not flush in the corners, which would allow debris to accumulate, the Cove Base Molding to pull away from the wall, as well as pest entry into the room. On 1/2/25 at approximately 1:15 p.m., the Interim Administrator ASM #1 (as of 12/30/24) was asked to provide the previously mentioned Administrative/Leadership walking-round logs. She stated she would email them to this writer. The logs were not emailed or made available to the survey team. On 1/2/25 at approximately 3:15 p.m., ASM#1 provided the building's pest control logs and service invoices to date. A review of the pest control logs to date identified multiple pests-centipedes on 9/30/24 from resident (room not listed on the log), whole building. This entry did not specify the identity of all the multiple pests but did specify centipede(s) sighting. According to ASM#1, it was her expectation and that of the pest control company that all pest sightings be entered in the pest control logs by all staff. Thus, the pest control company would address any need to treat specific areas or rooms; otherwise, they would perform monthly routine pest control maintenance throughout the facility. She stated that the company could be called for any need apart from the monthly service. The log did not list the centipede sightings shared by this writer nor the one identified by ASM #12 on 12/23/24. During the exit briefing on 1/2/25 at 4:30 p.m., ASM#1 said she called the ASM#11 and he validated all the environmental issues and the centipede sightings that were brought to his attention on 12/23/24. ASM#1 stated, All the issues brought forth during this survey were not under me, and I am glad of that but I care about the residents and vow to get everything corrected for them.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on resident interview, clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to act upon a reported grievance in a timely manner, for two (2) of 33 residents in the survey sample, Resident #21 and Resident #5. The findings include: 1. For Resident #21 (R21), the facility staff failed to respond to a reported grievance in a timely manner and provide a written response regarding the grievance. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/18/24, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 12/20/24 at 10:36 a.m., an interview was conducted with R21. R21 stated that they had filed multiple grievances with the social worker about care concerns, environmental concerns and food concerns and had not received any follow up. She stated that all she had heard was that education was provided to the staff which had not changed anything for very long. R21 stated that she had asked for copies of the grievance that was written up and for the grievance policy, but no one would give her anything. R21 stated that the most recent grievance was filed early in December 2024. On 12/30/24 at 10:40 a.m., R21 stated that they had filed another grievance the week of Christmas regarding new concerns and for follow up on her previous grievances. R21 stated that she had once again requested a copy of the grievance and the policy and had not received anything. Review of the facility service concern reports from 1/1/24 to the present failed to evidence any documented grievances for R21. On 1/2/25 at 1:53 p.m., an interview was conducted with OSM (other staff member) #33, social worker. OSM #33 stated that the social worker wrote up the grievances and gave them to the department head for the particular concern. She stated that the department did their investigation and resolution and signed off on the grievance form before returning it to them where they logged it in the grievance book. OSM #33 stated that they did not follow up with the resident, but the department head of the particular department did. She stated that they did not provide a copy of the grievance form, the resolution or a written explanation of the grievance process to the resident. On 1/2/25 at 3:25 p.m., an interview was conducted with OSM #14, director of social services. OSM #14 stated that when a resident had a concern, they went to speak with them one on one, filled out a concern form and gave it to the affected department depending on the concern. She stated that nursing concerns went to the director of nursing. She stated that after the concern was addressed, she went back to follow up with the resident and logged the grievance. OSM #14 stated that the resident was not given a copy of the grievance unless they requested it. She stated that R21 had concerns regarding call bell response and she was working with the director of nursing to provide education to the floor staff. OSM #14 stated that R21 had come to her office before Christmas, and she had advised her that the grievance was still in progress. At that time, a request was made to OSM #14 for a copy of the grievance filed by R21. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/3/25 at 7:58 a.m., OSM #14 provided a copy of the service concern report for R21 dated 12/26/24 and stated that it was still in progress. She stated that R21 had a grievance filed prior to 12/26/24 regarding care concerns and call bell response times but it had been misplaced. She stated that she had visited with R21 on 1/2/25 and updated them on the progress and provided a copy of the grievance. She stated that she had logged a concern for 12/2/24 regarding call bells with education provided to the staff that was ongoing but did not have a grievance form to provide. A service concern dated 12/26/24 for R21 documented in part, .Resident states that she keeps running out of medicine. Has been without pain meds for 4 days. Questions about Drs orders as nurse last night attempted to put her collar on, she said that she had a copy from the Dr. that said she no longer had to wear it. She stated she had a cardiology appt. transport was set up, but the appt. didn't happen. She also asked that her bathroom be cleaned. She reports feces on wall and floor for extended times. She also stated that she would like to hear back from previous concerns . Under Action Taken it documented Bathroom cleaned, order for neck brace to be worn prn (as needed). On 1/3/25 at 8:57 a.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 stated that when a concern came in involving nursing, she reviewed it and with the assistance of the unit manager they investigated it and came up with a resolution. She stated that the expectation was to resolve the grievance within five days depending on the urgency of the situation. ASM #3 stated that they followed up with the resident to discuss the resolution, but she was not aware of anyone giving the resident a copy of the grievance or a written summary of the grievance. She stated that she was not aware of any grievances for R21 prior to the one dated 12/26/24. The facility policy Service Concerns/Grievances effective 1/23/20, documented in part, .If an issue of concern cannot be immediately and satisfactorily resolved at the point of service, the management staff member will notify the patient/family member that the concern is being submitted to the appropriate department manager and that follow up for resolution will be provided as quickly as possible .The department manager receiving the [Name of facility] Service Concern Report actively and promptly initiates appropriate action (no later than 48 hours of receiving the concern). The department manager will follow up with the patient/family to determine satisfaction and will complete in full, the Step II Department Manager Response section on the yellow copy of the form and forward it immediately to the Administrator .The patient will be provided a written response from the Administrator regarding his or her grievance via the completed [Name of facility] Grievance Form . On 1/3/25 at 12:09 p.m., ASM #1, the interim administrator, ASM #2, the assistant administrator, ASM #3, the director of nursing, ASM #4, the regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit. 2. For Resident #5 (R5), the facility staff failed to fully resolve a grievance in a timely manner or provide a copy of the grievance. R5 was admitted to the facility with diagnoses that included but were not limited to fracture of right femur, fracture of lumbosacral spine and pelvis, fracture of tibia and right fibula, ribs and wedge compression fracture of thoracic vertebra. R5 no longer resided at the facility at the time of the survey. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/26/24, the resident was assessed as scoring 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. On 12/19/24 at 10:56 a.m. R5 was interviewed via telephone. R5 stated that they missed their scheduled follow-up appointment on 11/27/23 due to the facility not having any transportation to get them to the doctor's office. R5 stated that they were not able to get another appointment until February of 2024 because they missed the appointment. A service concern report for R5 dated 11/20/23 documented a concern reported regarding a missed neurophysiology appointment on 11/27/23 and concerns about medications. Under the action taken section, it documented the appointment was rescheduled for 2/12/24 at 3:00 p.m. and discussion about refusing medication and therapy. The service concern failed to evidence documentation regarding why the appointment was missed and documented action taken on 12/7/23 by the former assistant director of nursing. The progress notes for R5 failed to evidence documentation of an appointment scheduled on 11/27/23, the resident missing the appointment on 11/27/23 or the appointment being rescheduled for 2/12/24. On 12/20/24 at 12:54 p.m., an interview was conducted with CNA (certified nursing assistant) #25 who stated that they set up appointments and transportation for residents at the facility. She stated that she set up appointments based on resident and family requests if the physician approved them and when the physician requested them. CNA #25 stated that transportation was set up depending on the insurance and usually was arranged through the insurance. She stated that she did have problems with transportation not showing up and the appointments having to be rescheduled due to this. She stated that when this happened, she filed a grievance though the insurance and asked them not to be put on the list of transportation in the future. She stated that it was an ongoing issue, and she could not say why R5 missed the 11/27/23 appointment for sure because she did not work with them. On 1/2/25 at 1:53 p.m., an interview was conducted with OSM (other staff member) #33, social worker. OSM #33 stated that the social worker wrote up the grievances and gave them to the department head for the particular concern. She stated that the department did their investigation and resolution and signed off on the grievance form before returning it to them to log it and file in the grievance book. OSM #33 stated that they did not follow up with the resident, but the department head of the particular department would. She stated that they did not provide a copy of the grievance form, the resolution or a written explanation of the grievance process to the resident. On 1/2/25 at 3:25 p.m., an interview was conducted with OSM #14, director of social services. OSM #14 stated that when a resident had a concern, they went to speak with them one on one, filled out a concern form and gave it to the affected department depending on the concern. She stated that nursing concerns went to the director of nursing. She stated that after the concern was addressed, she went back to follow up with the resident and logged the grievance. OSM #14 stated that the resident was not given a copy of the grievance unless they requested it. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/3/25 at 8:57 a.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 stated that they did not work with R5 when they resided at the facility but when a concern came in involving nursing, she reviewed it and with the assistance of the unit manager they investigated it and came up with a resolution. ASM #3 stated that they followed up with the resident to discuss the resolution, but she was not aware of anyone giving the resident a copy of the grievance or a written summary of the grievance. ASM #3 reviewed the grievance for R5 dated 11/20/23 and stated that the staff member should have gotten more details about the medication concerns and the expectation was to resolve the grievance within five days. On 1/3/25 at 12:09 p.m., ASM #1, the interim administrator, ASM #2, the assistant administrator, ASM #3, the director of nursing, ASM #4, the regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility failed to protect four (4) of 33 residents in the survey sample from resident-to-resident abuse, Residents #33, #30, #18 and #9. The findings include: 1. For Resident #33 (R33), the facility staff failed to ensure that they were free from abuse from Resident #9 (R9) during a resident-to-resident incident on 8/14/24. On R33's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 9/21/24, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. The prior MDS with an ARD of 6/21/24 documented a score of 15 out of 15 on the BIMS assessment also. Review of a facility synopsis of events dated 8/14/24 for R33 documented a resident-to-resident incident between R33 and Resident #9 (R9). It documented in part, Residents observed in activity event and had an incident. Residents immediately separated . The investigation folder contained a five-day investigation summary dated 8/20/24 and a typed witness statement signed by the former administrator on 8/14/24. The final investigation summary documented in part, .When interviewed, [Name of R33] stated that [Name of R9] was touching him and when he tried to block her from touching him, she began to hit him. [Name of R9] stated that [Name of R33] was talking at her and then hit her, so she hit him back. Both residents were immediately separated. Both residents placed on Q15 (every fifteen) minute observation. A pain and skin assessment were completed on both residents. Both residents denied pain. [Name of R9] received red marks to the right side of face, neck and arm. [Name of R33] received scratches on his face and left hand . In conclusion and based on the findings the allegation of resident-to-resident altercation is substantiated . The investigation failed to evidence additional witness statements, statements from R33 or R9, the skin and pain assessments or other supporting investigation information. On 1/2/25 at 7:55 a.m., an interview was conducted with R33 who stated that they recalled the incident with R9. R33 stated that they were in the activity room and R9 kept touching him. R33 stated that he asked R9 to stop touching him repeatedly and she would not, so he had pushed her hand away and she started hitting him, so he hit back. When asked where R9 was touching him, R33 stated that it was in his groin area. R33 stated that R9 does not bother him anymore and he still attends activities and felt safe at the facility. The progress notes for R33 documented in part, - 08/14/2024 15:14 (3:14 p.m.) Situation: Reported to writer that resident was in altercation with another resident. Background: Resident was in activities in the dining room and got into altercation with another resident. Assessment (RN)/Appearance (LPN): Assessment: Resident was bought out of activity to be assessed for injuries. Recommendation: resident to be moved when room becomes available . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER: Colonial Heights Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 08/14/2024 16:40 (4:40 p.m.) MD and RP (responsible party) made aware. - 08/15/2024 01:00 (1:00 a.m.) Psychiatric Periodic Evaluation . Resident was referred today for being involved in artercation [sic] with another resident. Met in his room, sitting on bed, alert, calm, speech is clear, normal and coperative [sic]. When asked about the incident, resident stated, she started it. she hit me first, I told her to stop but she continued. I hit her also. She scrached [sic] my face and arm. She likes bothering me. I confirmed the scratches. Both residents were separated. Today he reports he is doing ok. Reports he feel safe at the facility [NAME] [sic] gets along well with his roommate . Recommendations: Referred for artercation [sic] with anotehr [sic] resident. He is doing well today. Continue with melatonin 5 mg po daily at bedtime. Do not recommend additional psychotropic medication at this time . - 08/15/2024 15:03 (3:03 p.m.) Social Services. Note Text: SW (social worker) met with resident 1:1 to assess psychosocial wellbeing. Resident met in room where he was resting on bed. SW observed scratches on resident face and hands. Resident states another resident fondled his private area and was rubbing on his legs so he took a foam glow stick and hit her with it so she would stop groping him. Resident states the female resident then began to hit and scratch him. Altercation was broken up by staff. Resident reports no SI/HI (suicidal ideation/homicidal ideation). Resident reports no other injuries. SW offered emotional support to resident. Administration notified. SW will continue to follow. The comprehensive care plan for R33 documented in part, Resident had physical aggression against another resident. Created on: 08/15/2024. On Resident #9's (R9) most recent MDS, a significant change assessment with an ARD of 10/29/24, the resident scored 15 out of 15 on the BIMS assessment, indicating they were cognitively intact for making daily decisions. The progress notes for R9 documented in part: - 3/26/2024 11:08 (11:08 a.m.) Type of Behavior: Touching residents and staff without permission and threatening staff that she will hit them. Non-pharmacological Intervention: Redirecting resident to room. Effect: no effect resident continued to touch residents and staff and threatens staff. - 3/26/2024 11:26 (11:26 a.m.) Type of Behavior: aggressive overt sexual behaviors and grabbing employees and attempting to grab residents. Non-pharmacological Intervention: Asked to stop and redirected to her room to prevent behavior from reoccurring since she has not stopped after repeated requests. Effect: pt stopped once removed from group of residents and the employees. PRN Medication: none. Outcome: pt stayed in her room and behavior stopped once redirected to her room. She did try swinging at one resident while walking away. - 4/20/2024 14:29 (2:29 p.m.) Type of Behavior: Resident verbally abusive to staff and other residents. Raising fist at staff and threatening to beat them up. Non-pharmacological Intervention: Redirecting resident to room. Effect: no intervention helped resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 4/30/2024 18:50 (6:50 p.m.) Type of Behavior: Resident observed touching and teasing another resident although he told her he disaprove [sic] with her actions. Non-pharmacological Intervention: Staff separated both residents and advise her not to touch or tease him because he does not like it. Effect: No further behavior problems at this time. - 5/22/2024 17:00 (5:00 p.m.) Note Text: SW met with resident to assess psychosocial well-being. Resident has a BIMS of 5. Resident accused of hitting another resident in the back. Resident has also been having inappropriate sexual behaviors toward staff. Seen today at the nurse's station, alert and oriented. Resident denied all the behaviors. Denied feeling depressed. Denied SI or HI. Resident referred to psych for follow up. SW also discussed placement in the community. SW will continue to work with transitioning resident to group home. - 8/14/2024 15:04 (3:04 p.m.) Situation: Reported to writer that resident was in altercation with another resident. Background: Resident was in activity in dining room and got into altercation with another resident. Assessment (RN)/Appearance (LPN): Assessment: Resident received scratches to right side of face, neck and right arm as well as across chest. Recommendation: Resident asked to stay in her room to prevent further altercations. - 8/15/2024 14:58 (2:58 p.m.) Note Text: SW met with resident 1:1 to assess psychosocial wellbeing. Resident was observed by staff hitting another resident in the dining room. Resident states she did not hit the other resident, and she does not know why he was upset with her. Resident states she has no injuries and no hi/si. SW educated the resident on safety and put resident in psych book for eval. SW will continue to follow. - 8/15/2024 01:00 (1:00 a.m.) Psychiatric Periodic Evaluation . History of Present Illness: Resident is a (age and sex of R9) with hx of anxiety disorder, bipolar disorder, hypersexuality and insomnia. Managed with Paxil 40 mg po (by mouth) daily, Trazodone 50 mg po daily and Depakote 500 mg po tid (three times a day) and Risperidal 2 mg po daily tid, Duloxetine 80 mg po daily. Resident was referred today after being involved in artercation [sic] with another resident. Met in her room she is laying on her bed comfortably, appear to be on [sic] a good mood, speech clear and normal and coperative [sic]. Today seh [sic] reports doing well. When asked about the incident. Resident stated, he started talking at me, and then hit me. I hit him back. it happened so first [sic] but the staff separated us. Education provided, to notify staff for fute [sic] incidents and verbalized understanding. Reports she has been doing good. States she feel happy, does nor [sic] feel depressed. no restlessness or irritability observed. Denied any thoguths [sic] of SI or HI. Denied any hallucination. Did nto [sic] appear to be respodning [sic] to internal stimuli. No adverse reaction reported or observed . The comprehensive care plan for R9 documented in part: - [Name of R9] 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 and staff, speaks inappropriately to staff, and residents, resident making threats to staff about going to hit them, physical aggressive towards resident, resident declines to wear undergarments and may have incontinence episodes in the floor. Created on: 12/08/2022. Revision on: 11/07/2024. - [Name of R9] has aggressive behaviors towards residents and staff. Created on: 05/28/2024. Revision on: 11/07/2024. (continued on next page)

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

- [Name of R9] was touched by a male resident on her arms. Created on: 08/01/2024. Revision on: 08/01/2024.

- Allegations of hitting another resident. Created on: 11/11/2024.

- Resident noted to have made sexual advances towards a male resident. Created on: 11/05/2024.

- Inappropriately touched by another resident. Created on: 12/21/2024.

- Behavior: resident has behaviors that she hoards things in her room various misc. items causing clutter in her room, hoards towels & wash cloths in room, prefers to keep towels /linen items on floor, places clothes in floor, cursing at another resident. Created on: 07/30/2024. Revision on: 11/11/2024.

Review of other facility synopsis of events documented additional resident to resident incidents with R9 either the aggressor or the recipient of aggression on 6/10/24, 11/3/24, 11/8/24, 11/20/24 and 12/21/24.

On 1/2/25 at 8:08 a.m., an interview was conducted with CNA (certified nursing assistant) #27 who stated that they worked with R9. She stated that she was not aware of R9 touching anyone inappropriately, but she had a habit of wanting to be touched by men.

On 1/2/25 at 11:06 a.m., an interview was conducted with CNA #28 who stated that R9 had just been moved to a different unit because of an incident with another resident. She stated that she had just started working on that unit was not aware of the residents who had inappropriate sexual behaviors, but it would be nice to know who had them so they could watch for them. When asked how other residents were protected from unwanted sexual behaviors from residents with behaviors, CNA #28 stated that they separated the residents when something happened, and she was unsure of anything else other than moving the resident to another unit. She stated that the moved residents would just do the same thing on the other unit.

On 1/2/25 at 11:31 a.m., an interview was conducted with LPN (licensed practical nurse) #28 who stated that they did not witness the incident between R33 and R9 on 8/14/24 but was told to do the skin assessments afterward. She stated that both residents had some scratches and R33 stated that R9 got in his face, so he had hit her. LPN #28 stated that R33 did not tell her that R9 was touching him prior to incident. She stated that R9 had sexual behaviors of touching on male staff and residents. LPN #28 stated that they had moved R9 from the unit several times and other male residents that were involved in incidents. She stated that R9 was still inappropriate will all the male staff asking for hugs and verbally inappropriate. She stated that when an incident happened, they separated the residents to prevent any further inappropriate behavior, reported it to the unit manager and director of nursing and documented what happened. She stated that after it was reported to administration, she was not sure what happened. She stated that they separated the residents because both parties would have to be able to consent to the activity. LPN #28 stated that to protect the other residents they tried to keep R9 away from them, did rounds to make sure she was not going into their rooms and moved her away from the residents that she had the incidents with. LPN #28 stated that one resident could abuse another resident, that they tried to avoid it, but it happened at times.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/2/25 at 1:53 p.m., an interview was conducted with OSM (other staff member) #33, social worker. OSM #33 stated that they had recently moved R9 to another unit to a room closer to the nurse's station to be in view and monitored more closely. On 1/2/25 at 2:35 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 stated that when there was a resident-to-resident incident they separated the residents, did skin assessments, notified the physician and the responsible party and tried to move the aggressor to another room if possible. She stated that they reported the incident to the state agency and the police. ASM #3 stated that the IDT (interdisciplinary team) was made aware of the incident to monitor the residents and the social worker and psychiatry both followed up with the residents. ASM #3 stated that psychiatry followed R9, and she did not feel that she had cognition enough to know if another resident could consent to sexual behavior. She stated that residents should not be allowed to touch other residents and that she thought that R9 could maybe use alternate placement. ASM #3 reviewed the investigation folder for the altercation between R33 and R9 and stated that it was not complete. She stated that there should be witness statements from the other residents in the activity who saw what happened, any staff who were in the activity and from both residents involved in the incident. On 1/2/25 at 3:25 p.m., an interview was conducted with OSM #14, director of social services. OSM #14 stated that R9 was followed by a therapist and psychiatry for inappropriate sexual behaviors. She stated that to protect the other residents they separated the residents when an incident occurred, moved the resident to another unit and had psychiatric services see them. She stated that they tried to keep R9 busy with activities, to get them out of their rooms and involved. The facility provided policy, Abuse/Neglect/Misappropriation/Crime effective 10/17/23 documented in part, . Patients of the Center have the legal right to be free from verbal, sexual, mental, and physical abuse, corporal punishment, involuntary seclusion including abuse facilitated or enabled through the use of technology, and free from chemical and physical restraints except in an emergency and/or as authorized in writing by a physician . Abuse, includes, but is not limited to: iii. Sexual abuse: Sexual harassment, inappropriate touching; Sexual coercion; Sexual assault or allowing a patient to be sexually abused by another; Inciting any of the above . On 1/3/25 at 12:09 p.m., ASM #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was presented prior to exit. 2. For Resident #30 (R30), the facility staff failed to ensure that they were free from abuse by Resident #9 (R9) during a resident-to-resident incident on 11/3/24. On R30's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/16/24, the resident scored 5 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were severely impaired for making daily decisions. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a final investigation of the facility synopsis of events dated 11/11/24 for R30 documented in part, . [Name of R9] was observed in bed with [Name of R30]. MDs and RPs (responsible parties) were made aware. Law Enforcement was notified . Charge nurse [Name of staff member] observed [Name of R9] in bed with [Name of R30] in his room. [Name of staff member] stated when she entered [Name of R30's] room, she observed [Name of R9] in bed on top of the covers with her clothes on and her hand under the covers. When the covers were pulled back, she observed [Name of R9] rubbing [Name of R30's] private area . When interviewed [Name of R9] stated, he wanted it, he wanted me over there. [Name of R9] has been moved to another unit .In conclusion and based on the findings the allegation of abuse is substantiated . The progress notes for R30 documented in part: - 11/01/2024 20:45 (8:45 a.m.) Type of Behavior: Resident is witness in [Room number of R9], laying in the bed with [Room number of R9] resident is advised that he can't be in that bed and escorted out the room. Non-pharmacological Intervention: re-diection [sic]. Effect: effective. PRN (as needed) Medication: none. Outcome: monitor. - 11/02/2024 16:48 (4:48 p.m.) Type of Behavior: Resident is in his bed [Room number of R30] with resident [Room number of R9] Non-pharmacological Intervention: redirect [Room number of R9] from the room. Effect: monitoring. PRN Medication: none. Outcome: monitor. - 11/04/2024 15:04 (3:04 p.m.) Note Text: MD and RP (responsible party) made aware of resident being the receiver of inappropriate sexual behavior over the weekend. No concerns voiced per RP. - 11/04/2024 15:50 (3:50 p.m.) Note Text: SS (social service) Director met with resident to assess psychosocial well-being. Resident was met in room. on 11/3, Female resident was found in resident bed asleep. Resident expressed that he does not recall incident. Resident denies SI/HI. No depression observed. Resident referred to psych for follow up. SW will continue to follow up. - 11/04/2024 17:29 (5:29 p.m.) Note Text: Addemdant [sic] to note 11/2/24 at 16:48. The RP was updated at the time of this incident. - 11/12/2024 00:00 (12:00 a.m.) Psychiatric periodic evaluation . Per staff ntoes 11/02 resident was met in bed with a female resident in her room. Eduation [sic] was provided by staff. Resident has not had any other incident reported. I still educated resident, male resident not supposed to go to female resident room and he verbalized understanding . - 11/13/2024 16:07 (4:07 p.m.) Note Text: SS Director met with resident to follow up assess psychosocial well-being. Per staff on 11/02 resident was met in bed with a female resident in her room. Resident has not had any other incident reported. Resident denies SI/HI. No depression observed. SW will continue to monitor and follow up. The comprehensive care plan for R30 documented in part: - Resident was the receiver of sexual advances from a female resident. Created on: 11/05/2024. Under Interventions it documented, The resident to be reviewed by psych therapy. Date Initiated: 11/05/2024. Created on: 11/05/2024. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On Resident #9's (R9) most recent MDS, a significant change assessment with an ARD of 10/29/24, the resident scored 15 out of 15 on the BIMS assessment, indicating they were cognitively intact for making daily decisions. The progress notes for R9 documented in part: - 4/30/2024 18:50 (6:50 p.m.) Type of Behavior: Resident observed touching and teasing another resident although he told her he disaprove [sic] with her actions. Non-pharmacological Intervention: Staff separated both residents and advise her not to touch or tease him because he does not like it. Effect: No further behavior problems at this time. - 5/22/2024 17:00 (5:00 p.m.) Note Text: SW met with resident to assess psychosocial well-being. Resident has a BIMS of 5. Resident accused of hitting another resident in the back. Resident has also been having inappropriate sexual behaviors toward staff. Seen today at the nurse's station, alert and oriented. Resident denied all the behaviors. Denied feeling depressed. Denied SI or HI. Resident referred to psych for follow up. SW also discussed placement in the community. SW will continue to work with transitioning resident to group home. - 8/14/2024 15:04 (3:04 p.m.) Situation: Reported to writer that resident was in altercation with another resident. Background: Resident was in activity in dining room and got into altercation with another resident. Assessment (RN)/Appearance (LPN): Assessment: Resident received scratches to right side of face, neck and right arm as well as across chest. Recommendation: Resident asked to stay in her room to prevent further altercations. - 11/02/2024 17:23 (5:23 p.m.) Type of Behavior: Inappropriate contact with others, respecting boundary [sic]. Resident is witness [sic] in [Room number for R30] in the bed with that resident with her hand in his groin is not, Non-pharmacological Intervention: Resident was redirected from this behavior serveral [sic] times this date; RP is updated and conference with the resident. Effect: in-effective continue with this behavior. PRN Medication: none. Outcome: monitor. - 11/03/2024 02:47 (2:47 a.m.) Note Text: Resident is alert and verbal. Noted at start of shift laying in the bed of male resident in [Room number for R30] asleep. Resident was awakened and escorted back to her bed. RP called with no answer. Pending return call. Resident was not wearing her boot on her right leg at the time. She was educated about behaviors and need to wear boot per orders when ambulating. - 11/03/2024 12:56 (12:56 p.m.) Type of Behavior: Inappropriate contact with another resident. Resident continues to climb into the bed with another resident. Non-pharmacological Intervention: Effect: PRN Medication: Outcome: Resident redirected several times during this shift. - 11/04/2024 13:49 (1:49 p.m.) Type of Behavior: Inappropriate dress in front of male residents, refusing to put on clothes. Non-pharmacological Intervention: Effect: PRN Medication: Outcome: will continue to monitor and report behaviors. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 11/04/2024 22:39 (10:39 p.m.) Note Text: SS Director met with resident 1:1 to assess psychosocial well-being. Resident was met in room, Resident was lying in bed. Per Nursing, on 11/3, resident was found in male resident's bed asleep. Resident states that she was lonely and needed company. Resident expressed that she didn't intend to fall asleep. Resident denies SI/HI. Resident did express that she is depressed. PHQ9 (patient health questionnaire) completed. Resident referred to psych for follow up. SW Will continue to follow up and provide emotional support. - 11/06/2024 19:32 (7:32 p.m.) Note Text: On 11/6: Resident [Room number of R9] is noted with resident [Room number of R30] laying on her bed; resident [Room number of R30] was laying on his left side facing the door with resident [Room number of R9] laying behind him. Resident [Room number of R30] was asked to get up and leave the room. [Room number of R9] advised staff that she felt very uncomforted with resident [Room number of R30] leaving. Resident [Room number of R30]'s RP asked what was the process for this, staff advised the center will eventually [sic] have to moved [sic] him, RP advised that may be a ideal. Resident is escorted back to his room Staff began 15minute observation on both residents. - 11/07/2024 00:00 (12:00 a.m.) psychiatric periodic evaluation . Recommendations: Referred for sexual inappropriate behaviors. Education was provided today and resident verbalized understanding. Preferably room change- separating her from male resident. Redirecting resident is encouraged to stop resident from going into other residents room. Enourage [sic] resident to participate in facility activities as tolerated . - 11/07/2024 09:36 (9:36 a.m.) Note Text: [Name of R9] notified of room change on 11/07/2024 9:36 AM. Family/Responsible party notified of change. [Name of responsible party] notified on 11/07/2024. Reason for change: Medical management (i.e. isolation, acuity, treatments, symptoms mgmt, etc.). The comprehensive care plan for R9 documented in part: - [Name of R9] 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 and staff, speaks inappropriately to staff, and residents, resident making threats to staff about going to hit them, physical aggressive towards resident, resident declines to wear undergarments and may have incontinence episodes in the floor. Created on: 12/08/2022. Revision on: 11/07/2024. - [Name of R9] has aggressive behaviors towards residents and staff. Created on: 05/28/2024. Revision on: 11/07/2024. - [Name of R9] was touched by a male resident on her arms. Created on: 08/01/2024. Revision on: 08/01/2024. - Allegations of hitting another resident. Created on: 11/11/2024. - Resident noted to have made sexual advances towards a male resident. Created on: 11/05/2024. - Inappropriately touched by another resident. Created on: 12/21/2024. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Behavior: resident has behaviors that she hoards things in her room various misc. items causing clutter in her room, hoards towels & wash cloths in room, prefers to keep towels /linen items on floor, places clothes in floor, cursing at another resident. Created on: 07/30/2024. Revision on: 11/11/2024. Review of other facility synopsis of events documented additional resident to resident incidents with R9 either the aggressor or the recipient of aggression on 6/10/24, 8/14/24, 11/8/24, 11/20/24 and 12/21/24. On 1/2/25 at 8:08 a.m., an interview was conducted with CNA (certified nursing assistant) #27 who stated that they worked with R9. She stated that she was not aware of R9 touching anyone inappropriately, but she had a habit of wanting to be touched by men. On 1/2/25 at 11:06 a.m., an interview was conducted with CNA #28 who stated that R9 had just been moved to a different unit because of an incident with another resident. She stated that she had just started working on that unit was not aware of the residents who had inappropriate sexual behaviors, but it would be nice to know who had them so they could watch for them. When asked how other residents were protected from unwanted sexual behaviors from residents with behaviors, CNA #28 stated that they separated the residents when something happened, and she was unsure of anything else other than moving the resident to another unit. She stated that the resident would just do the same thing on the other unit. On 1/2/25 at 11:31 a.m., an interview was conducted with LPN (licensed practical nurse) #28 who stated that R9 had sexual behaviors of touching on male staff and residents and had one incident where she was caught in a male resident's bed. She stated that the male resident was undressed, and she was lying beside him on top of the covers and did not want to leave when they told her to leave the room. LPN #28 stated that they had moved R9 from the unit at that time and that male resident was on another unit also. She stated that R9 was inappropriate will all the male staff also. She stated that when an incident happened, they separated the residents to prevent any further inappropriate behavior, reported it to the unit manager and director of nursing and documented what happened. She stated that after it was reported to administration, she was not sure what happened. She stated that they separated the residents because both parties would have to be able to consent to the activities. LPN #28 stated that to protect the other residents they tried to keep R9 away from them, did rounds to make sure she was not going into their rooms and moved her away from the resident she had the incident with. LPN #28 stated that in the incident with R30, they were cognitively impaired and not able to consent to sexual contact. LPN #28 stated that one resident could abuse another resident, that they tried to avoid it, but it happened at times. On 1/2/25 at 1:53 p.m., an interview was conducted with OSM (other staff member) #33, social worker. OSM #33 stated that they had recently moved R9 to another unit to a room closer to the nurse's station to be in view and monitored more closely. She stated that when there were resident to resident incident that they interviewed each resident separately to see what happened and make sure they felt safe. She stated that it was reported to the director of nursing, and she believed that it was a reportable incident. OSM #33 stated that she put in psychosocial notes for both residents and followed up for four weeks and had psychiatry consult on the residents. When asked how other residents were protected, she stated that they moved residents to another room, kept them close to the nurse's station. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/2/25 at 2:35 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 stated that when there was a resident-to-resident incident they separated the residents, did skin assessments, notified the physician and the responsible party and tried to move the aggressor to another room if possible. She stated that they reported the incident to the state agency and the police. ASM #3 stated that the IDT (interdisciplinary team) was made aware of the incident to monitor the residents and the social worker and psychiatry both followed up with the residents. ASM #3 stated that psychiatry followed R9, and she did not feel that the resident had cognition enough to know if another resident could consent to sexual behavior. She stated that residents should not be allowed to touch other residents and that maybe R9 could use alternate placement. On 1/2/25 at 3:25 p.m., an interview was conducted with OSM #14, director of social services. OSM #14 stated that R9 was followed by a therapist and psychiatry for inappropriate sexual behaviors. She stated that when there were resident to resident incidents they were reported to the appropriate agencies, they spoke to both residents, did a psychosocial note and had psychiatry services follow up with the residents. She stated for the R9 and R30 incident that R30 was cognitively impaired, and they had separated the residents and asked the family if they wanted to press charges against R9. She stated that to protect the other residents they separated the residents when an incident occurred, moved the resident to another unit and had psychiatric services see them. She stated that they tried to keep R9 busy with activities, get them out of their rooms and involved. On 1/2/25 at 4:56 p.m., an interview was conducted with LPN #29. LPN #29 stated that the aide had reported to them that R9 was in bed with R30 in their room. He stated that he went in and asked her to leave the room. LPN #29 stated that it happened several times and they had to keep redirecting R9 to leave the room and go back [TRUNCATED]

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Develop and implement policies and procedures to prevent abuse, neglect, and theft.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 2. For Resident #33 (R33), the facility staff failed to implement their abuse policy to ensure R33 was free of abuse from Resident #9 (R9) and complete and thorough investigation of a resident-to-resident altercation on 8/14/24.

On R33's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 9/21/24, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. The prior MDS with an ARD of 6/21/24 documented a score of 15 out of 15 on the BIMS assessment also.

Review of a facility synopsis of events dated 8/14/24 for R33 documented a resident-to-resident incident between R33 and Resident #9 (R9). It documented in part, Residents observed in activity event and had an incident. Residents immediately separated . The investigation folder contained a five-day investigation summary dated 8/20/24 and a typed witness statement signed by the former administrator on 8/14/24. The final investigation summary documented in part, .When interviewed, [Name of R33] stated that [Name of R9] was touching him and when he tried to block her from touching him, she began to hit him. [Name of R9] stated that [Name of R33] was talking at her and then hit her, so she hit him back. Both residents were immediately separated. Both residents placed on Q15 (every fifteen) minute observation. A pain and skin assessment were completed on both residents. Both residents denied pain. [Name of R9] received red marks to the right side of face, neck and arm. [Name of R33] received scratches on his face and left hand . In conclusion and based on the findings the allegation of resident-to-resident altercation is substantiated . The investigation failed to evidence additional witness statements, statements from R33 or R9, the skin and pain assessments or other supporting investigation information.

On 1/2/25 at 7:55 a.m., an interview was conducted with R33 who stated that they recalled the incident with R9. R33 stated that they were in the activity room and R9 kept touching him. R33 stated that he asked R9 to stop touching him repeatedly and she would not, so he had pushed her hand away and she started hitting him, so he hit back. When asked where R9 was touching him, R33 stated that it was in his groin area. R33 stated that R9 does not bother him anymore and he still attends activities and felt safe at the facility.

The progress notes for R33 documented in part:

- 08/14/2024 15:14 (3:14 p.m.) Situation: Reported to writer that resident was in altercation with another resident. Background: Resident was in activities in the dining room and got into altercation with another resident. Assessment (RN)/Appearance (LPN): Assessment: Resident was bought out of activity to be assessed for injuries. Recommendation: resident to be moved when room becomes available .

- 08/14/2024 16:40 (4:40 p.m.) MD and RP (responsible party) made aware.

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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 - Some	- 08/15/2024 01:00 (1:00 a.m.) Psychiatric Periodic Evaluation . Resident was referred today for being involved in artercation [sic] with another resident. Met in his room, sitting on bed, alert, calm, speech is clear, normal and coperative [sic]. When asked about the incident, resident stated, she started it. she hit me first, I told her to stop but she continued. I hit her also. She scrached [sic] my face and arm. She likes bothering me. I confirmed the scratches. Both residents were separated. Today he reports he is doing ok. Reports he feel safe at the facility [NAME] [sic] gets along well with his roommate . Recommendations: Referred for artercation [sic] with anotehr [sic] resident. He is doing well today. Continue with melatonin 5 mg po daily at bedtime. Do not recommend additional psychotropic medication at this time . - 08/15/2024 15:03 (3:03 p.m.) Social Services. Note Text: SW (social worker) met with resident 1:1 to assess psychosocial wellbeing. Resident met in room where he was resting on bed. SW observed scratches on resident face and hands. Resident states another resident fondled his private area and was rubbing on his legs so he took a foam glow stick and hit her with it so she would stop groping him. Resident states the female resident then began to hit and scratch him. Altercation was broken up by staff. Resident reports no SI/HI (suicidal ideation/homicidal ideation). Resident reports no other injuries. SW offered emotional support to resident. Administration notified. SW will continue to follow. The comprehensive care plan for R33 documented in part, Resident had physical aggression against another resident. Created on: 08/15/2024. On Resident #9's (R9) most recent MDS, a significant change assessment with an ARD of 10/29/24, the resident scored 15 out of 15 on the BIMS assessment, indicating they were cognitively intact for making daily decisions. The progress notes for R9 documented in part: - 8/14/2024 15:04 (3:04 p.m.) Situation: Reported to writer that resident was in altercation with another resident. Background: Resident was in activity in dining room and got into altercation with another resident. Assessment (RN)/Appearance (LPN): Assessment: Resident received scratches to right side of face, neck and right arm as well as across chest. Recommendation: Resident asked to stay in her room to prevent further altercations. The comprehensive care plan for R9 documented in part: - [Name of R9] 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 and staff, speaks inappropriately to staff, and residents, resident making threats to staff about going to hit them, physical aggressive towards resident, resident declines to wear undergarments and may have incontinence episodes in the floor. Created on: 12/08/2022. Revision on: 11/07/2024. - [Name of R9] has aggressive behaviors towards residents and staff. Created on: 05/28/2024. Revision on: 11/07/2024. - [Name of R9] was touched by a male resident on her arms. Created on: 08/01/2024. Revision on: 08/01/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Colonial Heights Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Allegations of hitting another resident. Created on: 11/11/2024. - Resident noted to have made sexual advances towards a male resident. Created on: 11/05/2024. - Inappropriately touched by another resident. Created on: 12/21/2024. - Behavior: resident has behaviors that she hoards things in her room various misc. items causing clutter in her room, hoards towels & wash cloths in room, prefers to keep towels /linen items on floor, places clothes in floor, cursing at another resident. Created on: 07/30/2024. Revision on: 11/11/2024. On 1/2/25 at 11:31 a.m., an interview was conducted with LPN (licensed practical nurse) #28 who stated that they did not witness the incident between R33 and R9 on 8/14/24 but was told to do the skin assessments afterward. She stated that both residents had some scratches and R33 stated that R9 got in his face, so he had hit her. LPN #28 stated that R33 did not tell her that R9 was touching him prior to incident. She stated that when an incident happened, they separated the residents to prevent any further inappropriate behavior, report it to the unit manager and director of nursing and document what happened. She stated that after it was reported to them, she was not sure what happened after that. LPN #28 stated that one resident could abuse another resident, that they tried to avoid it, but it happened at times. On 1/2/25 at 2:35 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing (DON). ASM #3 stated that when there was a resident-to-resident incident they separated the residents, did skin assessments, notified the physician and the responsible party and tried to move the aggressor to another room if possible. She stated that they reported the incident within two hours if abuse was suspected. She stated that residents should not be allowed to touch other residents and that R9 could use alternate placement. ASM #3 reviewed the investigation folder for the altercation between R33 and R9 and stated that it was not complete. She stated that there should be witness statements from the other residents in the activity who saw what happened, any staff who were in the activity and from both residents involved in the incident. On 1/2/25 at 4:21 p.m., an interview was conducted with ASM #1, the interim administrator. ASM #1 stated when there was an incident they reported to the state agency with an initial report, sending it to all parties that were necessary and submitted a five-day report after a complete investigation that consisted of witness statements, information to see or get what happened, and what may have transpired. The facility provided policy, Abuse/Neglect/Misappropriation/Crime effective 10/17/23 documented in part, . Patients of the Center have the legal right to be free from verbal, sexual, mental, and physical abuse, corporal punishment, involuntary seclusion including abuse facilitated or enabled through the use of technology, and free from chemical and physical restraints except in an emergency and/or as authorized in writing by a physician . Abuse, includes, but is not limited to: iii. Sexual abuse: Sexual harassment, inappropriate touching; Sexual coercion; Sexual assault or allowing a patient to be sexually abused by another; Inciting any of the above . The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigative protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations . (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/3/25 at 12:09 p.m., ASM #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was presented prior to exit. 3. For Resident #8 (R8), the facility staff failed to implement their abuse policy to report and investigate an injury of unknown origin reported to staff by family on 6/17/24. The progress notes for R8 documented in part: - 06/14/2024 19:32 (7:32 p.m.) Late Entry. Medical Note. patient doing well no new complaints . Extremities no cyanosis no clubbing or edema . - 06/17/2024 17:05 (5:05 p.m.) Late Entry. Note Text: Family made writer aware that after home visit one Sunday, resident was seen holding right wrist and not allowing anyone to touch it. NP (nurse practitioner) was made aware and stated she would see him on rounds the following day. NP and nurse both stated this was normal for him to favor that arm. Resident did not display any signs of pain or discomfort. - 06/21/2024 20:53 (8:53 p.m.) Note Text: Compression sleeve placed on residents right hand per order. Will continue to monitor. - 07/01/2024 22:16 (10:16 p.m.) Note Text: Resident's daughter was inquiring about an Xray to residents right arm and hand. MD aware. Family member also questioned why staff were still putting over the head shirts on resident instead of gowns for the comfort of the arm and hand. Daughter was also upset that compression sleeve was not on at the time of her visit. - 07/04/2024 12:50 (12:50 p.m.) Note Text: Per NP resident is to have a ortho consult related to family verbalizing resident appears to have pain and discomfort to right hand. Np suggested Scheduled ibuprofen and muscle relaxer which the RP (responsible party) agreed to but with a limit of only 3 days per family request. NP was made aware. Spoke with family today about ortho consult. They would like facility to attempt second X-ray, as first one was unsuccessful related to resident kicking techs machine. Np agreed to try second X-ray. Will continue to monitor. Review of the facility synopsis of events failed to evidence any reported injury of unknown origin investigation into the reported right wrist injury on 6/17/24. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/2/25 at 2:25 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 stated that when there was an injury of unknown origin reported that an assessment of the resident was done first and then the doctor, administrator, family, and police were called. She stated that the administrator started the reporting process within two hours if abuse was suspected. She stated that since the injury was unknown origin it would be reported. She stated that if the administrator was not available, she would be responsible for the initiation of the investigation by getting statements from everyone that worked with the resident in the past 72 hours. ASM #3 stated that they looked for any bruising and the stages of the bruising to determine the age of the injury and assessed the resident for pain. She stated that they strongly recommended to the physician or nurse practitioner for a visit to the emergency room for evaluation. ASM #3 stated that abuse in-service training was then started. ASM #3 stated that she was not at the facility in June of 2024 but knew that R8 had some chronic issues with the wrist and swelling. ASM #3 stated that if the resident came back from leave with the family and they reported pain and swelling, the family should have been questioned and an investigation should have been done as to what happened. On 1/2/25 at 4:21 p.m., an interview was conducted with ASM #1, the interim administrator. ASM #1 stated that if there was a report of an injury of unknown origin that they reported it to the state agency with an initial report and sent it to all parties necessary. ASM #1 stated that they completed the investigation and sent the five-day report. She stated that the investigation consisted of witness statements or anything to get the details or see what happened. On 1/3/25 at 12:09 p.m., ASM #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was presented prior to exit. 4. For Resident #30 (R30), the facility staff failed to implement the abuse policy to ensure that they were free from abuse by Resident #9 (R9) during a resident-to-resident incident on 11/3/24. On R30's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/16/24, the resident scored 5 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were severely impaired for making daily decisions. Review of a final investigation of the facility synopsis of events dated 11/11/24 for R30 documented in part, . [Name of R9] was observed in bed with [Name of R30]. MDs and RPs (responsible parties) were made aware. Law Enforcement was notified . Charge nurse [Name of staff member] observed [Name of R9] in bed with [Name of R30] in his room. [Name of staff member] stated when she entered [Name of R30's] room, she observed [Name of R9] in bed on top of the covers with her clothes on and her hand under the covers. When the covers were pulled back, she observed [Name of R9] rubbing [Name of R30's] private area . When interviewed [Name of R9] stated, he wanted it, he wanted me over there. [Name of R9] has been moved to another unit .In conclusion and based on the findings the allegation of abuse is substantiated . The progress notes for R30 documented in part: (continued on next page)

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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 - Some	- 11/01/2024 20:45 (8:45 a.m.) Type of Behavior: Resident is witness in [Room number of R9], laying in the bed with [Room number of R9] resident is advised that he can't be in that bed and escorted out the room. Non-pharmacological Intervention: re-diection [sic]. Effect: effective. PRN (as needed) Medication: none. Outcome: monitor. - 11/02/2024 16:48 (4:48 p.m.) Type of Behavior: Resident is in his bed [Room number of R30] with resident [Room number of R9] Non-pharmacological Intervention: redirect [Room number of R9] from the room. Effect: monitoring. PRN Medication: none. Outcome: monitor. - 11/04/2024 15:04 (3:04 p.m.) Note Text: MD and RP (responsible party) made aware of resident being the receiver of inappropriate sexual behavior over the weekend. No concerns voiced per RP. - 11/04/2024 15:50 (3:50 p.m.) Note Text: SS (social service) Director met with resident to assess psychosocial well-being. Resident was met in room. on 11/3, Female resident was found in resident bed asleep. Resident expressed that he does not recall incident. Resident denies SI/HI. No depression observed. Resident referred to psych for follow up. SW will continue to follow up. - 11/04/2024 17:29 (5:29 p.m.) Note Text: Addemdant [sic] to note 11/2/24 at 16:48. The RP was updated at the time of this incident. - 11/12/2024 00:00 (12:00 a.m.) Psychiatric periodic evaluation . Per staff ntoes [sic] 11/02 resident was met in bed with a female resident in her room. Eduation [sic] was provided by staff. Resident has not had any other incident reported. I still educated resident, male resident not supposed to go to female resident room and he verbalized understanding . - 11/13/2024 16:07 (4:07 p.m.) Note Text: SS Director met with resident to follow up assess psychosocial well-being. Per staff on 11/02 resident was met in bed with a female resident in her room. Resident has not had any other incident reported. Resident denies SI/HI. No depression observed. SW will continue to monitor and follow up. The comprehensive care plan for R30 documented in part: - Resident was the receiver of sexual advances from a female resident. Created on: 11/05/2024. Under Interventions it documented, The resident to be reviewed by psych therapy. Date Initiated: 11/05/2024. Created on: 11/05/2024. On Resident #9's (R9) most recent MDS, a significant change assessment with an ARD of 10/29/24, the resident scored 15 out of 15 on the BIMS assessment, indicating they were cognitively intact for making daily decisions. The progress notes for R9 documented in part: - 11/02/2024 17:23 (5:23 p.m.) Type of Behavior: Inappropriate contact with others, respecting boundary [sic]. Resident is witness [sic] in [Room number for R30] in the bed with that resident with her hand in his groin is not, Non-pharmacological Intervention: Resident was redirected from this behavior serveral [sic] times this date; RP is updated and conference with the resident. Effect: in-effective continue with this behavior. PRN Medication: none. Outcome: monitor. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 11/03/2024 02:47 (2:47 a.m.) Note Text: Resident is alert and verbal. Noted at start of shift laying in the bed of male resident in [Room number for R30] asleep. Resident was awakened and escorted back to her bed. RP called with no answer. Pending return call. Resident was not wearing her boot on her right leg at the time. She was educated about behaviors and need to wear boot per orders when ambulating. - 11/03/2024 12:56 (12:56 p.m.) Type of Behavior: Inappropriate contact with another resident. Resident continues to climb into the bed with another resident. Non-pharmacological Intervention: Effect: PRN Medication: Outcome: Resident redirected several times during this shift. - 11/04/2024 13:49 (1:49 p.m.) Type of Behavior: Inappropriate dress in front of male residents, refusing to put on clothes. Non-pharmacological Intervention: Effect: PRN Medication: Outcome: will continue to monitor and report behaviors. - 11/04/2024 22:39 (10:39 p.m.) Note Text: SS Director met with resident 1:1 to assess psychosocial well-being. Resident was met in room, Resident was lying in bed. Per Nursing, on 11/3, resident was found in male resident's bed asleep. Resident states that she was lonely and needed company. Resident expressed that she didn't intend to fall asleep. Resident denies SI/HI. Resident did express that she is depressed. PHQ9 (patient health questionnaire) completed. Resident referred to psych for follow up. SW Will continue to follow up and provide emotional support. - 11/06/2024 19:32 (7:32 p.m.) Note Text: On 11/6: Resident [Room number of R9] is noted with resident [Room number of R30] laying on her bed; resident [Room number of R30] was laying on his left side facing the door with resident [Room number of R9] laying behind him. Resident [Room number of R30] was asked to get up and leave the room. [Room number of R9] advised staff that she felt very uncomforted with resident [Room number of R30] leaving. Resident [Room number of R30]'s RP asked what was the process for this, staff advised the center will eventually [sic] have to moved [sic] him, RP advised that may be a ideal. Resident is escorted back to his room Staff began 15 minute observation on both residents. - 11/07/2024 00:00 (12:00 a.m.) psychiatric periodic evaluation . Recommendations: Referred for sexual inappropriate behaviors. Education was provided today and resident verbalized understanding. Preferably room change- separating her from male resident. Redirecting resident is encouraged to stop resident from going into other residents room. Enourage [sic] resident to participate in facility activities as tolerated . - 11/07/2024 09:36 (9:36 a.m.) Note Text: [Name of R9] notified of room change on 11/07/2024 9:36 AM. Family/Responsible party notified of change. [Name of responsible party] notified on 11/07/2024. Reason for change: Medical management (i.e. isolation, acuity, treatments, symptoms mgmt, etc.). The comprehensive care plan for R9 documented in part, - [Name of R9] 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 and staff, speaks inappropriately to staff, and residents, resident making threats to staff about going to hit them, physical aggressive towards resident, resident declines to wear undergarments and may have incontinence episodes in the floor. Created on: 12/08/2022. Revision on: 11/07/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Colonial Heights Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- [Name of R9] has aggressive behaviors towards residents and staff. Created on: 05/28/2024. Revision on: 11/07/2024. - [Name of R9] was touched by a male resident on her arms. Created on: 08/01/2024. Revision on: 08/01/2024. - Allegations of hitting another resident. Created on: 11/11/2024. - Resident noted to have made sexual advances towards a male resident. Created on: 11/05/2024. - Inappropriately touched by another resident. Created on: 12/21/2024. - Behavior: resident has behaviors that she hoards things in her room various misc. items causing clutter in her room, hoards towels & wash cloths in room, prefers to keep towels /linen items on floor, places clothes in floor, cursing at another resident. Created on: 07/30/2024. Revision on: 11/11/2024. Review of other facility synopsis of events documented additional resident to resident incidents with R9 either the aggressor or the recipient of aggression on 6/10/24, 8/14/24, 11/8/24, 11/20/24 and 12/21/24. On 1/2/25 at 8:08 a.m., an interview was conducted with CNA (certified nursing assistant) #27 who stated that they worked with R9. She stated that she was not aware of R9 touching anyone inappropriately, but she had a habit of wanting to be touched by men. On 1/2/25 at 11:06 a.m., an interview was conducted with CNA #28 who stated that R9 had just been moved to a different unit because of an incident with another resident. She stated that she had just started working on that unit was not aware of the residents who had inappropriate sexual behaviors, but it would be nice to know who had them so they could watch for them. When asked how other residents were protected from unwanted sexual behaviors from residents with behaviors, CNA #28 stated that they separated the residents when something happened, and she was unsure of anything else other than moving the resident to another unit. She stated that the resident would just do the same thing on the other unit. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/2/25 at 11:31 a.m., an interview was conducted with LPN (licensed practical nurse) #28 who stated that R9 had sexual behaviors of touching on male staff and residents and had one incident where she was caught in a male resident's bed. She stated that the male resident was undressed, and she was lying beside him on top of the covers and did not want to leave when they told her to leave the room. LPN #28 stated that they had moved R9 from the unit at that time and that male resident was on another unit also. She stated that R9 was inappropriate will all the male staff also. She stated that when an incident happened, they separated the residents to prevent any further inappropriate behavior, reported it to the unit manager and director of nursing and documented what happened. She stated that after it was reported to them, she was not sure what happened after that. She stated that they separated the residents because both parties would have to be able to consent. LPN #28 stated that to protect the other residents they tried to keep R9 away from them, did rounds to make sure she was not going into their rooms and moved her away from the resident she had the incident with. LPN #28 stated that in the incident with R30, they were cognitively impaired and not able to consent to sexual contact. LPN #28 stated that one resident could abuse another resident, that they tried to avoid it, but it happened at times. On 1/2/25 at 1:53 p.m., an interview was conducted with OSM (other staff member) #33, social worker. OSM #33 stated that they had recently moved R9 to another unit to a room closer to the nurse's station to be in view and monitored more closely. She stated that when there were resident to resident incident that they interviewed each resident separately to see what happened and make sure they felt safe. She stated that it was reported to the director of nursing, and she believed that it was a reportable incident. OSM #33 stated that she put in psychosocial notes for both residents and followed up for four weeks and had psychiatry consult on the residents. When asked how other residents were protected, she stated that they moved residents to another room, kept them close to the nurse's station. On 1/2/25 at 2:35 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 stated that when there was a resident-to-resident incident they separated the residents, did skin assessments, notified the physician and the responsible party and tried to move the aggressor to another room if possible. She stated that they reported the incident to the state agency and the police. ASM #3 stated that the IDT (interdisciplinary team) was made aware of the incident to monitor the residents and the social worker and psychiatry both followed up with the residents. ASM #3 stated that psychiatry followed R9, and she did not feel that the resident had cognition enough to know if another resident could consent to sexual behavior. She stated that residents should not be allowed to touch other residents and that R9 could use alternate placement. On 1/2/25 at 3:25 p.m., an interview was conducted with OSM #14, director of social services. OSM #14 stated that R9 was followed by a therapist and psychiatry for inappropriate sexual behaviors. She stated that when there were resident to resident incidents they were reported to the appropriate agencies, they spoke to both residents, did a psychosocial note and had psychiatry services follow up with the residents. She stated for the R9 and R30 incident that R30 was cognitively impaired, and they had separated the residents and asked the family if they wanted to press charges against R9. She stated that to protect the other residents they separated the residents when an incident occurred, moved the resident to another unit and had psychiatric services see them. She stated that they tried to keep R9 busy with activities, get them out of their rooms and involved. (continued on next page)

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 1/2/25 at 4:21 p.m., an interview was conducted with ASM #1, the interim administrator. ASM #1 stated when there was an incident they reported to the state agency with an initial report, sending it to all parties that were necessary and submitted a five-day report after a complete investigation that consisted of witness statements, information to see or get what happened, and what may have transpired.

On 1/2/25 at 4:56 p.m., an interview was conducted with LPN #29. LPN #29 stated that the aide had reported to them that R9 was in bed with R30 in their room. He stated that he went in and asked her to leave the room. LPN #29 stated that it happened several times and they had to keep redirecting R9 to leave the room and go back to her room. He stated that he never witnessed any contact between the two, only R30 hugging R9. He stated that the residents were separated because they both have responsible parties, are cognitively impaired and cannot consent. LPN #29 stated that he was not aware of any interventions in place to protect the residents because they did not use anything restrictive or any type of barriers. He stated that the behaviors should be care planned and the residents were allowed to visit each other.

On 1/3/25 at 12:09 p.m., ASM #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings.

No further information was presented prior to exit.

5. For Resident #18 (R18), the facility staff failed to implement the abuse policy to ensure that they were free from abuse by Resident #31 (R31) during a resident-to-resident incident on 4/22/24.

On R18's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/9/24, the resident scored 8 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were moderately impaired for making daily decisions.

On 12/19/24 at 11:09 a.m., an interview was attempted with R18 who stated, Get the [expletive] out.

Review of a facility synopsis of events dated 4/22/24 for R18 documented in part, . [Name of R31] was observed by staff performing oral sex with a male resident [Name of R18], in his room. Both residents were separated. MD and RP (responsible party) made aware .

The progress notes for R18 documented in part:

- 4/17/2024 22:11 (10:11 p.m.) Note Text: [Name of R18] notified of room change on 04/17/2024 12:00 AM. Family/Responsible party notified of change. notified on 04/17/2024. Reason for change: Safety.

- 4/19/2024 17:10 (5:10 p.m.) Type of Behavior: Resident observed by staff and visitor getting sexual gratification from a female resident in the doorway of his room. Non-pharmacological Intervention: Effect: PRN (as needed) Medication: Outcome: MD updated. Resident his own RP. Resident placed in psych book for consultation.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 4/22/2024 17:15 (5:15 p.m.) Note Text: SS met with resident 1:1 to assess psychosocial well-being. Resident has a BIMS of 8. Resident observed by staff and visitor getting sexual gratification from a female resident in the doorway of his room. Female resident removed from room. No other barriers reported. Resident referred to psych for follow up. SW will continue to follow up. - 4/22/2024 21:41 (9:41 p.m.) Type of Behavior: Resident ob[TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to report an injury of unknown origin for one (1) of 33 residents (Resident #8) in the survey sample. The findings include: For Resident #8 (R8), the facility staff failed to report an injury of unknown origin reported to staff by family on 6/17/24. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/14/24, the resident was assessed as being severely impaired for making daily decisions. Section GG documented R8 having impairment one side of the upper extremity. The progress notes for R8 documented in part: - 06/14/2024 19:32 (7:32 p.m.) Late Entry. Medical Note. patient doing well no new complaints .Extremities no cyanosis no clubbing or edema . - 06/17/2024 17:05 (5:05 p.m.) Late Entry. Note Text: Family made writer aware that after home visit one Sunday, resident was seen holding right wrist and not allowing anyone to touch it. NP (nurse practitioner) was made aware and stated she would see him on rounds the following day. NP and nurse both stated this was normal for him to favor that arm. Resident did not display any signs of pain or discomfort. - 06/21/2024 20:53 (8:53 p.m.) Note Text: Compression sleeve placed on residents right hand per order. Will continue to monitor. - 07/01/2024 22:16 (10:16 p.m.) Note Text: Resident's daughter was inquiring about an Xray to residents right arm and hand. MD aware. Family member also questioned why staff were still putting over the head shirts on resident instead of gowns for the comfort of the arm and hand. Daughter was also upset that compression sleeve was not on at the time of her visit. - 07/04/2024 12:50 (12:50 p.m.) Note Text: Per NP resident is to have a ortho consult related to family verbalizing resident appears to have pain and discomfort to right hand. Np suggested Scheduled ibuprofen and muscle relaxer which the RP agreed to but with a limit of only 3 days per family request. NP was made aware. Spoke with family today about ortho consult. They would like facility to attempt second X-ray, as first one was unsuccessful related to resident kicking techs machine. Np agreed to try second X-ray. Will continue to monitor. Review of the facility synopsis of events failed to evidence any reported injury of unknown origin investigation into the reported right wrist injury on 6/17/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/2/25 at 2:25 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing (DON). ASM #3 stated that when there was an injury of unknown origin reported that an assessment of the resident was done first and then the doctor, administrator, family, and police were called. She stated that the administrator started the reporting process within two hours if abuse was suspected. She stated that since the injury was unknown origin it would be reported. She stated that if the administrator was not available, she would be responsible for the initiation of the investigation by getting statements from everyone that worked with the resident in the past 72 hours. ASM #3 stated that they looked for any bruising and the stages of the bruising to determine the age of the injury and assessed the resident for pain. She stated that they strongly recommended to the physician or nurse practitioner for a visit to the emergency room for evaluation. ASM #3 stated that abuse in-service training was then started. ASM #3 stated that she was not at the facility in June of 2024 but knew that R8 had some chronic issues with the wrist and swelling. ASM #3 stated that if the resident came back from leave with the family and they reported pain and swelling, the family should have been questioned and an investigation should have been done to what happened. On 1/2/25 at 4:21 p.m., an interview was conducted with ASM #1, the interim administrator. ASM #1 stated that if there was a report of an injury of unknown origin that they reported it to the state agency with an initial report and sent it to all parties necessary. ASM #1 stated that they completed the investigation and sent the five-day report. She stated that the investigation consisted of witness statements or anything to get the details or see what happened. The facility provided policy, Abuse/Neglect/Misappropriation/Crime effective 10/17/23 documented 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 1/3/25 at 12:09 p.m., ASM #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was presented prior to exit.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to fully investigate an allegation of abuse and/or injury of unknown origin for three (3) of 33 residents, Resident #33, #8 and #1. The findings include: 1. For Resident #33 (R33), the facility staff failed to ensure a complete and thorough investigation of a resident-to-resident altercation on 8/14/24. Review of a facility synopsis of events dated 8/14/24 for R33 documented a resident-to-resident altercation between R33 and Resident #9 (R9). It documented in part, Residents observed in activity event and had an altercation. Residents immediately separated . The investigation folder contained a five-day investigation summary dated 8/20/24 and a typed witness statement signed by the former administrator on 8/14/24. The progress notes for R33 documented in part, - 08/15/2024 15:03 (3:03 p.m.) Social Services. Note Text: SW (social worker) met with resident 1:1 to assess psychosocial wellbeing. Resident met in room where he was resting on bed. SW observed scratches on resident face and hands. Resident states another resident fondled his private area and was rubbing on his legs so he took a foam glow stick and hit her with it so she would stop groping him. Resident states the female resident then began to hit and scratch him. Altercation was broken up by staff. Resident reports no SI/HI (suicidal ideation/homicidal ideation). Resident reports no other injuries. SW offered emotional support to resident. Administration notified. SW will continue to follow. On 1/2/25 at 2:35 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 stated that when there was a resident-to-resident altercation they separated the residents, did skin assessments, notified the physician and the responsible party and tried to move the aggressor to another room if possible. She stated that they reported the incident to the state agency and the police. ASM #3 stated that the IDT (interdisciplinary team) was made aware of the incident to monitor the residents and the social worker and psychiatry both followed up with the residents. ASM #3 reviewed the investigation folder for the altercation between R33 and R9 and stated that it was not complete. She stated that there should be witness statements from the other residents in the activity who saw what happened, any staff who were in the activity and both residents involved in the incident. On 1/2/25 at 4:21 p.m., an interview was conducted with ASM #1, the interim administrator. ASM #1 stated that the investigation consisted of witness statements or anything to get the details or see what happened. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided policy, Abuse/Neglect/Misappropriation/Crime effective 10/17/23 documented in part, . The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigative protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations . On 1/3/25 at 12:09 p.m., ASM #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was presented prior to exit. 2. For Resident #8 (R8), the facility staff failed to investigate an injury of unknown origin reported to staff by family on 6/17/24. The progress notes for R8 documented in part, - 06/14/2024 19:32 (7:32 p.m.) Late Entry. Medical Note. patient doing well no new complaints . Extremities no cyanosis no clubbing or edema . - 06/17/2024 17:05 (5:05 p.m.) Late Entry. Note Text: Family made writer aware that after home visit one Sunday, resident was seen holding right wrist and not allowing anyone to touch it. NP (nurse practitioner) was made aware and stated she would see him on rounds the following day. NP and nurse both stated this was normal for him to favor that arm. Resident did not display any signs of pain or discomfort. Review of the facility synopsis of events failed to evidence any reported injury of unknown origin investigation into the reported right wrist injury on 6/17/24. On 1/2/25 at 2:25 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 stated that when there was an injury of unknown origin reported that an assessment of the resident was done first and then the doctor, administrator, family, and police were called. She stated that the administrator started the reporting process within two hours if abuse was suspected. She stated that since the injury was unknown origin it would be reported. She stated that if the administrator was not available, she would be responsible for the initiation of the investigation by getting statements from everyone that worked with the resident in the past 72 hours. ASM #3 stated that they looked for any bruising and the stages of the bruising to determine the age of the injury and assessed the resident for pain. She stated that they strongly recommended to the physician or nurse practitioner for a visit to the emergency room for evaluation. ASM #3 stated that abuse in-service training was then started. ASM #3 stated that she was not at the facility in June of 2024 but knew that R8 had some chronic issues with the wrist and swelling. ASM #3 stated that if the resident came back from leave with the family and they reported pain and swelling, the family should have been questioned and an investigation should have been done to what happened. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/2/25 at 4:21 p.m., an interview was conducted with ASM #1, the interim administrator. ASM #1 stated that if there was a report of an injury of unknown origin that they reported it to the state agency with an initial report and sent it to all parties necessary. ASM #1 stated that they completed the investigation and sent the five-day report. She stated that the investigation consisted of witness statements or anything to get the details or see what happened. On 1/3/25 at 12:09 p.m., ASM #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was presented prior to exit. 3. For Resident #1 (R1), the facility staff failed to evidence a complete investigation for a fracture that the resident sustained In April 2024. The nurse practitioner note dated, 4/17/24 at 3:39 p.m. documented in part, Pt (patient) seen today for c/o (complaint of) left ankle pain and swelling x 1-2 weeks. Would like some Tylenol. Wears TED hose daily for support. Ankle feels stiff. Denies numbness and tingling. The nurses' note dated, 4/18/24 at 5:43 p.m. documented, Received call from (name of radiology company), reporting that she (R1) has a fractured distal fibular (sic). Left message for NP (nurse practitioner). Resident denied pain when asked. The nurse's note dated 4/18/24 at 6:31 p.m. documented, Received fax report of resident's results for x-ray taken earlier today. Report indicates fracture ot left distal fibular. Updated NP with results. Spoke with resident and asked if she experienced a fall recently. Resident stated that she has not fallen, but approximately two weeks ago there were two aids getting her up to her power chair, her foot somehow got caught on or beneath the power chair at the moment the aids pulled her upward to sit her in the chair. She remembers this because she states this particular incident hurt left ankle and this is the only incident that has occurred that caused significant pain to that body part. Resident did not recall the names of the aides that were assisting her but stated that they are not the regular staff that works with her. The x-ray report dated, 4/18/24 documented in part, Findings: A fracture of the distal fibula is identified. The fracture does not involve the articular surface. No callus formation is noted. The ankle mortise is intact. The surrounding soft tissues are normal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER: Colonial Heights Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility synopsis of event dated, 4/19/24, documented, This is the final for Injury of Unknown Origin related to (R1) reported April 18, 2024. (R1) stated that two weeks ago, two CNAs (certified nursing assistants) were getting her up to her power chair and her left foot got hung on the chair. MD (medical doctor) and RP (responsible party) made aware. (R1) is a [AGE] year-old female with medical diagnoses not limited to Cerebral Palsy, Type 2 diabetes mellitus, COPD (chronic obstructive pulmonary disease), glaucoma, GERD (gastroesophageal reflux disease), BIMS (brief interview for mental status) score is 14. Resident interviewed; medical records reviewed. On April 18, 2024, (R1) complained of pain in her left foot. Upon observation, (R1) foot was swollen. When asked if she had fallen, (R1) stated that two weeks ago, two CNAs were getting her up to her power wheelchair and her foot got hung as they were trying to position her in the chair. (R1) said she did not say anything at the tine it happened because she was not in any pain. An x-ray was ordered and done in which the results showed a fracture of the left distal fibular. (R1) denies any abuse from staff. (R1) as an ortho (orthopedic) appointment on April 22nd at 1425 (2:15 p.m.). Resident and staff interviewed; medical records reviewed. The allegation of abuse was unsubstantiated. Staff will have an in-service on safe transfers. The file with the above synopsis had no other documents in the file folder. There was no documented evidence of interviews with staff and further information regarding a complete investigation into the fracture. The folder containing the investigation into the fractured ankle was reviewed with ASM (administrative staff member) #4, the regional vice president of operations (RVPO). He stated there should be more documents, staff interviews, x-ray reports, in the folder. ASM #4 returned at 2:44 p.m. returned and stated he couldn't find any further documentation related to the fracture of R1. An interview was conducted with ASM #3, the director of nursing (DON), on 1/2/25 at 2:25 p.m. ASM #3 stated, For an injury of unknown origin we first do an assessment of the resident, contact the doctor, administrator, family and police. The administrator starts the reporting to the state agency within two hours if abuse is suspected. It's suspected since we don't know where the fracture is coming from. In the absence of the administrator, the director of nursing is responsible for the initiation of the investigation. We start getting statements. Everyone that has worked with the resident in the past 72 hours. We interview all the aides. We look at the stage of bruising; if it's yellow, purple or green, to help determine how long ago it occurred. We complete a pain assessment on the resident also. We strongly recommend to the physician/nurse practitioner, a visit to the emergency room for evaluation. Then abuse in-service training is started. An interview was conducted with ASM #1, the interim administrator, on 1/2/25 at 4:21p.m. ASM #1 stated once there is a report of an injury of unknown origin, from the administration side, we report to the state agency with an initial report, sending to all parties necessary. We submit the five-day report. The investigation consists of witness statements, anything to get what happened, to see how it happened, what may have transpired. We do a five-point plan of correction, that would include education. At 5:19 p.m. ASM #1 stated they did not have a five point of plan of correction related to the fracture for R1 in April 2024. ASM #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. (continued on next page)

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Colonial Heights Rehabilitation and Nursing Center	831 Ellerslie Ave Chesterfield, VA 23834

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 8. For Resident #5 (R5), the facility staff failed to implement the comprehensive care plan to administer medications as ordered. The comprehensive care plan for R5 documented in part, - Antipsychotics: the resident is at risk for adverse reactions related to the use of antipsychotics secondary to diagnosis of schizophrenia. Created on: 09/26/2023. Revision on: 01/23/2024. Under Interventions it documented in part, administer medications as ordered. Date Initiated: 09/26/2023. Created on: 09/26/2023. Revision on: 01/23/2024 . - Medications: the resident is at risk for complications related to psychoactive medication use secondary to diagnoses of insomnia. Created on: 10/04/2023. Revision on: 05/02/2024. Under Interventions it documented in part, administer medications as ordered. Date Initiated: 10/04/2023. Created on: 10/04/2023. Revision on: 05/02/2024 . - Anticoagulant: the resident is at risk for bleeding, hemorrhage, excessive bruising and complications related to anticoagulant use for prophylaxis. Created on: 10/04/2023. Revision on: 05/02/2024. Under Interventions it documented in part, administer medications as ordered. Date Initiated: 10/04/2023. Created on: 10/04/2023. Revision on: 05/02/2024 . Review of the Medication Administration Audit Report for R5 dated 12/1/23-12/31/23 documented the following medications administered late: - Depakote 125mg twice a day at 9:00 a.m. and 6:00 p.m. The 9:00 a.m. dose administered at 1:13 p.m. on 12/3/23, at 10:21 a.m. on 12/10/23, at 3:09 p.m. on 12/13/23, at 3:56 p.m. on 12/14/23, at 4:22 p.m. on 12/15/23, at 4:31 p.m. on 12/18/23, at 11:44 a.m. on 12/19/23, at 3:54 p.m. on 12/20/23, not documented as administered on 12/22/23, at 11:42 a.m. on 12/24/23, not documented as administered on 12/26/23, at 12:22 p.m. on 12/27/23, at 4:21 p.m. on 12/28/23 and at 10:50 a.m. on 12/30/23. The 6:00 p.m. dose administered at 9:45 p.m. on 12/14/23, at 8:31 p.m. on 12/18/23, at 7:32 p.m. on 12/20/23, at 10:17 p.m. on 12/21/23, at 8:56 p.m. on 12/22/23, at 9:22 p.m. on 12/23/23, at 9:15 p.m. on 12/25/23, at 8:43 p.m. on 12/27/23, at 8:16 a.m. on 12/30/23, and at 7:09 p.m. on 12/31/23. - Eliquis 5mg twice a day at 9:00 a.m. and 5:00 p.m. The 9:00 a.m. dose administered at 1:13 p.m. on 12/3/23, at 10:21 a.m. on 12/10/23, at 3:09 p.m. on 12/13/23, at 3:56 p.m. on 12/14/23, at 4:22 p.m. on 12/15/23, at 11:44 a.m. on 12/19/23, at 3:54 p.m. on 12/20/23, not documented as administered on 12/22/23, at 11:42 a.m. on 12/24/23, not documented as administered on 12/26/23, at 12:22 p.m. on 12/27/23, and at 10:50 a.m. on 12/30/23. The 5:00 p.m. dose administered at 9:45 p.m. on 12/14/23, at 7:32 p.m. on 12/20/23, at 10:17 p.m. on 12/21/23, at 8:56 p.m. on 12/22/23, at 9:22 p.m. on 12/23/23, at 9:15 p.m. on 12/25/23, at 8:16 a.m. on 12/30/23, and at 7:09 p.m. on 12/31/23. - Trazodone 100mg 2 tablets at bedtime at 9:00 p.m. The 9:00 p.m. for 12/6/23 dose administered at 7:26 a.m. on 12/7/23, at 10:17 p.m. on 12/21/23, at 8:56 p.m. on 12/22/23, at 9:22 p.m. on 12/23/23, and at 11:50 p.m. on 12/31/23. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Seroquel 200mg at bedtime at 9:00 p.m. The 9:00 p.m. dose for 12/6/23 administered at 7:26 a.m. on 12/7/23, at 10:17 p.m. on 12/21/23, at 9:22 p.m. on 12/23/23, and at 11:50 p.m. on 12/31/23. On 12/20/24 at 11:50 a.m., an interview was conducted with LPN (licensed practical nurse) #27 who stated that the purpose of the care plan was to individualize the care for the resident and document their needs. She stated that the care plan should be implemented because it was to provide care for the resident, and they implemented it by reviewing the interventions and the CNAs reviewed the Kardex. On 1/2/25 at 10:10 a.m., an interview was conducted with LPN #1 who stated that medications were to be administered within an hour before or an hour after the scheduled time. She stated that medication administration was evidenced by clicking yes or no on the eMAR and the unit manager, physician and responsible party should be notified when a medication was given late. On 1/3/25 at 12:09 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the assistant administrator, ASM #3, the director of nursing, ASM #4, the regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit. 9. For Resident #21 (R21), the facility staff failed to implement the care plan to A) assist with ADL (activities of daily living) care/showers and B) administer pain medication as ordered. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/18/24, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. Section GG documented R21 requiring substantial to maximal assistance with showering/bathing. Section J documented R21 receiving scheduled and as needed pain medications and having frequent pain. A) ADL care/showers On 12/20/24 at 10:36 a.m., an interview was conducted with R21 in their room. R21 stated that they had only had about three showers since their admission. She stated that on admission she was wearing a neck brace and was not allowed to take it off until the doctor cleared her later in October. R21 stated that getting a shower was like pulling teeth in the facility. She stated that the showers were supposed to be twice a week, but the staff always said they would be back to get them for the shower and never came back. The physician's progress notes documented in part, 10/25/2024 21:28 (9:28 p.m.) .she will keep the hard collar for 2 weeks then she can remove it and wears a soft collar, in the mean time she can sleep with a soft collar, she can also remove her hard collar when she isneating [sic] and showering . The comprehensive care plan for R21 documented in part, Short Term Care: the resident requires assistance with their activities of daily living due to recent spinal surgery, generalized weakness, bilateral hand numbness. Created on: 10/14/2024. Revision on: 10/15/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADL (activities of daily living) documentation for R21 provided by ASM (administrative staff member) #5, the regional director of clinical services was reviewed. The documentation from 12/1/24-12/31/24 documented showers scheduled on Mondays and Thursdays. The ADL documentation failed to evidence a shower provided on 12/9/24, 12/23/24 and 12/27/24. No shower sheets were provided. On 12/20/24 at 11:50 a.m., an interview was conducted with LPN (licensed practical nurse) #27 who stated that the purpose of the care plan was to individualize the care for the resident and document their needs. She stated that the care plan should be implemented because it was to provide care for the resident, and they implemented it by reviewing the interventions and the CNAs reviewed the Kardex. On 1/2/25 at 11:30 a.m., an interview was conducted with CNA (certified nursing assistant) #3 who stated that showers were given at least twice a week and as requested. She stated that they were documented on shower sheets and in the ADL documentation. On 1/3/25 at 12:09 p.m., ASM #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit. B) administer pain medication as ordered. On 12/30/24 at 10:36 a.m., an interview was conducted with R21 who stated that the facility ran out of their pain medication over Christmas. She stated that she went five days with none of the as needed pain medication and she was told that there was no physician to sign a prescription for the medication. R21 stated that she was having neck and arm pain and was told that she had to wait for the physician to sign a new prescription. R21 stated that she was able to get her scheduled pain medications, but they did not work like the as needed pain medication. A service concern dated 12/26/24 for R21 documented in part, .Resident states that she keeps running out of medicine. Has been without pain meds for 4 days . The comprehensive care plan for R21 documented in part, The resident has a risk for pain related to s/p (status post) spinal surgery, neuropathy, arthritis, bladder spasms. Created on: 10/14/2024. Revision on: 11/22/2024. Under Interventions it documented in part, administer medications as ordered. Date Initiated: 10/14/2024 . The physician order's for R21 documented in part, - Hydromorphone HCL Tablet 2mg Give 1 tablet by mouth every 4 hours as needed for pain. Order Date: 12/11/2024. - Hydromorphone HCL oral liquid 1mg/ml (hydromorphone HCL) Give 2 ml by mouth every 4 hours as needed for pain. Order Date: 12/27/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The eMAR (electronic medication administration record) for R21 dated 12/1/24-12/31/24 documented an order for Hydromorphone 1mg every 4 hours as needed for pain 4-10 from 10/14/24-12/11/24 administered as needed and an order for Hydromorphone 2mg every 4 hours as needed for pain beginning on 12/11/24. The eMAR documented R21 receiving as needed doses from 12/11/24-12/23/24 and then on 12/29/24. The eMAR further documented an order added on 12/27/24 for Hydromorphone liquid 1mg/ml 2ml every 4 hours as needed for pain with doses administered on 12/27/24-12/29/24. The eMAR documented no doses administered between 12/24/24-12/28/24. The progress notes for R21 documented in part, - 12/27/2024 03:30 (3:30 a.m.) Note Text: Per Pharm Script the residents Hydromorphone HCI is on back order and can only currently provide the medication in liquid form if the MD provides another prescription. This nurse reached out to MD and MD on call service with no response to obtain an order for Hydrocodone. Resident is aware of current situation. - 12/27/2024 10:10 (10:10 a.m.) Note Text: called made to pharmacy re Medication. new script was sent per pharmacy request however pill med pn [sic] back order. Liquid medication was available so new script was sent and will be available. Resident is claims she is 3/10 pain at this time and understand the delay. The progress notes failed to evidence any communication with the pharmacy prior to 12/27/24. On 12/20/24 at 11:50 a.m., an interview was conducted with LPN (licensed practical nurse) #27 who stated that the purpose of the care plan was to individualize the care for the resident and document their needs. She stated that the care plan should be implemented because it was to provide care for the resident, and they implemented it by reviewing the interventions and the CNAs reviewed the Kardex. On 1/2/25 at 10:10 a.m., an interview was conducted with LPN #1 who stated that when a medication was not available, they checked the in-house inventory to see if it was available and if not available, they called the physician to put the medication on hold or find an alternative for the resident. Review of the in-house inventory failed to evidence stock of Hydromorphone. On 1/3/25 at 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit. Reference: (1) Hydromorphone immediate-release tablets and oral solution are used as a short-term treatment to relieve severe pain (pain that begins suddenly, has a specific cause, and is expected to go away when the cause of the pain is healed) in people who are expected to need an opioid pain medication and whose pain cannot be controlled by the use of alternative pain medications. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682013.html (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. For Resident #27 (R27), the facility staff failed to implement the comprehensive care plan to check a wander guard every shift. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/20/24, the resident scored eight out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. Section E documented no wandering behaviors. The assessment documented the use of a wander/elopement alarm used daily. The comprehensive care plan for R27 documented in part, The resident is at risk for elopement related to Dementia. Created on: 04/18/2023. Revision on: 10/19/2023. Under Interventions it documented in part, . Wander guard to left ankle check placement every shift. Date Initiated: 10/10/2023. Created on: 10/10/2023. Revision on: 10/10/2023. The physician orders for R27 documented in part, Wander guard - Check placement, function and skin integrity every shift every shift for elopement. Order date: 05/01/2024. An elopement risk assessment dated [DATE] for R27 documented a high risk for elopement/exit seeking. The eTAR (electronic treatment administration record) for R27 dated 10/1/24-10/31/24 failed to evidence ordered wander guard checks completed on evening shift of 10/5/24, 10/10/24 and 10/11/24. The eTAR for R27 dated 11/1/24-11/30/24 failed to evidence ordered wander guard checks completed on day shift of 11/19/24 and night shift on 11/24/24. The eTAR for R27 dated 12/1/24-12/31/24 failed to evidence ordered wander guard checks completed on day shift of 12/12/24, 12/16/24, 12/23/24 and evening shift on 12/3/24 and 12/9/24. On 12/20/24 at 11:50 a.m., an interview was conducted with LPN (licensed practical nurse) #27 who stated that the purpose of the care plan was to individualize the care for the resident and document their needs. She stated that the care plan should be implemented because it was to provide care for the resident, and they implemented it by reviewing the interventions and the CNAs reviewed the Kardex. On 1/2/25 at 10:10 a.m., an interview was conducted with LPN #1 who stated that treatments were evidenced as completed by signing off on the eTAR. On 1/2/25 at 4:18 p.m., an interview was conducted with LPN #2 who stated that wander guards were checked every shift. She stated that they checked placement and function and documented it on the eTAR to evidence that it was done. On 1/3/25 at 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. For Resident #14 (R14), the facility staff failed to implement the comprehensive care plan to A) provide incontinence care in a timely manner, B) maintain trim and clean fingernails and C) provide treatment to pressure injuries as ordered. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 10/13/24, the resident scored 8 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions. R14 was assessed as being dependent on staff for toileting, substantial/maximal assistance with personal hygiene and frequently incontinent of bowel and bladder. Section M documented R14 having one Stage 3 pressure injury. A) Incontinence care On 1/2/25 at 11:49 a.m., an observation of R14 was conducted with LPN (licensed practical nurse) #28. R14 was observed lying in bed with a strong urine odor present. A draw sheet was visible underneath R14 on the left side with dried dark yellow stains underneath the resident. When asked about the stain and odor, LPN #28 stated that R14 should have been changed by now and that they needed to be cleaned up right now. At 11:52 a.m., ASM (administrative staff member) #3, the director of nursing entered the room and observed the odor and stained draw sheet underneath R14. ASM #3 stated that it appeared to have been there a while, and it would be taken care of right away. The comprehensive care plan for R14 documented in part, Urinary incontinence related to physical limitations/Dementia. Created on: 10/13/2020. Revision on: 01/12/2023. Under Interventions it documented in part, .Provide assistance with toileting or provide incontinent care as needed. Date Initiated: 10/13/2020. Created on: 10/13/2020 . On 12/20/24 at 11:01 a.m., an interview was conducted with CNA (certified nursing assistant) #26 who stated that incontinence care should be provided every two hours. On 12/20/24 at 11:50 a.m., an interview was conducted with LPN #27 who stated that the purpose of the care plan was to individualize the care for the resident and document their needs. She stated that the care plan should be implemented because it was to provide care for the resident, and they implemented it by reviewing the interventions and the CNAs reviewed the Kardex. LPN #27 stated that incontinence care should be provided every two hours to prevent skin breakdown and to provide adequate care. On 1/2/25 at 11:30 a.m., an interview was conducted with CNA #3 who stated that incontinence care was provided at least every two hours. B) Fingernails On 12/19/24 at 11:07 a.m., an observation of R14 was conducted. R14 was observed in bed asleep, the right hand was visible with the fingernails observed to be approximately 1/4 inch long. The pointer and thumb nails were uneven with a dark substance underneath. Additional observations of R14's fingernails as described above were made on 12/20/24 at 9:07 a.m., 12/30/24 at 10:32 a.m. and 1/2/25 at 7:58 a.m. (continued on next page)

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan for R14 documented in part, ADL Self care deficit related to physical limitations, Dementia. Created on: 10/13/2020. Revision on: 10/13/2020. Under Interventions it documented in part, Assist with daily hygiene, grooming, dressing, oral care and eating as needed. Date Initiated: 10/13/2020. Created on: 10/13/2020. On 12/20/24 at 11:50 a.m., an interview was conducted with LPN #27 who stated that the purpose of the care plan was to individualize the care for the resident and document their needs. She stated that the care plan should be implemented because it was to provide care for the resident, and they implemented it by reviewing the interventions and the CNAs reviewed the Kardex. On 1/2/25 at 11:30 a.m., an interview was conducted with CNA #3 who stated that CNAs should trim the fingernails. On 1/2/25 at 11:31 a.m., an interview was conducted with LPN #28 who stated that she trimmed as many resident fingernails as she could when she observed that they needed them or when residents asked. She stated that the CNAs should be cleaning the resident's nails and making sure that they were trimmed on the shower days which were twice a week. On 1/2/25 at 11:49 a.m., an observation of R14 was conducted with LPN #28. LPN #28 observed R14's fingernails and stated that they needed cleaning and trimming and she would take care of it. C) Provide treatment to pressure injuries as ordered. The comprehensive care plan for R14 documented in part, The resident has actual pressure ulcer to left ischium, sacrum, left heel & is at risk for pressure ulcers related to incontinence, chronic health conditions, cognitive impairment, reduced mobility, has redness and h/o (history of) skin excoriation to the R buttocks, has h/o open area to right posterior thigh, bilateral buttocks, Left heels, right heel. Has dx (diagnosis)- PAD (peripheral artery disease). Has pressure ulcer to sacrum, L heel and L ischium. Created on: 05/11/2023. Revision on: 12/18/2024. Under Interventions it documented in part, administer treatment as ordered. Date Initiated: 07/11/2024. Revision on: 09/18/2024. The current physician orders for R14 documented in part, - 10/09/2024 Air Mattress: Settings: (159.2lbs) Check Placement and functioning of Specialty mattress Q (every) Shift. every shift for Preventive measures. - 12/18/24 L Heel: Cleanse the area with half-strength Dakin's Solution, pat dry, apply Betadine-Soaked 4X4 gauze, place Silver Alginate to the Lateral and Medial side of the heel cover with ABD Pad, and Secure with rolled gauze. every day shift for Wound Care. - 11/24/24 R Heel: Skin Prep every shift for Skin integrity. - 12/18/24 Sacrum: Cleanse the area with half-strength Dakin's Solution, pat dry, apply Collagen Particles to Dakin's-Soaked gauze, pack into the wind [sic] bed, and cover with a Silicone Dressing every day shift for Pressure Ulcer. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The skin observation tool for R14 dated 9/16/24 documented in part, .skin tear with Calcium alginate applied with border gauze dressing to crease of buttocks. The assessment failed to evidence any measurements or staging. Additional skin observation tools for R14 dated 9/23/24 documented scratch to buttock healing well with Zinc, no new issues noted, 9/30/24 documented no new issues, treatment continues to sacrum, 10/7/24 documented 3 areas noted to sacral/buttocks area. Treatment orders in place. None of the skin assessments documented any measurements, descriptions or staging of the wound. A wound assessment report for R14 dated 10/9/24 by the wound nurse practitioner documented a Stage 3 pressure injury acquired in house measuring 8.5cm (length) x 3.4cm (width) x 0.20 cm (depth). It documented a treatment recommendation to cleanse with wound cleanser, treat with silver alginate and cover with a silicone dressing daily and as needed. A wound assessment report for R14 dated 11/20/24 by the wound nurse practitioner documented the Stage 3 pressure injury resolved with recommendations to continue zinc oxide paste to the area as needed. A wound assessment report for R14 dated 12/4/24 by the wound nurse practitioner documented the Stage 3 pressure injury reopening measuring 6cm x 5.5cm x 0.10 cm. It documented a treatment recommendation to cleanse with wound cleanser, apply medical grade honey and cover with a bordered gauze daily. The skin observation tool for R14 dated 11/24/24 documented in part, Pressure area noted to L heel. Wound care nurse notified; MD notified. Treatment orders added to administration. Plan of care continues. A wound assessment report for R14 dated 11/25/24 documented assessment of the L heel by the wound nurse practitioner as an unstageable pressure injury acquired in house measuring 6cm x 6cm x 0.10 cm with treatment recommendation to cleanse with wound cleanser, apply Betadine moistened gauze and cover with abd dressing and rolled gauze daily. The eTAR for R14 dated 9/1/24-9/30/24 failed to evidence the ordered zinc treatment to the sacrum and buttocks and skin prep to bilateral heels completed on night shift on 9/3/24, 9/7/24, 9/17/24, 9/22/24 and 9/26/24. The eTAR for R14 dated 10/1/24-10/31/24 failed to evidence the ordered daily sacral treatment completed on 10/18/24, 10/26/24 and 10/27/24. The eTAR for R14 dated 11/1/24-11/30/24 failed to evidence the ordered daily L heel Betadine treatment completed on 11/29/24 or the R heel skin prep completed on day shift of 11/29/24. The eTAR for R14 dated 12/1/24-12/31/24 failed to evidence the ordered daily L heel Betadine treatment completed on 12/21/24, the R heel skin prep completed on night shift 12/3/24 and day shift 12/21/24 or the sacral treatment completed on 12/1/24, 12/2/24, 12/20/24, 12/21/24 and 12/24/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/20/24 at 10:04 a.m., an interview was conducted with LPN #3. LPN #3 stated that skin assessments were completed weekly and if an area was identified the nurse called the physician to get a treatment order and put the resident in the wound nurse practitioner's book for them to assess the resident. She stated that the wound nurse practitioner came in twice a week and saw residents weekly. She stated that when a nurse identified a wound, they would document it and describe the wound. LPN #3 stated that the LPNs could only measure the wounds and did not stage the pressure injuries so they would get an RN (registered nurse) to come in to assess the wound. She stated that she measures any pressure injuries observed but did not stage them and let the RN do the staging. LPN #3 stated that there had been occasions when she had gone to do treatments and found dressings that had been documented as done but the dressings had old dates on them. She stated that treatments were evidenced as done by signing them off on the eTAR. On 12/20/24 at 11:50 a.m., an interview was conducted with LPN #27 who stated that the purpose of the care plan was to individualize the care for the resident and document their needs. She stated that the care plan should be implemented because it was to provide care for the resident, and they implemented it by reviewing the interventions and the CNAs reviewed the Kardex. On 12/30/24 at 4:30 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 stated that she had reviewed R14's record and it appeared that the facility staff had started treating the sacrum prior to its opening with zinc oxide and when it opened, they had changed the treatment, but the nurse did not measure or stage the wound. She stated that the wound did not improve so the wound nurse practitioner had assessed the wound and changed the treatment at that time, but it should have been measured and staged prior to that. On 1/2/25 at 10:10 a.m., an interview was conducted with LPN #1 who stated that treatments were evidenced as completed by signing off on the eTAR and initialing and dating the dressing. On 1/2/25 at 5:35 p.m., ASM #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit. Reference: (1) Pressure injury A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm. (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

12. For Resident #22 (R22), the facility staff failed to implement the comprehensive care plan to A) Provide and assist with showers and B) provide incontinence care in a timely manner.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/17/24, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. Section GG documented R22 being dependent on staff for showering/bathing. Section H documented R22 always being incontinent of bowel and bladder.

A) Showers

On 12/20/24 at 10:38 a.m., an interview was conducted with R22 in their room. R22 stated that she did not get showers twice a week like scheduled and had to beg the staff to get them. R22 stated that there were only certain staff that would give her a shower when they were working, and the others always said they would be back to get them for the shower and never came back.

The comprehensive care plan for R22 documented in part, ADL (activities of daily living) Self care deficit related to disease process, decreased mobility, obesity, COPD (chronic obstructive pulmonary disease). Doesn't like to wear socks. Created on: 03/08/2018. Revision on: 12/16/2019. Under Interventions it documented in part, .Assist to bathe/shower as needed. Date Initiated: 03/08/2018. Created on: 03/08/2018 .

ADL (activities of daily living) documentation for R22 provided by ASM (administrative staff member) #5, the regional director of clinical services was reviewed. The documentation from 11/1/24-12/31/24 documented showers scheduled on Tuesdays and Thursdays. The ADL documentation failed to evidence a shower provided on 11/7/24, 11/12/24, 11/14/24, 11/21/24, 11/28/24, 12/14/24, and 12/27/24. No shower sheets were provided.

On 12/20/24 at 11:50 a.m., an interview was conducted with LPN (licensed practical nurse) #27 who stated that the purpose of the care plan was to individualize the care for the resident and document their needs. She stated that the care plan should be implemented because it was to provide care for the resident, and they implemented it by reviewing the interventions and the CNAs reviewed the Kardex.

On 1/2/25 at 11:30 a.m., an interview was conducted with CNA (certified nursing assistant) #3 who stated that showers were given at least twice a week and as requested. She stated that they were evidenced by the shower sheets and in the ADL documentation.

B) Incontinence care

On 12/20/24 at 10:38 a.m., an interview was conducted with R22 in their room. R22 stated that she was incontinent and dependent on staff for incontinence care. R22 stated that she had not been changed since around 6:00 a.m. that morning before the night shift left and was wet at that time. She stated that no one had come in to provide incontinence care since the night shift. R22 stated that this happened all the time and there were many times when she waited hours to be changed. R22 stated that she felt that the CNAs had their favorites and took care of those residents first and made their room the last one on purpose and it pisses me off. R22 stated that her backside was sore from laying in the wetness and they had to keep putting on the zinc cream to help it.

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Colonial Heights Rehabilitation and Nursing Center	831 Ellerslie Ave Chesterfield, VA 23834

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/20/24 at 11:01 a.m., during the interview with R22, CNA #26 entered the room to provide incontinence care and get the resident out of bed. With R22's permission, an observation was made of incontinence care provided. A strong urine odor was present when the sheet was removed from R22, the brief, drawsheet, fitted sheet and mattress were observed to be wet. When asked about care provided to R22 on the shift, CNA #26 stated that they had come in to say hello to the residents and deliver the breakfast tray. CNA #26 confirmed that she had not provided incontinence care since the beginning of day shift. She stated that she had started working the floor independently the week prior and was assigned four total care residents. She stated that she was assigned 15 residents that day and had prioritized the ones who had to be out of the bed, but it was impossible to get to all of them timely. She stated that incontinence care should be provided every two hours, and it would be easier to get to everyone timely if they had more CNA staff. The comprehensive care plan for R22 documented in part, Urinary/Bowel incontinence episodes related to physical limitations. She has dx of renal insufficiency. Created on: 03/20/2018. Revision on: 03/20/2018. Under &q[TRUNCATED]

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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** 3. For Resident #5 (R5), the facility staff failed to administer medications in a timely manner. Review of the Medication Administration Audit Report for R5 dated 12/1/23-12/31/23 documented the following medications administered late: - Physician order: Depakote 125mg twice a day at 9:00 a.m. and 6:00 p.m. The 9:00 a.m. dose was administered as follows: On 12/3/23, at 10:21 a.m. On 12/10/23, at 3:09 p.m. On 12/13/23, at 3:56 p.m. On 12/14/23, at 4:22 p.m. On 12/15/23, at 4:31 p.m. On 12/18/23, at 11:44 a.m. On 12/19/23, at 3:54 p.m. On 12/20/23, not documented as administered. On 12/22/23, at 11:42 a.m. On 12/24/23, not documented as administered. On 12/26/23, at 12:22 p.m. On 12/27/23, at 4:21 p.m. On 12/28/23 and at 10:50 a.m. The 6:00 p.m. dose was administered as follows: On 12/30/23, at 9:45 p.m. On 12/14/23, at 8:31 p.m. On 12/18/23, at 7:32 p.m. On 12/20/23, at 10:17 p.m. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/21/23, at 8:56 p.m. On 12/22/23, at 9:22 p.m. On 12/23/23, at 9:15 p.m. On 12/25/23, at 8:43 p.m. On 12/27/23, at 8:16 p.m. On 12/31/23, at 7:09 p.m. - Physician orders: Eliquis 5mg twice a day at 9:00 a.m. and 5:00 p.m. The 9:00 a.m. dose was administered as follows: On 12/3/23 at 1:13 p.m., On 12/10/23 at 10:21 a.m. On 12/13/23 at 3:09 p.m. On 12/12/23 at 3:56 p.m. On 12/15/23 at 4:22 p.m. On 12/19/23 at 11:44 a.m. On 12/20/23 at 3:54 p.m. On 12/22/23, not documented as administered. On 12/24/23 at 11:42 a.m. On 12/26/23, not documented as administered. On 12/27/23 at 12:22 p.m. On 12/30/23 at 10:50 a.m. The 5:00 p.m. dose was administered as follows: On 12/14/23 at 9:45 p.m. On 12/20/23 at 7:32 p.m. On 12/21/23 at 10:17 p.m. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/22/23 at 8:56 p.m. On 12/23/23 at 9:22 p.m. On 12/25/23 at 9:15 p.m. On 12/30/23 at 8:16 p.m. On 12/31/23 7:09 p.m. - Physician orders: Trazodone 100 mg 2 tablets at bedtime at 9:00 p.m. The 9:00 p.m. dose was administered as follows: On 12/7/23, at 10:17 p.m. On 12/31/23 at 11:50 p.m. - Physician orders: Seroquel 200mg at bedtime at 9:00 p.m. On 12/21/23 at 10:17 p.m. On 12/31/23 at 11:50 p.m. On 1/2/25 at 10:10 a.m., an interview was conducted with LPN (licensed practical nurse) #1 who stated that medications were to be administered within an hour before or an hour after the scheduled time. She stated that medication administration was evidenced by clicking yes or no on the eMAR and the unit manager, physician and responsible party should be notified when a medication was given late. The facility policy General Guidelines for Medication Administration effective 9/2018 documented in part, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to administer . According to Fundamentals of Nursing 6th Edition, 2005: [NAME] A. [NAME] and [NAME] Perry; Mosby, Inc., page 843, All routinely ordered medications should be given within 60 minutes of the times ordered. On 1/3/25 at 12:09 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the assistant administrator, ASM #3, the director of nursing, ASM #4, the regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit. 4. For R3, the facility staff failed to notify the physician of a heparin lock (1). R3 was admitted with diagnoses that included but were not limited to hemiplegia (2) and hemiparesis (3). (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 04/23/2024, R3 scored 8 (eight) out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired of cognition for making daily decisions. The After Visit Summary from (Name of Hospital) for RX (doctor's prescription) dated 05/02/2023 documented in part, Medications Given: sodium chloride Stopped at 9:14 PM (p.m.). sodium chloride Stopped at 11:41 PM. The facility's nurse's note for R3 dated 05/03/2024 documented in part, admission Note: Noted report received from nurse in emergency department that all tests, labs, and assessments were normal. IV (into a vein) Intact and patent with no new orders from hospital. Will continue to monitor. Review of the ehr (electronic health record) for R3 failed to evidence physician's orders for the use of a heparin lock. On 01/02/2024 at approximately 10:00 a.m., an interview was conducted with ASM (administrative staff member) #5, regional director of clinical services. When asked about the IV for R3, u. ASM #5 stated, R3 received a peripheral IV at the hospital and when R3 came back to the facility from the hospital there were no new physician orders and R3 also had a heparin lock. When asked if the physician was notified of R3 having the heparin lock ASM #5 stated that they could not find any orders for the heparin lock or documentation a facility nurse notified the physician of the heparin lock. ASM #5 further stated that since there were no physician's orders for the heparin lock there would not be any IV fluids, flushes or the need for IV supplies. On 01/03/2025 at approximately 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. Reference: (1) a type of intermittent intravenous device for the administration of heparin. It does not require a continuous flow of fluids; the intravenous fluid flow can be disconnected and the heparin lock filled with a heparin solution that maintains patency of the needle. This information was obtained from the wesite: Heparin lock | definition of heparin lock by Merick Medical dictionary (2) The loss of muscle function in part of your body. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. (3) Paralysis is the loss of muscle function in part of your body. This information was obtained from the website: https://medlineplus.gov/paralysis.html. Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for four (4) of 33 residents in the survey sample, Residents #1, #23, #5 and #3. (continued on next page)

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	01/03/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

The findings include:

1. For Resident #1, the nurse failed to document an assessment on 10/1/24 of the resident's skin.

An interview was conducted with LPN (licensed practical nurse) #3 on 12/19/24 at 10:09 a.m. LPN #3 stated she was called on 10/1/24 to assess R1's skin. She stated it, It wasn't a wound. It was severe bruising that was spreading. Apparently, the bruise was reported to the doctor that the bruising was in the peri area. The bruising was not there when the wound nurse practitioner saw her on 9/27/24. The other nurse (not available for interview) was the first to see the bruise. I was pulled off the medication cart to see it. I saw purple discoloration. The pubis was purplish in color, and it moved to the buttocks. It was deep purple in color. When asked if the area had any open areas, LPN #3 stated, No, just the bruising. LPN #3 was asked where was the documentation of her assessment of the resident's skin. LPN #3 stated, I didn't write one. I was on the medication cart and didn't think at that time to write a note.

Review of the clinical record failed to evidence a skin assessment by LPN #3 on 10/1/24.

The facility policy, Nursing Care & Services documented in part, Nursing staff will provide nursing care and services following current standards of practice recognized by state boards of nursing as informed by national nursing organizations and by hiring individuals who graduate from an approved nursing school and/or nurse aide curriculum and have or will, have successfully passed a licensing and/or certification examination.

ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m.

No further information was provided prior to exit.

2. For Resident #23 (R23), the facility staff failed to administer medications in the prescribed time frame.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/4/24, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions.

An interview was conducted with R23 on 12/20/24 at 12:52 p.m. R23 stated she did not get her evening medications on time. She stated, My medications are to be given before or during meals. The nurse is very rigid in administering medications. She won't give you your medications in the hallway, only in your room. They will not stop and give you your medications if you go to her medication cart on your way to the dining room. Many times, I get my medications well after her meals.

The physician orders dated, 10/1/24, documented, Renvela Tablet (Sevelamer Carbonate) (1) 800 MG (milligrams); Give 3 tablets by mouth before meals for CKD (chronic kidney disease). The medication was scheduled for 4:30 p.m.

On the following dates the medication was given at the following times:

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/2/24 at 8:11 p.m. 12/4/24 at 6:05 p.m. 12/5/24 at 5:57 p.m. 12/7/24 at 7:15 p.m. 12/9/24 at 6:24 p.m. 12/11/24 at 6:02 p.m. 12/16/24 at 6:11 p.m. 12/17/24 at 6:48 p.m. 12/18/24 at 6:35 p.m. 12/19/24 at 6:19 p.m. The physician order dated, 11/27/24, documented, Humalog Kwik Pen Solution Pen-Injector (2) 100 UNIT/ML (units per milliliter); inject as per sliding scale: if (blood sugar) 0-149 = 0 units - notify MD (medical doctor) for FSBS (fingerstick blood sugar) < (less than) 60; 150 -199 = 4 (units); 200 - 249 = 6; 250 -299 = 8; 300 - 349 = 10; 350 - 400 = 12; 401 + notify MD, subcutaneously before meals and at bedtime for DM -2 (diabetes mellitus type 2). notify MD of BS <60 or > (greater than) 400. On the following dates the medication was given at the following times: 12/1/24 at 6:26 p.m. 12/2/24 at 8:16 p.m. 12/4/24 at 6:08 p.m. 12/5/24 at 5:53 p.m. 12/9/24 at 6:18 p.m. 12/11/24 at 6:00 p.m. 12/16/24 at 6:09 p.m 12/17/24 at 6:48 p.m. 12/18/24 at 8:35 p.m. 12/19/24 at 6:19 p.m. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan dated 5/19/2022, documented in part, Focus: Renal insufficiency related to ESRD (end stage renal disease). The Interventions documented in part, Administer medications per physician orders. Focus: Endocrine system related to Diabetes. The Interventions documented in part, Administer medications per physician orders. An interview was conducted with ASM (administrative staff member) #10, the medical director, on 1/2/25 at 12:52 p.m. He stated, Renvela is a phosphorus binding agent, it gets rid of the phosphorus when someone eats with kidney failure. Those residents can't remove the phosphorus, and it builds up in their system. If it's given after the meal, the medication will not be as effective. Sliding scale insulin is done before the meal to cover the resident for what they are about to eat. If given afterwards, it isn't a true reading, and the resident could possibly get more insulin than what they really need. An interview was conducted with LPN #2 on 1/2/25 at 4:44 p.m. LPN #2 said, For Renvela, it has to be given before meals because it has to do with the absorption of medications with food. There are parameters that state it can be given within an hour to an hour and a half after the meal. The physician order says before meals so that wouldn't be following the physician orders. LPN #2 further stated, Sliding scale insulin shouldn't be done after the meal as it would give you a false reading. Many of the diabetic residents go to the dining room before I can get their blood sugar and give them insulin if needed. On occasion residents come to the medication cart and I can't always get to the resident at that time then they disappear and I can't find the resident. But in the end, it's on nursing, we are the professionals, and we should make sure the medications are given per the physician orders. ASM #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit. (1) Sevelamer is used to control high blood levels of phosphorus in people with chronic kidney disease who are on dialysis (medical treatment to clean the blood when the kidneys are not working properly). Sevelamer is in a class of medications called phosphate binders. It binds phosphorus that you get from foods in your diet and prevents it from being absorbed into your blood stream. Sevelamer comes as a tablet and as a powder for suspension to take by mouth. It is usually taken three times a day with meals. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601248.html. (2) (Humalog) Insulin lispro injection products are also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697021.html.

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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 2. For Resident #21 (R21), the facility staff failed to provide showers at least twice a week per the resident's preferences.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/18/24, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. Section GG documented R21 requiring substantial to maximal assistance with showering/bathing.

On 12/20/24 at 10:36 a.m., an interview was conducted with R21 in their room. R21 stated that they had only had about three showers since their admission. She stated that on admission she was wearing a neck brace and was not allowed to take it off until the doctor cleared her later in October. R21 stated that getting a shower was like pulling teeth in the facility. She stated that the showers were supposed to be twice a week, but the staff always said they would be back to get them for the shower and never came back.

The physician's progress notes documented in part, 10/25/2024 21:28 (9:28 p.m.) .she will keep the hard collar for 2 weeks then she can remove it and wears a soft collar, in the mean time she can sleep with a soft collar, she can also remove her hard collar when she isneating [sic] and showering .

The comprehensive care plan for R21 documented in part, Short Term Care: the resident requires assistance with their activities of daily living due to recent spinal surgery, generalized weakness, bilateral hand numbness. Created on: 10/14/2024. Revision on: 10/15/2024.

ADL (activities of daily living) documentation for R21 provided by ASM (administrative staff member) #5, the regional director of clinical services was reviewed. The documentation from 12/1/24-12/31/24 documented showers scheduled on Mondays and Thursdays. The ADL documentation failed to evidence a shower provided on 12/9/24, 12/23/24 and 12/27/24. No shower sheets were provided.

On 1/2/25 at 11:30 a.m., an interview was conducted with CNA (certified nursing assistant) #3 who stated that showers were given at least twice a week and as requested. She stated that they were evidenced by the shower sheets and in the ADL documentation.

The facility policy Shift Responsibilities for CNA effective 11/1/19 documented in part, .Perform shift responsibilities/assignments that promote quality of care .

The facility provided policy, Nursing Care & Services effective 1/29/24 documented in part, .The center will utilize Mosby's Textbook for Long-Term Care Assistants by Kostelnick and/or Clinical Nursing Skills & Techniques by [NAME], [NAME], and Ostendorff, as a reference for nursing services and skills not otherwise provided in the Policies and Procedures Manuals.

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

According to Mosby's Textbook for Long-Term Care Nursing Assistants 7th edition, Unit IV Assisting with activities of daily living pg. 273 documented in part, .Bathing cleans the skin. It also cleans the mucous membranes of the genital and anal areas. Microbes, dead skin, perspiration, and excess oils are removed. A bath is refreshing and relaxing. Circulation is stimulated and body parts exercised. Observations are made and you have time to talk to the person. Complete or partial baths, tub baths, or showers are given. The method depends on the person's condition, self-care abilities, and person choice . Dry skin occurs with aging. Soap also dries the skin. Dry skin is easily damaged. Therefore older persons usually need a complete bath or shower twice a week .

On 1/3/25 at 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

3. For Resident #14 (R14), the facility staff failed to A) provide incontinence care in a timely manner and B) maintain trim and clean fingernails.

On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 10/13/24, the resident scored 8 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions. R14 was assessed as being dependent on staff for toileting, substantial/maximal assistance with personal hygiene and frequently incontinent of bowel and bladder.

A) Incontinence care

On 1/2/25 at 11:49 a.m., an observation of R14 was conducted with LPN (licensed practical nurse) #28. R14 was observed lying in bed with a strong urine odor present. A draw sheet was visible underneath R14 on the left side with dried dark yellow stains underneath the resident. When asked about the stain and odor, LPN #28 stated that R14 should have been changed by now and that they needed to be cleaned up right now. At 11:52 a.m., ASM (administrative staff member) #3, the director of nursing entered the room and observed the odor and stained draw sheet underneath R14. ASM #3 stated that it appeared to have been there a while, and it would be taken care of right away.

The comprehensive care plan for R14 documented in part, Urinary incontinence related to physical limitations/Dementia. Created on: 10/13/2020. Revision on: 01/12/2023. Under Interventions it documented in part, .Provide assistance with toileting or provide incontinent care as needed. Date Initiated: 10/13/2020. Created on: 10/13/2020 .

On 12/20/24 at 11:01 a.m., an interview was conducted with CNA (certified nursing assistant) #26 who stated that incontinence care should be provided every two hours.

On 12/20/24 at 11:50 a.m., an interview was conducted with LPN #27 who stated that incontinence care should be provided every two hours to prevent skin breakdown and to provide adequate care.

On 1/2/25 at 11:30 a.m., an interview was conducted with CNA #3 who stated that incontinence care was provided at least every two hours.

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

B) Fingernails

On 12/19/24 at 11:07 a.m., an observation of R14 was conducted. R14 was observed in bed asleep, the right hand was visible with the fingernails observed to be approximately 1/4 inch long. The pointer and thumb nails were uneven with a dark substance underneath.

Additional observations of R14's fingernails as described above were made on 12/20/24 at 9:07 a.m., 12/30/24 at 10:32 a.m. and 1/2/25 at 7:58 a.m.

The comprehensive care plan for R14 documented in part, ADL Self care deficit related to physical limitations, Dementia.

Created on: 10/13/2020. Revision on: 10/13/2020. Under Interventions it documented in part, Assist with daily hygiene, grooming, dressing, oral care and eating as needed. Date Initiated: 10/13/2020. Created on: 10/13/2020.

On 1/2/25 at 11:30 a.m., an interview was conducted with CNA #3 who stated that CNAs should trim the fingernails.

On 1/2/25 at 11:31 a.m., an interview was conducted with LPN #28 who stated that she trimmed as many resident fingernails as she could when she observed that they needed them or when residents asked. She stated that the CNAs should be cleaning the resident's nails and making sure that they were trimmed on the shower days which were twice a week. On 1/2/25 at 11:49 a.m., an observation of R14 was conducted with LPN #28. LPN #28 observed R14's fingernails and stated that they needed cleaning and trimming and she would take care of it.

The facility provided policy, Nursing Care & Services effective 1/29/24 documented in part, .The center will utilize Mosby's Textbook for Long-Term Care Assistants by Kostelnick and/or Clinical Nursing Skills & Techniques by [NAME], [NAME], and Ostendorff, as a reference for nursing services and skills not otherwise provided in the Policies and Procedures Manuals.

According to Mosby's Textbook for Long-Term Care Nursing Assistants 7th edition, Unit VI Assisting with care needs pg. 528, .Prevent skin exposure to moisture. Check persons who are incontinent of urine or feces often. Provide good skin care and change linens and garments at the time of soiling. Use incontinence products as directed by the nurse and the care plan . It further documented in Unit IV, Assisting with activities of daily living pg. 301 documented in part, .Nail and foot care prevents infection, injury and odors. Hangnails, ingrown nails (nails that grown in at the side), and nails torn away from the skin cause skin breaks. These breaks are portals of entry for microbes. Long or broken nails can scratch skin or snag clothing .Nails are easier to trim and clean right after soaking or bathing. Use nail clippers to cut fingernails .

On 1/2/25 at 5:35 p.m., ASM #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the concern regarding incontinence care and fingernail care.

No further information was provided prior to exit.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. For Resident #22 (R22), the facility staff failed to A) provide showers at least twice a week per the resident's preferences and B) provide incontinence care in a timely manner. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/17/24, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. Section GG documented R22 being dependent on staff for showering/bathing. Section H documented R22 always being incontinent of bowel and bladder. A) Showers On 12/20/24 at 10:38 a.m., an interview was conducted with R22 in their room. R22 stated that she did not get showers twice a week like scheduled and had to beg the staff to get them. R22 stated that there were only certain staff that would give her a shower when they were working, and the others always said they would be back to get them for the shower and never came back. The comprehensive care plan for R22 documented in part, ADL (activities of daily living) Self care deficit related to disease process, decreased mobility, obesity, COPD (chronic obstructive pulmonary disease). Doesn't like to wear socks. Created on: 03/08/2018. Revision on: 12/16/2019. Under Interventions it documented in part, .Assist to bathe/shower as needed. Date Initiated: 03/08/2018. Created on: 03/08/2018 . ADL (activities of daily living) documentation for R22 provided by ASM (administrative staff member) #5, the regional director of clinical services was reviewed. The documentation from 11/1/24-12/31/24 documented showers scheduled on Tuesdays and Thursdays. The ADL documentation failed to evidence a shower provided on 11/7/24, 11/12/24, 11/14/24, 11/21/24, 11/28/24, 12/14/24, and 12/27/24. No shower sheets were provided. On 1/2/25 at 11:30 a.m., an interview was conducted with CNA (certified nursing assistant) #3 who stated that showers were given at least twice a week and as requested. She stated that they were evidenced by the shower sheets and in the ADL documentation. B) Incontinence care On 12/20/24 at 10:38 a.m., an interview was conducted with R22 in their room. R22 stated that she was incontinent and dependent on staff for incontinence care. R22 stated that she had not been changed since around 6:00 a.m. that morning before the night shift left and was wet at that time. She stated that no one had come in to provide incontinence care since the night shift. R22 stated that this happened all the time and there were many times when she waited hours to be changed. R22 stated that she felt that the CNAs had their favorites and took care of those residents first and made their room the last one on purpose and it pisses me off. R22 stated that her backside was sore from laying in the wetness and they had to keep putting on the zinc cream to help it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/20/24 at 11:01 a.m., during the interview with R22, CNA #26 entered the room to provide incontinence care and get the resident out of bed. With R22's permission, an observation was made of incontinence care provided. A strong urine odor was present when the sheet was removed from R22, the brief, drawsheet, fitted sheet and mattress were observed to be wet. When asked about care provided to R22 on the shift, CNA #26 stated that they had come in to say hello to the residents and deliver the breakfast tray. CNA #26 confirmed that she had not provided incontinence care since the beginning of day shift. She stated that she had started working the floor independently the week prior and was assigned four total care residents. She stated that she was assigned 15 residents that day and had prioritized the ones who had to be out of the bed, but it was impossible to get to all of them timely. She stated that incontinence care should be provided every two hours, and it would be easier to get to everyone timely if they had more CNA staff. The comprehensive care plan for R22 documented in part, Urinary/Bowel incontinence episodes related to physical limitations. She has dx of renal insufficiency. Created on: 03/20/2018. Revision on: 03/20/2018. Under Interventions it documented in part, .Provide assistance with toileting or provide incontinent care as needed. Date Initiated: 03/20/2018 . On 1/3/25 at 12:09 p.m., ASM #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the concern regarding showers and incontinence care. No further information was provided prior to exit. 5. For Resident #8 (R8), the facility staff failed to A) evidence feeding assistance on multiple dates in October 2024, November 2024, and December 2024 and B) evidence incontinence care provided on multiple dates in October 2024, November 2024, and December 2024. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/14/24, the resident was assessed as being severely impaired for making daily decisions. Section GG documented impairment on one side of the upper extremity and requiring substantial/maximal assistance with eating. The assessment documented no weight loss in the past month or past six months and R8 being always incontinent of bowel and bladder. A) Feeding assistance Observations of R8 conducted during the survey dates revealed staff providing total assistance with feeding during all meals observed. The comprehensive care plan for R8 documented in part, The resident is at risk for malnutrition and dehydration related to Sepsis, Anemia, Hyperlipidemia, HTN (hypertension), CAD (coronary artery disease), PCM (protein calorie malnutrition), Dementia, Metabolic encephalopathy, calculus of kidney, malignant neoplasm of prostate, gastrointestinal hemorrhage, non significant weight loss 10/7/24. significant weight loss 12/24. *Resident prefers to exercise his right to direct his own care, resident reserves the right to refuse weights.* Created on: 04/05/2023. Revision on: 12/09/2024. Under Interventions it documented in part, . feeding assistance / encourage po (by mouth) intake. Date Initiated: 04/05/2023. Created on: 04/05/2023. Revision on: 04/04/2024 . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the ADL (activities of daily living) documentation for R8 dated 10/1/24-10/31/24 failed to evidence assistance provided with eating on day shift 10/26/24 and evening shift 10/31/24. It failed to document meal intake for breakfast and lunch 10/26/24 and dinner 10/31/24. Review of the ADL documentation for R8 dated 11/1/24-11/30/24 failed to evidence assistance provided with eating on day shift 11/18/24, 11/19/24 and 11/30/24 and evening shift 11/24/24 and 11/30/24. It failed to document meal intake for lunch on 11/18/24, breakfast and lunch 11/19/24, dinner 11/24/24 and all meals on 11/30/24. Review of the ADL documentation for R8 dated 12/1/24-12/31/24 failed to evidence assistance provided with eating on day shift 12/1/24 and 12/15/24. It failed to document meal intake for breakfast and lunch on 12/15/24. On 1/2/25 at 11:30 a.m., an interview was conducted with CNA (certified nursing assistant) #3 who stated that the care that was provided to the resident was evidenced by the documentation that was completed in the medical record. B. Incontinence care The comprehensive care plan for R8 documented in part, The resident is always incontinent of bladder and always incontinent of bowels due to muscle weakness, advanced age, impaired mobility, cognitive impairment, communication impairment, dementia, metabolic encephalopathy. Created on: 04/05/2023. Revision on: 03/19/2024. It further documented, The resident is frequently incontinent of bladder and bowels and is not a candidate for a toileting program due to: Created on: 04/05/2023. Under Interventions it documented in part, .Check and change briefs frequently as needed. Date Initiated: 04/05/2023. Created on: 04/05/2023. Revision on: 05/05/2023 . provide toileting hygiene with brief changes. Date Initiated: 05/05/2023. Created on: 05/05/2023 . Review of the ADL (activities of daily living) documentation for R8 dated 10/1/24-10/31/24 failed to evidence assistance provided with toileting on day shift 10/26/24, evening shift 10/31/24 and night shift on 10/24/24. Review of the ADL documentation for R8 dated 11/1/24-11/30/24 failed to evidence toileting assistance provided on day shift 11/18/24, 11/19/24 and 11/30/24, evening shift 11/3/24, 11/24/24, and 11/30/24. Review of the ADL documentation for R8 dated 12/1/24-12/31/24 failed to evidence toileting assistance provided on day shift 12/15/24 and evening shift 12/7/24. On 12/20/24 at 11:50 a.m., an interview was conducted with LPN (licensed practical nurse) #27 who stated that incontinence care should be provided every two hours to prevent skin breakdown and to provide adequate care. On 1/2/25 at 11:30 a.m., an interview was conducted with CNA #3 who stated that the care that was provided to the resident was evidenced by the documentation that was completed in the medical record. She stated that incontinence care was provided at least every two hours. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/3/25 at 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit. Based on observations, resident interviews, staff interviews, clinical record review it was determined, facility staff failed to provide ADL (activities of daily living) care for seven of 33 residents, Resident #3 (R3), R21, R14, R22, R8, R23 and R13. The findings include: 1. For R3, the facility staff failed to provide scheduled showers, oral hygiene and personal hygiene. R3 was admitted with diagnoses that included but were not limited to hemiplegia (1) and hemiparesis (2). On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 04/23/2024, R3 scored 8 (eight) out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired of cognition for making daily decisions. Section GG Functional Abilities and Goals coded R3 as requiring substantial/maximum assistance for oral hygiene, and dependent for showers and personal hygiene. The facility's POC (point of care) sheet for R3 dated April 2024 documented a blank on 04/01/2024 for showers during the evening shift on (3:00 a.m. to 11:00 p.m.). On 04/04/2024 and 04/15/2024 the POC was coded 1 (one) indicating showers were not provided. The bed bath POC for bed bath dated 04/01/2024 and 04/06/2024 were blank. The POC for personal hygiene (combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands) on 04/01/2024 and 04/06/2024 were blank for the day shift and on 04/01/2024 and 04/25/2024 were blank for the evening shift. The facility's POC (point of care) sheet for R3 dated May 2024 coded 1 (one) on 05/06/2024 and 05/13/2024 indicating showers were not provided during the evening shift on (3:00 a.m. to 11:00 p.m.). The POC for personal hygiene (combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands) and oral hygiene on 05/01/2024 and 05/13/2024 were blank for the night shift. The comprehensive care plan for R3 dated 03/23/2024 documented in part, Focus. The resident requires assistance with their activities of daily living due to chronic health conditions, h/o (history of) CVA (cerebral vascular accident - stroke). Created on: 03/23/2024. Under Interventions it failed to document interventions for ADL care. On 01/02/2025 at approximately 11:30 a.m., an interview was conducted with CNA (certified nursing assistant) #3. When asked how often residents were to receive showers CNA #3 stated residents were scheduled for showers two times a week and when ever they ask for one. When asked about documenting ADL care she stated, When care is provided it is documented in PCC (point click care - electronic health record). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Colonial Heights Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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	The facility's policy General Care. Shift Responsibilities for CNA documented in part, 1. CNAs will report to a designated unit at the beginning of a shift to obtain the shift responsibilities/patient assignments as determined by a licensed nurse. 2. Obtain patient assignment at the beginning of each shift from/with a licensed nurse . 3. Provide pertinent patient information to the on-coming shift, such as tasks not completed, etc. 4. Perform shift responsibilities/assignments that promote quality of care; make rounds, identify and address any immediate patient needs, promptly respond to call lights and notify the licensed nurse of any pertinent patient findings (reddened skin, etc.). The facility's Resident Rights documented in part, Receive adequate and appropriate care. On 01/03/2025 at approximately 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References: (1) The loss of muscle function in part of your body. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. (2) Paralysis is the loss of muscle function in part of your body. This information was obtained from the website: https://medlineplus.gov/paralysis.html. 6. For Resident #23 (R23), the facility staff failed to provide showers. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/4/24, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section GG - Functional Status and Goals, the resident was coded as requiring substantial to maximum assist for showering/bathing. An interview was conducted with R23 on 12/20/24 at 12:52 p.m. R23 stated she was not getting her showers as ordered and scheduled for Monday and Friday. She said she was told they were too short-staffed to get them or too busy to give showers. R23 stated that at times, showers are given between 9:00 p.m. and 9:30 p.m., which is late when she has to get up at 5:30 a.m. for dialysis the following day. The comprehensive care plan documented in part, Focus: (R23) has self-care deficits requiring assistance with ADLs (activities of daily living), transfers, bed mobility, toileting, related to weakness, goes out to dialysis 3x/wk (three times per week) & requires increased assistance on dialysis days, ADLs fluctuates, SOB (shortness of breath) on continuous O2 (oxygen) use, impaired vision, she refers to get up early in the am (morning). The Interventions documented in part, Assist to bathe/shower as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ADL documentation for October 2024, documented the resident received a shower on 10/10/24, 10/29/24 and 10/31/24. The ADL documentation for November 2024, documented the resident received a shower on 11/26/24. The December 2024 ADL documentation documented the resident received a shower on 12/19/24. An interview was conducted with CNA (certified nursing assistant) #3 on 1/2/25 at 11:30 a.m. CNA #3 stated showers are given twice a week but if a resident wants one, she tries to give it to them. CNA #3 stated the showers given are documented in the PCC (electronic medical record). ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit. 7. For Resident #13 (R13), the facility staff failed to provide incontinence care in a timely manner. Observation was made of R13 on 12/30/24 at 10:38 a.m. The resident was in the bed on their back. There was a wedge pillow next to the resident but not under the resident. A second observation was made at 12:39 p.m. The resident was still in the same position as at 10:38 a.m. The wedge pillow was not under the resident. At 1:38 p.m. the resident was still in the same position. CNA #35 was asked to turn the resident onto her side. At that time, when the resident was turned over, a urine-soaked towel was wadded up under the resident. The smell of urine was very strong. CNA #35 stated she had just checked her, and she was fine. CNA #35 didn't know how the towel got under her. When asked how she knows how to take care of a resident, CNA #35 stated no one told her how to care for R13. She supposed it was in the resident's chart. The most recent MDS, a quarterly assessment with an assessment reference date of 10/3/24. The resident was coded as rarely or never understood or understands. In Section GG - Functional Status and Goals, R13 was coded as being dependent for all of her activities of daily living, to include toileting needs. The comprehensive care plan dated, Focus: The resident has a reopened pressure ulcer to the sacrum. The resident has a risk for development of additional wounds related to chronic health conditions, reduced mobility, inability to turn and reposition independently, h/o (history of) sacral pressure. The Interventions documented in part, Assist the resident to turn and reposition often. Keep Skin clean and dry as possible. An interview was conducted on 1/2/25 at 11:30 a.m. with CNA #3. CNA #3 stated incontinence care should be provided a minimum of every two hours but if a resident is a heavy wetter, then more frequently. She stated that if you check a resident as you should, a resident should not have a urine-soaked towel under them. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. For Resident #21 (R21), the facility staff failed to administer ordered Metoclopramide 10mg on 10/14/24 and 10/15/24 when the medication was available in the facility in house medication supply. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/18/24, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 12/20/24 at 10:36 a.m., an interview was conducted with R21 who stated that there were times when their medication was not available from the pharmacy, and they had to wait days to get it. R21 stated that a few months ago the physician had prescribed a medication for their stomach, and they missed doses because it had not come in from the pharmacy. The physician orders for R21 documented in part, - Metoclopramide HCL Tablet 10mg 0.5 tablet four times a day. Give 0.5 tablet by mouth four times a day for N/V (nausea/vomiting) for 30 days 30 minutes before meals or food and at bedtime. Order Date 10/14/24. Start Date: 10/14/24 2100 (9:00 p.m.). Review of the eMAR (electronic medication administration record) for R21 documented the Metoclopramide not administered at 9:00 p.m. on 10/14/24, 6:30 a.m. on 10/15/24 or 9:00 p.m. on 10/15/24. The chart codes documented Other/See Progress notes and Hold/See Progress notes. The progress notes for R21 documented in part, - 10/14/24 22:20 (10:20 p.m.) Note Text: Metoclopramide HCl Tablet 10 MG Give 0.5 tablet by mouth four times a day for N/V for 30 Days 30 MINUTES BEFORE MEALS OR FOOD AND AT BEDTIME. unavailable, awaiting arrival. - 10/15/2024 06:53 (6:53 a.m.) Note Text: Metoclopramide HCl Tablet 10 MG Give 0.5 tablet by mouth four times a day for N/V for 30 Days 30 MINUTES BEFORE MEALS OR FOOD AND AT BEDTIME. - 10/15/2024 21:21 (9:21 p.m.) Note Text: Metoclopramide HCl Tablet 10 MG Give 0.5 tablet by mouth four times a day for N/V for 30 Days 30 MINUTES BEFORE MEALS OR FOOD AND AT BEDTIME. awaiting arrival from pharmacy. Review of the facility provided inventory of the Omnicell in house medication supply documented a par level of 10 Metoclopramide 5mg tablets available in the machine. On 1/2/25 at 10:10 a.m., an interview was conducted with LPN (licensed practical nurse) #1 who stated that if medications were not available, they checked the in-house stocked medications to see if they were available and if they were they could pull them out for the resident. LPN #1 stated that she was not sure if the agency nurses had access to the Omnicell and there was someone from the company who gave everyone access. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/3/25 at 12:09 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the assistant administrator, ASM #3, the director of nursing, ASM #4, the regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit. 5. For R16, facility staff failed to administer Piperacillin (1) and Tigecycline (2) according to the physician's orders. R16 was admitted to the facility with diagnoses that included but were not limited to osteomyelitis (3) of vertebra (bone of the spine), sacral (bottom of the spine) and sacrococcygeal region (base of the spine) and sepsis (4). On the most recent comprehensive MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 10/10/2024, R16 scored 13 out of 15 on the BIMS (brief interview for mental status), indicating R16 was cognitively intact for making daily decisions. The POS (physician's order sheet) dated 09/01/2024 through 09/30/2024 documented in part, Piperacillin Sod (sodium)-Tazobactam So (sodium) Solution Reconstitute 3-0.375 GM (grams). Use 3.373 gram intravenously (5) every 8 (eight) hours for wound infection until 09/06/2024. Order Date: 08/01/2024. Start Date: 08/01/2024. End Date: 09/06/2024. The POS dated 11/01/2024 through 11/30/2024 documented in part, Tigecycline Intravenous Solution Reconstituted 50 MG (Tigecycline) Use 50 mg intravenously two times a day for sacral wound/ osteomylitis until 11/30/2024. Order Date: 11/08/2024. Start Date: 11/09/2024. End Date: 11/30/2024. The eMAR (electronic medication administration record) dated September 2024 for R16 documented the physician's order as stated above for the administration of Piperacillin. Further review if the eMAR revealed blanks at 6:00 a.m. on 09/02/2024, 09/06/2024, 09/14/2024, 09/16/2024, 09/19/2024, 09/22/2024 and 09/31/2024; at 2:00 p.m. on 09/16/2024 and at 10:00 p.m. on 09/17/2024. The eMAR dated November 2024 for R16 documented the physician's order as stated above for the administration of Tigecycline. Further review if the eMAR revealed a blank on 11/15/2024 at 5:00 p.m. The facility's nursing progress notes for R16 dated 09/01/2024 failed to evidence the administration of Piperacillin at 6:00 a.m. on 09/02/2024, 09/14/2024, 09/16/2024, 09/19/2024, 09/22/2024 and 09/31/2024; at 2:00 p.m. on 09/16/2024 and at 10:00 p.m. on 09/17/2024. The facility's nursing progress notes for R16 dated 11/15/2024 failed to evidence the administration of Tigecycline at 5:00 p.m. The comprehensive care plan for R16 dated 11/14/2024 documented in part, Focus. The resident has a PICC (peripherally inserted central catheter) Line (6) venous access. Created on: 11/14/2024. Under Interventions it documented in part, Administer medications as ordered. Created on: 11/14/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/02/2025 at approximately 10:10 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked how it is evidenced that she administered a medication to a resident LPN #1 stated that it is checked on the eMAR. On 01/03/2025 at approximately 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References: (1) used to treat pneumonia and skin, gynecological, and abdominal (stomach area) infections caused by bacteria. Obtained from the website: Piperacillin and Tazobactam Injection: MedlinePlus Drug Information. (2) Used to treat certain serious infections including community acquired pneumonia (a lung infection that developed in a person who was not in the hospital), skin infections, and infections of the abdomen (area between the chest and the waist). Obtained from the website: Tigecycline Injection: MedlinePlus Drug Information. (3) Bone infection. Obtained from the website: Osteomyelitis: MedlinePlus Medical Encyclopedia (4) your body's overactive and extreme response to an infection. Sepsis is a life-threatening medical emergency. Without quick treatment, it can lead to tissue damage, organ failure, and even death. Obtained from the website: Sepsis: MedlinePlus (5) Occurring within or entering by way of a vein. Obtained from the website: Intravenous Definition & Meaning - Merriam-Webster (6) A long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart. Obtained from the website: Peripherally inserted central catheter (PICC) line - Mayo Clinic. Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services per the physician orders for five of 33 residents in the survey sample, Residents #1, #4, #23, #21, and #16. The findings include: 1. For Resident #1 (R1), the facility failed to administer medications per the physician orders. The physician orders documented: 1. Famotidine Tablet (1) 20 MG (milligrams); Give 20 mg by mouth one time a day related to GASTGROESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. MONTELUKAST TAB (Tablet) (2) 10 MG; Give 1 tablet orally in the evening for allergies. 3. Novolin N Suspension NPH (3) - Inject 24 units subcutaneously in the evening for DM (diabetes mellitus) notify MD (medical doctor) of BS (blood sugar < (less than) 60 or > (greater than) 400. 4. Novolin N Suspension NPH - Inject 55 units subcutaneously in the morning for DIABETES MELLITUS WITHOUT COMPLICATIONS. 5. Omeprazole Cap (Capsule) (4); Give 1 capsule orally in the morning related to GASTGROESOPHAGEAL REFLUX DISEASE (GERD) WITHOUT ESOPHAGITIS. 6. Novolog Pen Fill Solution Cartridge (5) 100 UNIT/ML; inject as sliding scale. The August 2024 MAR (medication administration record) documented the above orders. The following medications had blanks on the MAR: Famotidine - 8/5/24 at 6:00 a.m. Montelukast Tablet - 8/28/24 at 4:30 p.m. Novolin N Suspension NPH - 8/28/24 at 5:00 p.m. Novolin N Suspension NPH - 8/5/24 and 8/20/24 at 6:30 a.m. Omeprazole - 8/5/24 and 8/20/24 at 6:30 a.m. Novolog Pen Fill Solution Cartridge on 8/5/24 and 8/20/24 at 6:30 a.m. and 8/28/24 at 4:30 p.m. The September 2024 MAR documented the above orders. The following medications had blanks on the MAR: Famotidine - 9/8/24 at 6:00 a.m. Omeprazole - 9/8/24 at 6:30 a.m. Novolin N Suspension NPH - 9/8/24 at 6:30 a.m. 6. Novolog Pen Fill Solution Cartridge - 9/8/24 and 9/12/24 at 6:30 a.m. Review of the nurse's notes failed to evidence documentation as to why the medications were not administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan, documented in part, Focus: RESPIRATORY: the resident is at risk for respiratory complications secondary to acute laryngitis, COPD (chronic obstructive pulmonary disease). The Interventions documented in part, Administer medications as ordered. Focus: Endocrine system related to Insulin Dependent Diabetes. Interventions documented in part, Administer medications/insulin per physician orders. Focus: GI (gastrointestinal) distress related to GERD. The Interventions documented in part, Administer medications per physician orders. An interview was conducted with LPN (licensed practical nurse) #1, on 1/2/25 at 10:10 a.m. LPN #1 stated she evidences having given a medication by checking yes on the MAR. The facility policy, General Guidelines for Medication Administration documented in part, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to administer .The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit. References: (1) Prescription famotidine is used to treat ulcers (sores on the lining of the stomach or small intestine); gastroesophageal reflux disease (GERD, a condition in which backward flow of acid from the stomach causes heartburn and injury of the esophagus [tube that connects the mouth and stomach]). This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a687011.html. (2) Montelukast is used to prevent wheezing, difficulty breathing, chest tightness, and coughing caused by asthma in adults and children 12 months of age and older. Montelukast is also used to prevent bronchospasm (breathing difficulties) during exercise in adults and children 6 years of age and older. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a600014.html. (3) Novolin N Suspension NPH - Human insulin is used to control blood sugar in people who have type 1 diabetes (condition in which the body does not make insulin and therefore cannot control the amount of sugar in the blood) or in people who have type 2 diabetes (condition in which the blood sugar is too high because the body does not produce or use insulin normally) that cannot be controlled with oral medications alone. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682611.html. (4) Prescription omeprazole is used alone or with other medications to treat the symptoms of gastroesophageal reflux disease (GERD), a condition in which backward flow of acid from the stomach causes heartburn and possible injury of the esophagus (the tube between the throat and stomach) in adults and children 1 year of age and older. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a693050.html (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(5) Novolog Pen Fill Solution Cartridge - Insulin Aspart is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood) in adults and children. It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a605013.html 2. For Resident #4(R4), the facility staff failed to administer Lovenox (1) and Vancomycin (2) per the physician order. The physician order dated 3/1/24, documented, Lovenox injection Solution Prefilled [NAME] 30 MG/0.3 ML (milligrams per 0.3 milliliters) (enoxaparin sodium); Inject 0.3 ml subcutaneously two times a day for Prophylactic. The March 2024, MAR (medication administration record) documented the above order. On the following dates and times, the following was documented: 3/1/24 at 9:00 p.m., a 5 was documented. A 5 indicates Hold/see nurses note. 3/9/24 at 9:00 a.m., a 15 was documented. A 15 indicates No coverage required. 3/11/24 at 9:00 a.m., a 5 was documented. 3/12/24 at 9:00 a.m., a 5 was documented. The nurse's note dated 3/1/24 at 10:27 p.m. documented, Awaiting arrival. There were no nurse's notes for 3/9/24 and 3/11/24. For 3/12/24 at 9:38 a.m. the nurse's note documented, discharged . The nurse's note dated, 3/12/24 at 10:34 a.m. documented, Resident out to ortho (orthopedic) appointment. Taken by family member in his car. The nurse's note dated, 3/12/24 at 12:35 p.m. documented in part, Resident returned appointment. g/0.3 ML/ The Omnicell (in house back up pharmacy system) list of medications on hand documented, Enoxaparin Sodium 30 mg/0.3 ML in the system. The physician order dated, 3/22/24 documented, Vancomycin HCL (hydrochloride) Intravenous Solution Reconstituted 1.25 GM (gram); Use 1250 mg intravenously two times a day for MRSA (3)/WOUND. The physician order dated, 4/10/24, documented, Vancomycin HCL (hydrochloride) Intravenous Solution Reconstituted 1 GM (gram); Use 1 gram intravenously every 12 hours for Right Hip Infection. The April 2024 MAR documented the above order. On the following dates and times the following was documented: (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

4/13/24 at 10:00 p.m. - nothing documented, blank

4/14/24 at 10:00 p.m. - nothing documented, blank

4/15/24 at 10:00 a.m. - a 5 was documented. A 5 indicates Hold/see nurses note.

Review of the nurse's notes failed to evidence documentation related to the administration of the Vancomycin on these dates.

The comprehensive care plan date, 3/25/24, documented in part, Focus: Surgical Wound: The resident has a surgical wound to the right femur fx (fracture) incision and is at risk for infection and complications secondary to MRSA.

An interview was conducted with LPN (licensed practical nurse) #1, on 1/2/25 at 10:10 a.m. LPN #1 stated she evidences having given a medication by checking yes on the MAR. LPN #1 stated that if a medication is not available on the medication cart, the nurse should check for the medication in the Omnicell. If it's not in the Omnicell, then the nurse should contact the doctor to put it on hold or follow their instructions. All the actions taken should be documented in a progress note. When asked if all nurses have access to the Omnicell, LPN #1 stated, they should but she was not sure if the agency nurses have access.

An interview was conducted with ASM (administrative staff member) #3, the director of nursing, on 1/2/25 at 2:25 p.m. ASM #3 stated the facility would have to get access to the Omnicell for the agency nurses. She further stated that the regular staff nurses should get the medications from the Omnicell for the agency nurses that don't have access. ASM #3 stated her expectation of the staff nurses is to assist the agency nurses with locating the medications.

The facility policy, Medication Unavailability documented, POLICY: A licensed nurse discovering a medication on order that is unavailable will initiate appropriate steps to ensure medical treatment is provided as ordered. PROCEDURE: 1. A licensed nurse will notify the provider of the unavailability of medication and discuss an alternative order, if necessary. 2. If alternate medication is ordered and is not available, the licensed nurse will activate the backup pharmacy process and procedures. 3. A licensed nurse will document notification to the provider of the unavailability in the medical record. 4. A licensed nurse will notify the responsible party of any new orders and document notification.

ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m.

References:

(1) Enoxaparin is used to prevent blood clots in the leg in patients who are on bedrest or who are having hip replacement, knee replacement, or stomach surgery. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601210.html

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(2) Vancomycin injection is used alone or in combination with other medications to treat certain serious infections such as endocarditis (infection of the heart lining and valves), peritonitis (inflammation of the lining of the abdomen), and infections of the lungs, skin, blood, and bones. This information was obtained [NAME] the following website: https://medlineplus.gov/druginfo/meds/a601167.html#:~:text=Vancomycin%20injection%20is%20used%20alone%20or (3) MRSA stands for methicillin-resistant Staphylococcus aureus. It causes a staph infection (pronounced staff infection) that is resistant to several common antibiotics. This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=mrsa. 3. For Resident #23 (R23), the facility staff failed to administer sliding scale insulin per the physician orders. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/4/24, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. An interview was conducted with R23 on 12/20/24 at 12:52 p.m. R23 stated she doesn't get her evening medications on time. Her medications are to be given before or during meals. The nurse is very rigid in administering medications. She won't give you your medications in the hallway, only in your room. The nurse will not stop and give you your medications if you go to her medication cart on your way to the dining room. Many times, she gets her medications well after her meals. The physician order dated, 11/27/24, documented, Humalog Kwik Pen Solution Pen-Injector (1) 100 UNIT/ML (units per milliliter); inject as per sliding scale: if (blood sugar) 0-149 = 0 units - notify MD (medical doctor) for FSBS (fingerstick blood sugar) < (less than) 60; 150 -199 = 4 (units); 200 - 249 = 6; 250 -299 = 8; 300 - 349 = 10; 350 - 400 = 12; 401 + notify MD, subcutaneously before meals and at bedtime for DM -2 (diabetes mellitus type 2). notify MD of BS <60 or > (greater than) 400. On the following dates the medication was given at the following times: 12/1/24 at 6:26 p.m. 12/2/24 at 8:16 p.m. 12/4/24 at 6:08 p.m. 12/5/24 at 5:53 p.m. 12/7/24 at 9:11 p.m. 12/9/24 at 6:18 p.m. 12/11/24 at 6:00 p.m. 12/16/24 at 6:09 p.m (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/17/24 at 6:48 p.m. 12/18/24 at 8:35 p.m. 12/19/24 at 6:19 p.m. The comprehensive care plan dated5/19/2022, documented in part, Focus: Endocrine system related to Diabetes. The Interventions documented in part, Administer medications per physician orders. An interview was conducted with ASM (administrative staff member) #10, the medical director, on 1/2/25 at 12:52 p.m. He stated sliding scale insulin is done before the meal to cover the resident for what they are about to eat. If given afterwards, it isn't a true reading, and the resident could possibly get more insulin than what they really need. An interview was conducted with LPN #2 on 1/2/25 at 4:44 p.m. LPN #2 stated the sliding scale insulin shouldn't be done after the meal as it would give you a false reading. Many of her diabetic residents go to the dining room before she can get their blood sugar and give them insulin if needed. LPN #2 stated R23, on occasion, comes to her medication cart and she can't always get to her at that time. She then disappears and she can't find the resident. But in the end, it's on nursing, we are the professionals, and we should make sure the medications are given per the physician orders. ASM #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit. (1) (Humalog) Insulin lispro injection products are also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697021.html.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. For Resident #14 (R14), the facility staff failed to provide care and services to promote healing of a facility acquired pressure injury (1). The facility failed to provide treatments as ordered to the sacrum and the heels on multiple dates in September 2024, October 2024, November 2024 and December 2024. Also, R14's sacral pressure injury was first documented as a skin tear on 9/16/24 and was not staged or measured until 10/9/24 when the wound nurse practitioner assessed the wound as a Stage 3 pressure injury. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 10/13/24, the resident scored 8 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions. Section M documented R14 having one Stage 3 pressure injury. The current physician orders for R14 documented in part, - 10/09/2024 Air Mattress: Settings: (159.2lbs) Check Placement and functioning of Specialty mattress Q (every) Shift. every shift for Preventive measures. - 12/18/24 L Heel: Cleanse the area with half-strength Dakin's Solution, pat dry, apply Betadine-Soaked 4X4 gauze, place Silver Alginate to the Lateral and Medial side of the heel cover with ABD Pad, and Secure with rolled gauze. every day shift for Wound Care. - 11/24/24 R Heel: Skin Prep every shift for Skin integrity. - 12/18/24 Sacrum: Cleanse the area with half-strength Dakin's Solution, pat dry, apply Collagen Particles to Dakin's-Soaked gauze, pack into the wind [sic] bed, and cover with a Silicone Dressing every day shift for Pressure Ulcer. The skin observation tool for R14 dated 9/16/24 documented in part, .skin tear with Calcium alginate applied with border gauze dressing to crease of buttocks. The assessment failed to evidence any measurements or staging. Additional skin observation tools for R14 dated 9/23/24 documented scratch to buttock healing well with Zinc, no new issues noted, 9/30/24 documented no new issues, treatment continues to sacrum, 10/7/24 documented 3 areas noted to sacral/buttocks area. Treatment orders in place. None of the skin assessments documented any measurements, descriptions or staging of the wound. A wound assessment report for R14 dated 10/9/24 by the wound nurse practitioner documented a Stage 3 pressure injury acquired in house measuring 8.5cm (length) x 3.4cm (width) x 0.20 cm (depth). It documented a treatment recommendation to cleanse with wound cleanser, treat with silver alginate and cover with a silicone dressing daily and as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A wound assessment report for R14 dated 11/20/24 by the wound nurse practitioner documented the Stage 3 pressure injury resolved with recommendations to continue zinc oxide paste to the area as needed. A wound assessment report for R14 dated 12/4/24 by the wound nurse practitioner documented the Stage 3 pressure injury reopening measuring 6cm x 5.5cm x 0.10 cm. It documented a treatment recommendation to cleanse with wound cleanser, apply medical grade honey and cover with a bordered gauze daily. The skin observation tool for R14 dated 11/24/24 documented in part, Pressure area noted to L heel. Wound care nurse notified; MD notified. Treatment orders added to administration. Plan of care continues. A wound assessment report for R14 dated 11/25/24 documented assessment of the L heel by the wound nurse practitioner as an unstageable pressure injury acquired in house measuring 6cm x 6cm x 0.10 cm with treatment recommendation to cleanse with wound cleanser, apply Betadine moistened gauze and cover with abd dressing and rolled gauze daily. The eTAR for R14 dated 9/1/24-9/30/24 failed to evidence the ordered zinc treatment to the sacrum and buttocks and skin prep to bilateral heels completed on night shift on 9/3/24, 9/7/24, 9/17/24, 9/22/24 and 9/26/24. The eTAR for R14 dated 10/1/24-10/31/24 failed to evidence the ordered daily sacral treatment completed on 10/18/24, 10/26/24 and 10/27/24. The eTAR for R14 dated 11/1/24-11/30/24 failed to evidence the ordered daily L heel Betadine treatment completed on 11/29/24 or the R heel skin prep completed on day shift of 11/29/24. The eTAR for R14 dated 12/1/24-12/31/24 failed to evidence the ordered daily L heel Betadine treatment completed on 12/21/24, the R heel skin prep completed on night shift 12/3/24 and day shift 12/21/24 or the sacral treatment completed on 12/1/24, 12/2/24, 12/20/24, 12/21/24 and 12/24/24. The comprehensive care plan for R14 documented in part, The resident has actual pressure ulcer to left ischium, sacrum, left heel & is at risk for pressure ulcers related to incontinence, chronic health conditions, cognitive impairment, reduced mobility, has redness and h/o (history of) skin excoriation to the R buttocks, has h/o open area to right posterior thigh, bilateral buttocks, Left heels, right heel. Has dx (diagnosis)- PAD (peripheral artery disease). Has pressure ulcer to sacrum, L heel and L ischium. Created on: 05/11/2023. Revision on: 12/18/2024. Under Interventions it documented in part, administer treatment as ordered. Date Initiated: 07/11/2024. Revision on: 09/18/2024. (continued on next page)

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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 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 12/20/24 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that skin assessments were completed weekly and if an area was identified the nurse called the physician to get a treatment order and put the resident in the wound nurse practitioner's book for them to assess the resident. She stated that the wound nurse practitioner came in twice a week and saw residents weekly. She stated that when a nurse identified a wound, they would document it and describe the wound. LPN #3 stated that the LPNs could only measure the wounds and did not stage the pressure injuries so they would get an RN (registered nurse) to come in to assess the wound. She stated that she measures any pressure injuries observed but did not stage them and let the RN do the staging. LPN #3 stated that there had been occasions when she had gone to do treatments and found dressings that had been documented as done but the dressings had old dates on them. She stated that treatments were evidenced as done by signing them off on the eTAR.

On 12/30/24 at 4:30 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 stated that she had reviewed R14's record and it appeared that the facility staff had started treating the sacrum prior to its opening up with zinc oxide and when it opened, they had changed the treatment, but the nurse did not measure or stage the wound. She stated that the wound did not improve so the wound nurse practitioner had assessed the wound and changed the treatment at that time, but it should have been measured and staged prior to that.

On 1/2/25 at 10:10 a.m., an interview was conducted with LPN #1 who stated that treatments were evidenced as completed by signing off on the eTAR and initialing and dating the dressing.

The facility policy Wounds/Skin Impairments effective 7/17/24 documented in part, .The Skin Observation Tool will be completed by a licensed nurse at least every 7 days, detailing any wound/ulcers, pressure ulcers/injuries, skin tears, etc .

On 1/2/25 at 5:35 p.m., ASM #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

Reference:

(1) Pressure injury

A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services for pressure injuries for four of 33 residents in the survey sample, Residents #1, #17, #13 and #14. The findings include: 1. For Resident #1, the facility staff failed to administer the physician prescribed treatments to prevent pressure injuries. The physician order dated, 4/10/24, documented, SACRUM: BARRIER CREAM: every shift for skin integrity. The September TAR (treatment administration record) documented the above order. There were blanks on the TAR on the following dates and shifts: 9/2/24 - evening shift 9/4/24 - evening shift 9/6/24 - night shift 9/7/24 - evening and night shift. 9/28/24 - evening shift. The physician order dated 5/13/24, documented, L (Left) BUTTOCK: Cleanse the area with NS (normal Saline), pat dry, apply LIQUID MEDI HONEY (1) and cover with silicone border dressing every evening shift. The September TAR documented the above order. There were blanks on the TAR on the following dates: 9/2/24, and 9/4/24. On 9/5/24 a 7 was documented, A 7 indicates the resident was sleeping. The physician order dated, 9/6/24, documented, BILATERAL BUTTOCK: Cleanse the area with NS/WC (normal saline/wound cleanser), pat dry, apply Liquid Medi Honey, and cover with silicone border dressing, every evening shift for MASD (moisture associated dermatitis) (2) The September TAR documented the above order. There was a blank on the TAR on 9/7/24. The physician order dated, 9/20/24, documented, GREERS GOO (3) 1%; apply to BILATERAL BUTTOCKS topically every shift for skin integrity for 14 days. The September TAR documented the above order. There was a blank on the TAR for 9/28/24, evening shift. Review of the nurse's notes failed to evidence why the treatment were not administered. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan dated, 2/5/2018 and revised on 9/23/24, documented in part, Focus: The resident is at risk for impaired skin integrity .alteration in skin integrity to bilateral buttocks. The Interventions documented in part, Administer treatments as ordered. An interview was conducted with LPN (licensed practical nurse) #1 on 1/2/25 at 10:10 a.m. LPN #1 stated a nurse evidences that they've done treatment by signing it off on the TAR and writing on the dressing the date and their initials. LPN #1 stated if a treatment is once a shift, evening shift, it isn't appropriate to sign if off as sleeping. The facility policy, Wound/Skin Impairments, documented in part, 5. Provide treatments as ordered. ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit. References: (1) MEDIHONEY is a brand name wound and burn gel made from 100% Leptospermum (Manuka) honey. Manuka honey is unique in that it has antibacterial and bacterial resistant properties, meaning it prevents bacteria from building a tolerance to its beneficial effects. This information was obtained from the following website: https://www.carewell.com/resources/blog/what-is-medi-honey/ (2) Moisture Associated Dermatitis is superficial skin damage caused by sustained exxposure to moisture such as incontinence, wound exudate or perspiration. CMA - RAI Version 3.0 Manual. Page M - 35. (3) [NAME]'s goo is a type of barrier cream used in the treatment of intertrigo. Its composition is a mixture containing nystatin powder, hydrocortisone powder and zinc oxide paste, which is a skin rash, manifests as diaper rash in babies. This information was obtained from the following website: https://www.reference.com/world-view/[NAME]-s-goo-c0352f86ad2cb97d. 2. For Resident #17, the facility staff failed to administer the physician prescribed treatments to prevent pressure injuries. The physician order dated, 11/13/24, documented, SACRUM: Cleanse the area with NS/WC, pat dry, apply LIQUID MEDI HONEY to the wound bed and cover with a BORDER DRESSING every day shift for Wound Care. The November 2024 TAR documented the above order. On 11/22/24, 11/24/24 and 11/28/24, there were blanks on the TAR. The physician order dated, 11/28/24, documented, SACRUM: Cleanse area with NS/WC, pat dry, apply [NAME]'s [NAME] to surrounding skin, apply LIQUID MEDI HONEY to the wound bed, and cover with a BORDER DRESSING, every day shift for Wound Care. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Colonial Heights Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The December TAR documented the above order. On 12/3/24 and 12/5/24, there were blanks on the TAR. The physician order dated, 11/28/24, documented, GREERS GOO 1%; apply to AFFECTED AREAS topically every shift for MASD. Apply [NAME]'s [NAME] to peritoneal area and surrounding wound skin. The December TAR documented the above order. On 12/3/24 and 12/5/24 on the day shift and on 12/7/24 for the evening shift, there were blanks. The physician order dated, 11/28/24, documented, SACRUM: Cleanse the area with NS/WC, pat dry, apply SANTYL COLLAGENASE OINTMENT (1) to slough, apply ZINC OXIDE paste to surrounding skin, and cover with a BORDER DRESSING, every day shift for Wound Care. The December 2024 TAR documented the above order. On 12/17/24, there was a blank on the TAR. The physician order dated, 10/23/24, documented, Zinc Oxide Cream 20% CREAM, apply to BILATERAL BUTTOCKS, apply topically every shift for Skin Integrity. The December 2024 TAR documented the above order. On 12/3/24 and 12/5/24 day shift and 12/7/24 evening shift, there were blanks on the TAR. The comprehensive care plan dated, 8/12/24, documented in part, Focus: SKIN IMPAIRMENT: The resident has a skin impairment .redness to buttocks, open area to buttock, red excoriated sacrum. The Interventions documented in part, Treatment as ordered. An interview was conducted with LPN (licensed practical nurse) #1 on 1/2/25 at 10:10 a.m. LPN #1 stated a nurse evidences that they've done treatment by signing it off on the TAR and writing on the dressing the date and their initials. LPN #1 stated if a treatment is once a shift, evening shift, it isn't appropriate to sign if off as sleeping. ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit. References: (1) Santyl is a sterile enzymatic debriding ointment used to that has a unique ability to digest collagen in necrotic tissue. This information was obtained from the following website: http://www.rxlist.com/santyl-drug.htm. 3.a. For Resident #13(R13), the facility staff failed to turn the resident every two hours. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation was made of R13 on 12/30/24 at 10:38 a.m. The resident was in the bed on their back. There was a wedge pillow next to the resident but not under the resident. A second observation was made at 12:39 p.m. The resident was still in the same position as at 10:38 a.m. The wedge pillow was not under the resident. At 1:38 p.m. the resident was still in the same position. CNA #35 was asked to turn the resident onto her side. At that time, when the resident was turned over, a urine-soaked towel was wadded up under the resident. The smell of urine was very strong. CNA #35 stated she had just checked her, and she was fine. CNA #35 didn't know how the towel got under the resident. When asked how often a resident is to be turned, CNA #35 stated every two hours, but this was her first day at the facility. The Wound Assessment Report, dated 12/30/24, documented in part, Location: Sacrum; Etiology: pressure; Stage/Severity: Stage 3; Wound status: Improving with delayed wound closure. 70% granulation; 30% slough; 0% eschar. Length: 1.00 cm (centimeters); Width: 0.6 cm; Depth: 0.3 cm. An interview was conducted with LPN #1 on 1/2/25 at 10:10 a.m. LPN #1 stated a resident should be turned every two hours, especially if they have a pressure injury. The comprehensive care plan dated, Focus: The resident has a reopened pressure ulcer to the sacrum. The resident has a risk for development of additional wounds related to: chronic health conditions, reduced mobility, inability to turn and reposition independently, h/o (history of) sacral pressure. The Interventions documented in part, Assist the resident to turn and reposition often. Keep Skin clean and dry as possible. 3.b. For Resident #13, the facility staff failed to administer physician ordered treatments for the pressure injury. The physician order dated, 10/28/24, documented, SACRUM: Cleanse the area with NS/WC, pat dry, apply LIQUID MEDI HONEY to the wound bed, and cover with a SILICONE DRESSING every day shift for Wound Care. The November TAR documented the above order. On 11/18/24 and 11/26/24, there were blanks on the TAR. The December TAR documented the above order. On 12/9/24 and 12/14/24, there were blanks on the TAR. The physician order dated, 12/17/24, documented, SACRUM: Cleanse the area with half-strength Dakin's Solution (1), pat dry, pack a 2x2 (inches) CALCIUM ALGINATE (2) square to the wound bed, and cover with a SILICONE DRESSING, every day shift for Wound Care. The December 2024 TAR documented the above order. On 12/18/24 and 12/24/24, there were blanks on the TAR. The comprehensive care plan dated, Focus: The resident has a reopened pressure ulcer to the sacrum. The resident has a risk for development of additional wounds related to: chronic health conditions, reduced mobility, inability to turn and reposition independently, h/o (history of) sacral pressure. The Interventions documented in part, Treatment per TAR. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with LPN (licensed practical nurse) #1 on 1/2/25 at 10:10 a.m. LPN #1 stated a nurse evidences that they've done treatment by signing it off on the TAR and writing on the dressing the date and their initials. LPN #1 stated if a treatment is once a shift, evening shift, it isn't appropriate to sign if off as sleeping. ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit. References: (1) Dakin's solution is used to prevent and treat skin and tissue infections that could result from cuts, scrapes and pressure sores. This information was obtained from the following website: https://www.webmd.com/drugs/2/drug-62261/dakins-solution/details. (2) Calcium Ag (alginate) (Calcium alginate is a highly absorbent, biodegradable alginate dressing derived from seaweed. Alginate dressings maintain a physiologically moist microenvironment that promotes healing, and the formation of granulation tissue cover with dry dressing.) This information was obtained from the following website: https://www.o-wm.com/content/wonder-calcium-alginate

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. For Resident #27 (R27), the facility staff failed to check placement and function of a wander guard (1) as ordered on multiple dates in October, November and December of 2024. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/20/24, the resident scored eight out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. Section E documented no wandering behaviors. The assessment documented the use of a wander/elopement alarm used daily. The physician orders for R27 documented in part, Wander guard - Check placement, function and skin integrity every shift every shift for elopement. Order date: 05/01/2024. An elopement risk assessment dated [DATE] for R27 documented a high risk for elopement/exit seeking. The comprehensive care plan for R27 documented in part, The resident is at risk for elopement related to Dementia. Created on: 04/18/2023. Revision on: 10/19/2023. Under Interventions it documented in part, . Wander guard to left ankle check placement every shift. Date Initiated: 10/10/2023. Created on: 10/10/2023. Revision on: 10/10/2023. The eTAR (electronic treatment administration record) for R27 dated 10/1/24-10/31/24 failed to evidence ordered wander guard checks completed on evening shift of 10/5/24, 10/10/24 and 10/11/24. The eTAR for R27 dated 11/1/24-11/30/24 failed to evidence ordered wander guard checks completed on day shift of 11/19/24 and night shift on 11/24/24. The eTAR for R27 dated 12/1/24-12/31/24 failed to evidence ordered wander guard checks completed on day shift of 12/12/24, 12/16/24, 12/23/24 and evening shift on 12/3/24 and 12/9/24. On 1/2/25 at 10:10 a.m., an interview was conducted with LPN (licensed practical nurse) #1 who stated that treatments were evidenced as completed by signing off on the eTAR. On 1/2/25 at 4:18 p.m., an interview was conducted with LPN #2 who stated that wander guards were checked every shift. She stated that they checked placement and function and documented it on the eTAR to evidence that it was done. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/3/25 at 8:21 a.m., an interview was conducted with OSM (other staff member) #9, the director of maintenance. OSM #9 stated that the nurses applied the wander guards and checked them. He stated that once a month he checked the door alarms to ensure that the sensors worked. He stated that only the outside exterior doors had the alarms, and all the doors were checked daily Monday through Friday. On 1/3/25 at approximately 9:20 a.m. an observation was made of all facility doors, wander guard sensors were observed to be on the main entrance door, side administration door, rehab entrance and courtyard entrance. Other facility doors were observed to have emergency exit alarms and keypad locks. All doors were functioning at that time. The facility policy Elopement/Exit-Seeking Behaviors effective 1/29/24 failed to evidence guidance on checking the wander guard. On 1/3/25 at 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit. Reference: (1) A WanderGuard system relies on three components: bracelets that residents wear, sensors that monitor doors and a technology platform that sends safety alerts in real time. When a resident with a bracelet approaches a monitored door, the system alerts your caregivers. Even more important, when paired with optional magnetic door locks, the door automatically locks. When a caregiver needs to escort a wander-prone resident outside the safe area, the caregiver can use a secure code to bypass the system. The system also works in areas without physical doors. These virtual boundaries help a community feel welcoming without compromising safety. This information was obtained from the website: https://www.securitashealthcare.com/blog/3-reasons-you-need-wanderguard-system 3. For Resident #8 (R8), the facility staff failed to ensure fall mats were in place when in bed as care planned for fall risk. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/14/24, the resident was assessed as being severely impaired for making daily decisions. The assessment documented no falls since the prior assessment. On 12/19/24 at 8:16 a.m., an observation was made of R8 in bed asleep. R8 was observed with the bed in the low position with no fall mats on either side of the bed. The comprehensive care plan for R8 documented in part, Resident has had actual falls & is at risk for falls related to cognitive impairment, muscle weakness, poor balance, unsteady gait recent, poor safety awareness, dementia, Prostate CA, incontinence, impaired mobility, cognitive impairment, dementia, communication impairment, metabolic encephalopathy, OA (osteoarthritis), nonambulatory, psychotropic med use, depression, malnutrition, HTN (hypertension). Created on: 04/05/2023. Revision on: 03/19/2024. Under Interventions it documented in part, .falls mats to side of bed (bilateral) while in bed. Date Initiated: 06/02/2023. Created on: 06/02/2023. Revision on: 09/06/2023 . A post fall risk assessment dated [DATE] for R8 documented a low risk for falls. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/20/24 at 11:50 a.m., an interview was conducted with LPN (licensed practical nurse) #27 who stated that fall mats were interventions to prevent falls. She stated that the nurses had access to the care plan and could see if a resident required fall mats when in bed and the CNAs (certified nursing assistants) had access to the Kardex. On 12/20/24 at approximately 12:15 p.m., an observation was made of R8's room where LPN #27 stated that she was not sure where the fall mat was for R8, but they should have one if it was on the care plan. The facility policy Falls Management Program effective 1/29/24 documented in part, .The center utilizes a systematic approach to a falls management program that facilitates an interdisciplinary approach with evidence-based interventions to develop individual care strategies . On 12/20/24 at 4:00 p.m., ASM (administrative staff member) #14, interim administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, ASM #5, regional director of clinical services, ASM #11, regional vice president of operations, ASM #15, regional director of clinical services, and ASM #12, administrator from sister facility were made aware of the findings. No further information was provided prior to exit. 4. For Resident #24 (R24), the facility staff failed to check placement and function of a wander guard (1) as ordered on multiple dates in June, July, and August of 2024. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/15/24, the resident scored three out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section E documented no wandering behaviors. The assessment documented the use of a wander/elopement alarm used daily. The physician orders for R24 documented in part, Check Wander Prevention patient Band every shift. every shift for Monitoring. Order date: 04/29/2024. An elopement risk assessment dated [DATE] for R24 documented at risk for elopement/exit seeking. The comprehensive care plan for R24 documented in part, The resident is at risk for elopement related to cognitive impaired, resident removes wanderguard. Created on: 04/17/2023. Revision on: 08/20/2024. Under Interventions it documented in part, Continue to check placement to right ankle every shift. Date Initiated: 04/17/2023. Created on: 04/17/2023. Revision on: 08/20/2024 . The eTAR (electronic treatment administration record) for R24 dated 6/1/24-6/30/24 failed to evidence ordered wander guard checks completed on day shift on 6/3/24 and on evening shift of 6/24/24. The eTAR for R24 dated 7/1/24-7/31/24 failed to evidence ordered wander guard checks completed on day shift of 7/21/24 and evening shift on 7/21/24. The eTAR for R24 dated 8/1/24-8/31/24 failed to evidence ordered wander guard checks completed on day shift of 8/4/24. The progress notes for R24 documented in part, (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	- 01/07/2024 16:41 (4:41 p.m.) Note Text: This nurse was notified by Kitchen staff that the resident was outside lying on the ground. Resident was lying on in the grass on his left side. There were obvious abrasions to the left side of the face and eye. Residents mouth was actively bleeding. Staff immediately called 911 as well as contacted the MD and residents POA (power of attorney). Emergency services arrived and assisted staff with placing resident on the stretcher and resident was transferred to [Name of hospital]. - 01/07/2024 17:30 (5:30 p.m.) Note Text: This nurse communicated with the residents POA. POA was concerned about resident wearing his wander guard. POA was told that resident was seen walking down the hall with a bag of clothing at the start of the shift and this nurse and a CNA (certified nursing assistant) redirected the resident back to his room and checked to make sure that the wander guard was intact and it was. POA stated that she has known him to cut the wander guard off in the past. - 01/07/2024 22:52 (10:52 p.m.) Note Text: Resident returned to the facility via ambulance on a stretcher, resident was alert with confusion. Resident cleaned up and put clean dry clothes on. Evening medications were administered also PRN (as needed) Tramadol for complaints 7/10 all over pain. Resident continues to walk around the nurses station with redirection for safety reasons. Will continue to monitor. - 07/07/2024 17:20 (5:20 p.m.) Situation: Resident was walking around the facility and another resident's family member went outside and let [Name of R24] out. Activities employee spotted him and flagged down a CNA to redirect the resident back inside. Resident proceeded to walk to the back of the building when this nurse escorted the resident back inside the building without difficulty. Background: Resident has a histor [sic] of exit seeking behaviors. Assessment (RN)/Appearance (LPN): Resident unharmed in any wat [sic] alert and oriented VS (vital signs) WNL (within normal limits) NP (nurse practitioner) and Emergency contact aware . - 07/31/2024 19:15 (7:15 p.m.) Situation: Staff member was in dinner break and observed [Name of R24] outside in the parking lot. Staff was able to redirect resident back into the facility without difficulty into the door that is closest to his room. Background: Resident has a history of exit seeking and wears a wander guard per MD order that tested functional before and after this incident. Assessment (RN)/Appearance (LPN): Resident alert and oriented at baseline. Did not say where he was going or how he exit the building. No visible injuries were noted. VS 143\64 97.3 70 18 97% ORA (on room air) Resident denies any pain. Assessment: Residents's [sic] daughter was called at 2135 (9:35 p.m.) but this caller got no response. NP has been notified as well. Recommendation: Resident currently in TV room watching TV and staff is making frequent rounds . A high-risk note dated 7/12/24 documented a high-risk meeting with the IDT (interdisciplinary team) reviewing the elopement on 7/7/24 with R24's photo updated in the elopement book and the resident encouraged to attend activities. Facility elopement incident reports dated 7/7/24 and 7/31/24 were reviewed. A facility synopsis of events for R24 dated 1/7/24 documented in the final investigation, .On January 7, 2024, at about 1630 (4:30 p.m.), [Name of R24] removed his wander guard and exited the facility's front door. He walked on facility grounds and had a ground level fall with injury near an entrance on the left side. He was found by dietary staff who alerted nursing. Emergency first aid was provided, and he was sent out to the emergency department . (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

Review of the documented door monitor and patient wandering system checks evidenced the doors checked Monday through Friday and functioning on Friday 1/5/24, Monday 1/8/24, Friday 7/5/24, Monday 7/8/24, and Wednesday 7/31/24.

On 1/2/25 at 1:53 p.m., an interview was conducted with OSM (other staff member) #33, social worker who stated that they remembered R24 walking the hallways in the facility. She stated that she never saw R24 leave the facility, and he was easily redirectable.

On 1/2/25 at 4:18 p.m., an interview was conducted with LPN (licensed practical nurse) #2 who stated that wander guards were checked every shift. She stated that they checked placement and function and documented it on the eTAR to evidence that it was done. She stated that R24 exited the building a couple of times following visitors out of the front door. She stated that one time the front desk person did not recognize him as a resident, and they found him in the parking lot and another time he followed someone out. She stated that she was unsure how the wander guards worked because she did not recall the door alarms going off when R24 was found in the parking lot however the wander guard was in place and functioning when he came back inside. She stated that she never witnessed R24 taking or cutting the wander guard off.

On 1/2/25 at 4:56 p.m., an interview was conducted with LPN #29 who stated that wander guards were checked by holding a wand up to the device on the resident and it beeped green if working correctly or red if not working properly or the battery was getting low. He stated that they were checked at least once a day that he knew of and documented on the eTAR. He stated that he recalled R24 having a wander guard and the resident going out in the parking lot on one occasion and falling but he was not working that day.

On 1/3/25 at 8:21 a.m., an interview was conducted with OSM (other staff member) #9, the director of maintenance. OSM #9 stated that the nurses applied the wander guards and checked them. He stated that once a month he checked the door alarms to ensure that the sensors worked. He stated that only the outside exterior doors had the alarms, and all the doors were checked daily Monday through Friday. On 1/3/25 at approximately 9:20 a.m. an observation was made of all facility doors, wander guard sensors were observed to be on the main entrance door, side administration door, rehab entrance and courtyard entrance. Other facility doors were observed to have emergency exit alarms and keypad locks. All doors were functioning at that time.

On 1/3/25 at 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

Reference:

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(1) A WanderGuard system relies on three components: bracelets that residents wear, sensors that monitor doors and a technology platform that sends safety alerts in real time. When a resident with a bracelet approaches a monitored door, the system alerts your caregivers. Even more important, when paired with optional magnetic door locks, the door automatically locks. When a caregiver needs to escort a wander-prone resident outside the safe area, the caregiver can use a secure code to bypass the system. The system also works in areas without physical doors. These virtual boundaries help a community feel welcoming without compromising safety. This information was obtained from the website: https://www.securitashealthcare.com/blog/3-reasons-you-need-wanderguard-system 5. For R2, facility staff failed to complete a fall investigation following a fall on 06/11/2023. R2 was admitted to the facility with diagnoses that included but were not limited to hemiplegia (1) and muscle weakness. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 05/11/2023, R2 scored 11 out of 15 on the BIMS (brief interview for mental status), indicating R2 was moderately impaired of cognition for making daily decisions. The comprehensive care plan for R2 documented, Focus: the resident has had actual fall & (and) is at risk for falls/injuries related to impaired mobility, psychotropic medication use, pain medication use/c/o pain, incontinence of B&B (bowel and bladder), brain tumor, left sided weakness, neuropathy, malnutrition, RA (rheumatoid arthritis), difficulty walking, glaucoma, eyeglasses Created on: 05/05/2023. Under Interventions it documented, administer medications as ordered. Date Initiated: 01/02/2025 Created on: 05/16/2023 Revision on: 01/02/2025; encourage the resident to wear their glasses when out of bed. Date Initiated: 01/02/2025 Created on: 05/16/2023 Revision on: 01/02/2025; ensure proper positioning in bed. Date Initiated: 01/02/2025 Created on: 06/09/2023 Revision on: 01/02/2025; ensure the resident wears shoes when ambulating. Date Initiated: 01/02/2025 Created on: 05/16/2023 Revision on: 01/02/2025; falls mats to sides of bed Date Initiated: 01/02/2025 Created on: 06/09/2023 Revision on: 01/02/2025; non-skid socks while out of bed. Date Initiated: 01/02/2025 Created on: 05/16/2023 Revision on: 01/02/2025; place bed in lowest position while resident is in bed. Date Initiated: 01/02/2025 Created on: 06/09/2023 Revision on: 01/02/2025; place common items within reach of the resident Date Initiated: 01/02/2025 Created on: 05/05/2023 Revision on: 01/02/2025; remind the resident to use their call light to ask for assistance with ADLS. Date Initiated: 01/02/2025 Created on: 05/05/2023 Revision on: 01/02/2025; Therapy referral as indicated. Date Initiated: 01/02/2025 Created on: 05/16/2023 Revision on: 01/02/2025; use of wedges for bed positioning. Date Initiated: 01/02/2025 Created on: 06/09/2023 Revision on: 01/02/2025; wheelchair for ambulation and transfers Date Initiated: 01/02/2025. The facility's Fall Risk Evaluation for R2 dated 06/09/2023 documented in part, Mental Status: intermittent confusion. History of falling (in the last 3 months])? No. Category: No fall or fracture. Further review of the fall assessment indicated R2 was at moderate risk for falls. (continued on next page)

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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 0689

Level of Harm - Actual harm

Residents Affected - Few

The facility's nurse's note dated 06/11/2023 documented, Description of the fall/V (vitals)/S (situation)/injuries if any: VS (vital signs) 98.4 (temperature), 144/80 (blood pressure) 88 (pulse) 20 (respiration). unwitnessed fall lying on floor left side of bed on back. What Interventions were in place at the time of the fall? : fall mat. What are the risk factors that could have contributed to the fall?: pain, anxiety preexisting health hx (history). What new Interventions were implemented in response to the fall?: na (not applicable). Was the Provider/resident and RP (responsible party) notified at the time of the fall?: yes MD (medical doctor)/POA (power of attorney) Additional Comments: Resident sent to ER (emergency room) for evaluation.

The facility's nurse's note dated 06/12/2023 documented, Note Text: LOA (leave of absence) to Hospital.

On 01/02/2025 at approximately 10:15 a.m., an interview was conducted with ASM (administrative staff member) #23 and ASM #5, regional director of clinical services. ASM #5 stated that the facility did not have evidence of a fall investigation for R2's fall on 06/11/2023.

On 01/03/2025 at approximately 9:05 a.m., an interview was conducted with ASM #3 regarding the procedure following a resident's unwitnessed fall. She stated that residents should be assessed for injury, a skin assessment should be conducted, notification to the physician and responsible party as well as the administrator and director of nursing. According to ASM #3, a post-fall evaluation and neurological checks should be completed. If the resident demonstrates anything abnormal, notify the physician to send the resident to the hospital and obtain a staff statement. ASM #3 further stated if the resident sustained a serious or immediate injury such as a fracture, 911 would be called immediately.

On 01/02/2025 at 11:16 a.m., a request was made to obtain hospital records related to R2's fall and admission to the hospital's emergency room.

By the time of this writing, 01/08/2025 at 12:06 p.m., the requested hospital records regarding R2's fall and admission to the hospital on [DATE] were not received.

On 01/03/2025 at approximately 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services, were made aware of the above findings.

No further information was provided prior to exit.

References:

(1) The loss of muscle function in part of your body. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

Based on staff interview, facility document review and clinical review, it was determined the facility staff failed to provide supervision and to implement safety procedures to prevent injuries for five (5) of 33 residents in the survey sample, Resident #1, #27, #8, #24, and #2. For Resident #1, the facility staff failed to ensure a resident was transferred in a manner to prevent a fracture of the distal fibula (lower end, near the ankle, of the small bone in the lower leg) that resulted in harm.

The findings include:

1. For Resident #1(R1), the facility staff failed to ensure the resident was transferred in a manner to prevent a fracture of the distal fibula in April 2024 that resulted in harm.

The most recent MDS (minimum data set) assessment, prior to the fracture in April 2024, with an assessment reference date of 3/28/24, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section GG, Functional Abilities and Goals, the resident was coded as being dependent for sit to standing and for chair/bed-to chair transfers. In Section GG0115 - Functional Limitation in Range of Motion, R1 was coded as having limitations in range of motion on one upper extremity (arms) and both lower extremities (legs).

The comprehensive care plan dated 2/2/2018 and revised on 1/4/24, documented in part, Focus: At risk for falls due to impaired balance/poor coordination. She uses a motorized w/c (wheelchair) for transportation. She is able to release seat belt on command, peripheral neuropathy, OA (osteoarthritis) HTN (high blood pressure), RA (rheumatoid arthritis), poor musculoskeletal control, muscle weakness, other lack of coordination, incontinence, neuropathy, CP (cerebral palsy), visual impairment. The Interventions revised on 9/8/22, documented in part, Provide assistance to transfer as needed (assist of two as needed). Focus: ADL (activity of daily living) Self-care deficit related to physical limitations. She has a dx (diagnosis) of Cerebral Palsy, R (right) hand contracture. The Interventions revised on 9/8/22, documented in part, Assist of (1 person/2 person) with ADL's as needed.

The nurse practitioner note dated, 4/17/24 at 3:39 p.m. documented in part, Pt (patient) seen today for c/o (complaint of) left ankle pain and swelling x 1-2 weeks. Would like some Tylenol. Wears TED (anti-embolism stockings) hose daily for support. Ankle feels stiff. Denies numbness and tingling.

The nurses' note dated, 4/18/24 at 5:43 p.m. documented, Received call from (name of radiology company), reporting that she (R1) has a fractured distal fibular (sic). Left message for NP (nurse practitioner). Resident denied pain when asked.

The nurse's note dated 4/18/24 at 6:31 p.m. documented, Received fax report of resident's results for x-ray taken earlier today. Report indicates fracture to left distal fibular. Updated NP with results. Spoke with resident and asked if she experienced a fall recently. Resident stated that she has not fallen, but approximately two weeks ago there were two aids getting her up to her power chair, her foot somehow got caught on or beneath the power chair at the moment the aids pulled her upward to sit her in the chair. She remembers this because she states this particular incident hurt left ankle and this is the only incident that has occurred that caused significant pain to that body part. Resident did not recall the names of the aides that were assisting her but stated that they are not the regular staff that works with her.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The x-ray report dated, 4/18/24 documented in part, Findings: A fracture of the distal fibula is identified. The fracture does not involve the articular surface (1). No callus formation is noted. The ankle mortise (2) is intact. The surrounding soft tissues are normal. The facility synopsis of event dated, 4/19/24, documented, This is the final for Injury of Unknown Origin related to (R1) reported April 18, 2024. (R1) stated that two weeks ago, two CNAs (certified nursing assistants) were getting her up to her power chair and her left foot got hung on the chair. MD (medical doctor) and RP (responsible party) made aware. (R1) is a [AGE] year-old female with medical diagnoses not limited to Cerebral Palsy, Type 2 diabetes mellitus, COPD (chronic obstructive pulmonary disease), glaucoma, GERD (gastroesophageal reflux disease), BIMS (brief interview for mental status) score is 14. Resident interviewed; medical records reviewed. On April 18, 2024, (R1) complained of pain in her left foot. Upon observation, (R1) foot was swollen. When asked if she had fallen, (R1) stated that two weeks ago, two CNAs were getting her up to her power wheelchair and her foot got hung as they were trying to position her in the chair. (R1) said she did not say anything at the time it happened because she was not in any pain. An x-ray was ordered and done in which the results showed a fracture of the left distal fibular. (R1) denies any abuse from staff. (R1) as an ortho (orthopedic) appointment on April 22nd at 1425 (2:15 p.m.). Resident and staff interviewed; medical records reviewed. The allegation of abuse was unsubstantiated. Staff will have an in-service on safe transfers. The file with the above synopsis had no other documents in the file folder. There was no documented evidence of interviews with staff and further information regarding a complete investigation into the fracture. The folder containing the investigation into the fractured ankle was reviewed with ASM (administrative staff member) #4, the regional vice president of operations. He stated there should be more documents, staff interviews, x-ray reports, in the folder. ASM #4 returned at 2:44 p.m. returned and stated he couldn't find any further documentation related to the fracture of R1. An interview was conducted with CNA (certified nursing assistant) #4 on 1/2/25 at 11:38 a.m. CNA #4 was normally assigned to provide care and transfers to R1. CNA #4 explained and demonstrated, R1 was transferred in two different ways. Some days two staff members would lift under her arms, grab the back of her pants, put her (CNA) foot in front of the resident's feet and lift. CNA #4 said, The resident could pivot a little, she could not stand or bear weight, just put her feet on the floor. Other days, when the resident couldn't help, we lifted her with one CNA on each side of the resident, lifting her under the arms and under her knees, a full lift. The CNA said a gait belt was not used, but sometimes they grabbed the resident's pants and waistband to facilitate transfers. CNA #4 said she was not involved with the transfer of R1 when the resident's left foot was caught on or beneath the power chair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility policy provided, in part, Bed to Chair or Wheelchair Transfers documented in part, The following stand and pivot transfers are used if: the person's legs are strong enough to bear some or all of his or her weight. The person is cooperative and can follow directions. The person can assist with the transfer .Safety: The chair, wheelchair, or other device must support the person's weight. The number of staff members needed for a transfer depends on the person' abilities, condition and size. For some persons, you will use mechanical assist devices. The person must not put his or her arms around your neck. Otherwise, the person can pull you forward or cause you to lose your balance. Neck, back and other injuries from falls are possible. If not using a mechanical device, using a gait/transfer belt is the preferred method for chair or wheelchair transfers. It is safer for the person and you. Putting your arms around the person and grasping the shoulder blades is the other method. It can cause the person discomfort. And it can be stressful for you. Use this method only if instructed to do so by the nurse and the care plan .16. Apply the transfer belt. a. Stand in front of the person. b. Have the person hold on to the mattress. c. Make sure the person's feet are flat on the floor. d. Have the person lean forward. e. Grasp the transfer belt at each side. Grasp the handles or grasp the belt from underneath. f. Prevent the person from sliding or falling by doing one of the following: 1. Brace your knees against the person's knees. Block his or her feet with your feet. 2. Use the knee and foot of one leg to black the person's weak leg or foot. Place your other foot slightly behind you for balance. 3. Straddle your legs around the person's weak leg. ASM #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern for harm on 1/2/25 at 5:36 p.m. No further information was provided prior to exit. (1) Articular Surface - any surface of a skeletal formation (bone, cartilage) that makes normal direct contact with another skeletal structure as part of a synovial joint; bony articular surfaces are usually covered with articular cartilage. This information was obtained from the following website: https://medical-dictionary.thefreedictionary.com/articular+surface. (2) The ankle mortise is the socket formed by the tibia and fibula bones of the lower leg. This socket holds the talus bone of the foot, creating the ankle joint. The alignment and interaction between these bones allow for smooth and stable movement of the foot. This information was obtained from the following website: https://radiologyinplainenglish.com/ankle-mortise

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services for a feeding tube for one of 33 residents in the survey sample, Resident #13. The findings include: For Resident #13 (R13), the facility staff failed to change a dressing around the feeding tube insertion site per the physician order. Observation was made on 12/30/24 at 1:45 p.m. of R13, accompanied by CNA (certified nursing assistant) #35. The dressing around the insertion site of the tube feeding tube was dated 12/28/24. This was verified by the CNA #35. The physician order dated, 6/23/24, documented, Enteral Feed Order: Every day shift change split gauze. The November 2024 TAR (treatment administration record) documented the above order. On 10/26/24, there was a blank where it should be documented the treatment was completed. The December 2024 TAR documented the above order. On 12/9/24 and 12/18/24, there were blanks where it should be documented the treatment was completed. On 12/29/24, the nurse initialed that the treatment was completed. An interview was conducted with LPN (licensed practical nurse) #1, on 1/2/25 at 10:10 a.m. When asked how a nurse evidences that they have completed a treatment, LPN #1 stated they label all their treatments with their initials and date; and sign it off on the TAR. LPN #1 stated they shouldn't sign off something they didn't do as it's illegal. LPN #1 stated the tube feeding dressings should be done every day. The facility policy, Enteral Feeding Tubes documented in part, Gastrostomy/Jejunostomy Tubes .3. Provide peristomal site care and dressing, if indicated, per provider order. ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to store a nebulizer mouthpiece in a sanitary manner for one of 33 residents in the survey sample, Resident #11. The findings include: For Resident #11 (R11), the facility staff failed to store a nebulizer mouthpiece in a sanitary manner. Observation was made of R11 on 12/19/24 at 3:43 p.m. The nebulizer mouthpiece was lying on her nightstand. R11 stated she uses her nebulizer at times when she can't breathe. A second observation was made on 12/20/24 at 7:55 a.m., the nebulizer mouthpiece was still uncovered. On 12/30/24 at 10:36 a.m. The nebulizer mouthpiece was attached to the nebulizer machine, not covered in any manner. The physician order dated, 10/10/24, documented, Ipratropium - Albuterol Solution 0.5 - 2.5 (3) MG/3 ML (milligrams per 3 milliliters); 3 ml inhale orally every 4 hours as needed for SOB (shortness of breath) or Wheezing via nebulizer. An interview was conducted with LPN (licensed practical nurse) #1 on 1/2/25 at 10:10 a.m. LPN #1 stated the nebulizer mask/mouthpiece should be in a plastic bag and dated when not in use. The facility policy Respiratory Care & Services, documented in part, 2. Store tubing/masks.yankers, etc. in plastic storage bag when not in use. ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on resident interview, clinical record review, staff interview and facility document review it was determined that the facility staff failed to provide a complete pain management program for one (1) of 33 residents in the survey sample, Resident #21. The findings include: For Resident #21 (R21), the facility staff failed to obtain prescribed pain medication Hydromorphone (1) in a timely manner. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/18/24, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section J documented R21 receiving scheduled and as needed pain medications and having frequent pain. On 12/30/24 at 10:36 a.m., an interview was conducted with R21 who stated that the facility ran out of their pain medication over Christmas. She stated that she went five days with none of the as needed pain medication and she was told that there was no physician to sign a prescription for the medication. R21 stated that she was having neck and arm pain and was told that she had to wait for the physician to sign a new prescription. R21 stated that she was able to get her scheduled pain medications, but they did not work like the as needed pain medication. A service concern dated 12/26/24 for R21 documented in part, .Resident states that she keeps running out of medicine. Has been without pain meds for 4 days . The physician order's for R21 documented in part, - Hydromorphone HCL Tablet 2mg Give 1 tablet by mouth every 4 hours as needed for pain. Order Date: 12/11/2024. - Hydromorphone HCL oral liquid 1mg/ml (hydromorphone HCL) Give 2 ml by mouth every 4 hours as needed for pain. Order Date: 12/27/2024. The eMAR (electronic medication administration record) for R21 dated 12/1/24-12/31/24 documented an order for Hydromorphone 1mg every 4 hours as needed for pain 4-10 from 10/14/24-12/11/24 administered as needed and an order for Hydromorphone 2mg every 4 hours as needed for pain beginning on 12/11/24. The eMAR documented R21 receiving as needed doses from 12/11/24-12/23/24 and then on 12/29/24. The eMAR further documented an order added on 12/27/24 for Hydromorphone liquid 1mg/ml 2ml every 4 hours as needed for pain with doses administered on 12/27/24-12/29/24. The eMAR documented no doses administered between 12/24/24-12/28/24. The progress notes for R21 documented in part, - 12/27/2024 03:30 (3:30 a.m.) Note Text: Per Pharm Script the residents Hydromorphone HCl is on back order and can only currently provide the medication in liquid form if the MD provides another prescription. This nurse reached out to MD and MD on call service with no response to obtain an order for Hydrocodone. Resident is aware of current situation. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12/27/2024 10:10 (10:10 a.m.) Note Text: called made to pharmacy re Medication. new script was sent per pharmacy request however pill med pn [sic] back order. Liquid medication was available so new script was sent and will be available. Resident is claims she is 3/10 pain at this time and understand the delay. The progress notes failed to evidence any communication with the pharmacy prior to 12/27/24. The comprehensive care plan for R21 documented in part, The resident has a risk for pain related to s/p (status post) spinal surgery, neuropathy, arthritis, bladder spasms. Created on: 10/14/2024. Revision on: 11/22/2024. Under Interventions it documented in part, administer medications as ordered. Date Initiated: 10/14/2024 . On 1/2/25 at 10:10 a.m., an interview was conducted with LPN (licensed practical nurse) #1 who stated that when a medication was not available, they checked the in-house inventory to see if it was available and if not available, they called the physician to put the medication on hold or find an alternative for the resident. Review of the in-house inventory failed to evidence stock of Hydromorphone. The facility policy Pain Management Assessments effective 1/29/24 documented in part, .Administration of pain medication and effectiveness will be documented in the medical record . If pain is not relieved, notify the provider. Any unusual findings and follow-up interventions are to be documented in the medical record, as well as notification of physician and responsible party. Care plan specific interventions will be developed based on pain assessment and individual patient needs. The facility policy Medication Unavailability effective 1/29/24 documented in part, A licensed nurse discovering a medication on order that is unavailable will initiate appropriate steps to ensure medical treatment is provided as ordered. Procedure: 1 A licensed nurse will notify the provider of the unavailability of medication and discuss an alternative order, if necessary. 2. If alternative medication is ordered and is not available, the licensed nurse will activate the backup pharmacy process and procedures . On 1/3/25 at 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit. Reference: (1) Hydromorphone immediate-release tablets and oral solution are used as a short-term treatment to relieve severe pain (pain that begins suddenly, has a specific cause, and is expected to go away when the cause of the pain is healed) in people who are expected to need an opioid pain medication and whose pain cannot be controlled by the use of alternative pain medications. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682013.html

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to maintain adequate staffing to consistently meet the needs of the residents on three of three facility units. The findings include: Review of the reported quarter four 2024 PBJ staffing data report for the facility documented triggered areas of concern for one star staffing and excessively low weekend staffing. During the dates of the survey private interviews were conducted with cognitively intact residents and resident representatives. Multiple concerns were expressed regarding the facility staffing and care not being provided due to not having enough staff to provide the care. The resident council minutes from 9/30/24 to the present documented concerns regarding slow call bell responses, snacks not being passed to residents, resident dignity and privacy, rounding on residents every 2-3 hours, medications not administered in a timely manner, getting residents out of bed, taking residents to activities and the dining room, long wait times for care, and bad attitudes from staff. The minutes documented education provided to staff but failed to document any review of staffing or patient assignment acuity. Review of the nursing staffing schedules from 10/1/24-present documented an average staffing coverage as follows: Day shift: [NAME] unit (64 resident capacity): 2 nurses and 3-4 CNA [NAME] unit (60 resident capacity): 2-3 nurses and 2-5 CNA [NAME] unit (72 resident capacity): 2-3 nurses and 2-5 CNA Evening shift: [NAME] unit: 2 nurses and 4-5 CNA [NAME] unit: 2-3 nurses and 3-5 CNA [NAME] unit: 2-3 nurses and 2 CNA Night shift: [NAME] unit: 1 nurse and 2-3 CNA [NAME] unit: 1 nurse and 2-3 CNA [NAME] unit: 2 nurses and 3-5 CNA Review of the as worked staffing schedules documented frequent call outs, no call-no shows, staff being moved from one unit to cover the other unit and staff working double shifts or extended shifts to cover call outs. (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/20/24 at 11:01 a.m., during an interview with a cognitively intact resident who stated that they had not been provided incontinence care since around 6:00 a.m., CNA (certified nursing assistant) #26 entered the room to provide care. With the resident's permission, an observation was made of incontinence care provided. A strong urine odor was present when the sheet was removed from the resident, the brief, drawsheet, fitted sheet and mattress were observed to be wet. When asked about care provided to this resident on the shift, CNA #26 stated that they had come in to say hello to the residents and deliver the breakfast tray. CNA #26 confirmed that she had not provided incontinence care since the beginning of day shift. She stated that she had started working the floor independently the week prior and was assigned four total care residents. She stated that she was assigned 15 residents that day and had prioritized the ones who had to be out of the bed, but it was impossible to get to all of them timely. She stated that incontinence care should be provided every two hours, and it would be easier to get to everyone timely if they had more CNA staff. On 12/20/24 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that they were trained in wound care and normally were the treatment nurse. She stated that she had not been doing the treatments in a long time because she was always pulled to work on a medication cart due to staffing issues. She stated that the nurses did the treatments to the residents that they were assigned in their areas when they did not have a treatment nurse. On 12/30/24 at 11:37 a.m., an interview was conducted with OSM (other staff member) #29, long term care ombudsman who stated that they had received multiple concerns from the residents and family members regarding wound care not being done, resident to resident altercations, medication issues, care concerns and staffing concerns at the facility. On 12/20/24 at 11:50 a.m., an interview was conducted with LPN #27. LPN #27 stated that they worked on the [NAME] unit. She stated that there was an assignment sheet that was pre-printed that they filled in with CNA names each day. A review of the assignment sheet documented room numbers assigned to each staff member with two assigned 15-minute breaks and a 30-minute lunch break for each CNA. LPN #27 stated that the [NAME] unit was normally staffed with two nurses for medications and four CNA's. She stated that the unit had 64 available beds and a census of 61 that day. She stated that the staff should be able to provide incontinence care every 1-2 hours because the residents needed the care to prevent skin breakdown. On 1/2/25 at 8:08 a.m., an interview was conducted with CNA #27 who stated that they had worked at the facility for about a year, mostly on the [NAME] unit. She stated that staffing varied depending on the day of the week and the weekends were always short. CNA #27 stated that there were normally three CNAs on the unit on weekdays but there had been weekends when she was the only CNA on the unit and other times when there were only two. She stated that when she first started working at the facility, she worked on the unit by herself and then they made it mandatory to have at least two CNAs on each unit. She stated that when there were only one or two CNA's they prioritized the call bells, fall risk residents, and checked on the certain residents that they knew wanted water or snacks. She stated that they did the best that they could to check on everyone to make sure they were okay. She stated that she would go room to room and focus on trying to keep everyone clean and there were only a couple of rooms that she did not get a chance to do but everyone received care, and no one had any falls. She stated that there was a nurse who offered to pass ice, but they did not have time to help with patient care. She stated that since the state survey had been in the building the staffing had improved and having the extra CNA staff on the floor decreased the number of residents they were assigned. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/2/25 at 9:40 a.m., an interview was conducted with LPN #4 who stated that they worked at the facility for many years on the [NAME] unit. She stated that she worked the day and evening shift and on average cared for 30 residents. She stated that the normal staffing on the unit was two nurses but since the state survey had been in the building they had an extra nurse on each shift. She stated that this had changed the workflow tremendously because it gave them more time to give the medication and talk to the residents. She stated that it was so nice to be able to provide the care that the residents needed and not rush. On 1/2/25 at 10:10 a.m., an interview was conducted with LPN #1 who stated that they work the day shift on the [NAME] unit. She stated that she normally cared for 31 residents provided medications and treatments. She stated that she was able to provide all the medications and treatments to the residents by starting to work as soon as she arrived at the facility. LPN #1 stated that the staffing had changed since the survey had started and there were a lot more CNAs and they were doing great. On 1/2/25 at 11:06 a.m., an interview was conducted with CNA #28 who stated that they worked on the [NAME] and [NAME] unit. CNA #28 stated that when she worked on the [NAME] unit the average CNA staffing was five or six in August but then started dropping in September and did not go back up until the survey started. She stated that currently they had more staff than they ever had and that on 1/1/25 they had seven aides on the floor and had time to do the vital signs and weights which was nice. CNA #28 stated, It is wonderful, they are getting the care that they need. We were not able to do all of the care before, the nurses were not helping. CNA #28 stated that only a few nurses who help them, but most were too busy with their own assignment to assist with any patient care. On 1/2/25 at 11:30 a.m., an interview was conducted with CNA #3 who stated that they normally cared for 14-15 residents but had 10 today. She stated that she was able to care for the residents but was good at her job. She stated that when they were short staffed, and residents had to wait they would go to the resident and let them know and they understood. She stated that even when short staffed she never made residents wait for incontinence care and delayed things like showers, but she did it later in the shift. On 1/2/25 at 11:31 a.m., an interview was conducted with LPN #28 who stated that they worked on the [NAME] and [NAME] units. She stated that they normally cared for 32 residents, providing medications and treatments. LPN #28 stated that the staffing had changed since the start of the survey and currently they had 4-5 aides for the 62 residents and two medication nurses and one treatment nurse. She stated that previously they had 3-4 aides and often 2 on the weekends. LPN #28 stated that the current improvement in the staffing had made a difference in the care they were able to provide to the residents. On 1/2/25 at 2:17 p.m., an interview was conducted with OSM #34, staffing coordinator for nursing who stated that they had been in their role for two and a half years. OSM #34 stated that staffing prior to the survey start on 12/18/24 was as follows: - [NAME] long term care unit (60 residents if full): Day shift: 5 CNA and 2 nurses. Evening shift: 5 CNA and 2 nurses. Night shift: 3 CNA and 1 nurse. She stated that the unit was budgeted for 4 CNA staff on night shift, but they normally only had 3 due to call outs and the fourth CNA being pulled to the other unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- [NAME] skilled unit (72 residents if full): Day shift: 6 CNA and 3 nurses. Evening shift: 5 CNA and 3 nurses. Night shift: 3 CNA and 2 nurses. - [NAME] long term care unit (64 residents if full): Day shift: 6 CNA and 2 nurses. Evening shift: 5 CNA and 2 nurses. Night shift: 4 CNA and 1 nurse. She stated that after the survey start on 12/18/24 they were now staffing with 8 CNA on each unit on day shift, 6 on evening shift and 4 on night shift. She stated that they were trying to schedule 3 nurses on each unit on day shift, 2 on evening shift and 2 on night shift. She stated that this change was made to ensure that they had the coverage for any call outs with viruses going around. She stated that there had been staffing challenges and they had been better with the change in management. She stated that they were trying to hire more people, looking at pay, pulling from five different agencies and having a bigger resource to pull from has made things a lot better. She stated that the employed staff are happier having the agency staff in the building to help them provide the care to the residents. On 1/2/25 at 4:18 p.m., an interview was conducted with LPN #2 who stated that they worked evening and night shifts on the [NAME] unit. LPN #2 stated that the evening shift normally had 2 nurses and from 2-4 CNAs which could change multiple times throughout the shift. She stated that there had been one occasion where they were the only nurse for the whole unit and there were times when there was no CNAs. She stated that if there is only one nurse, you put out calls to anyone who may come in and do what you can do. She stated that when they were short staffed, they always said, keep them alive, off the floor, clean and dry. LPN #2 stated that since the start of the survey they had been getting more CNAs on the unit and her mind was blown when she had 4 nurses on her unit. She stated that since working at the facility there had never been four nurses on the unit for a shift. She stated that the culture is already so different, that it was great and has made a difference in the care that they provide. LPN #2 stated that she was able to assign a staff member to do vital signs and weights without taking someone off the floor and had staff to give medications, do treatments and still had a nurse to do skilled nursing assessments and notes. She stated that normally she has 32 residents, and it was overwhelming, and she never wanted to tell the CNA that she would not help them because she did not have time. The facility assessment reviewed 10/17/24 documented in part, .Staffing plan: At our facility, we make a good faith effort to evaluate the overall number of facility staff to ensure enough qualified staff are available to meet each resident's needs. This is not an all-inclusive list. Please refer to the organizational chart. As a contingency, we utilize staffing agencies to ensure resident care and support needs are met .Hours per a resident days (HPRD) Days: RN: 1; LPN: 6; CNA/STNA: 18; Evenings: RN:1; LPN: 6; CNA/STNA: 18; Nights: RN: 1; LPN: 4; CNA/STNA: 12 . [Name of facility] will adjust staffing needs based on acuity level as well as changes in resident population. Staffing needs are also adjust to meet facility PPD . On 1/3/25 at 12:09 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the assistant administrator, ASM #3, the director of nursing, ASM #4, the regional vice president of operations, and ASM #5, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on employee record review, staff interview and facility document review, it was determined that the facility staff failed to ensure that four out of 10 CNA (certified nursing assistant) records reviewed evidenced training that included the required abuse and neglect, dementia, resident rights, infection control, communication, and/or behavioral health. The findings include: On [DATE] at 2:00 p.m., a review of a sample of five facility CNAs and five agency CNAs were reviewed for evidence of required training. 1. Review of CNA #5's agency employee record documented a current license, background check and sworn statement. The file failed to evidence education for abuse and neglect, dementia, resident rights, infection control, communication, and behavioral health. 2. Review of CNA #6's agency employee record documented a current license, background check dated [DATE] and sworn statement. The file failed to evidence education for communication and behavioral health. 3. For CNA #7, no agency file was provided. 4. Review of CNA #8's agency employee record documented a current license, background check and sworn statement. The file failed to evidence education for abuse and neglect, dementia, resident rights, infection control, communication, and behavioral health. The staff educator for the facility was not working and unavailable for interview during the survey dates. On [DATE] at 3:48 p.m., ASM (administrative staff member) #1, interim administrator, stated that the files provided was all that they had to provide. She stated that they would continue reaching out to the agency to see if anything else could be provided. On [DATE] at 2:17 p.m., an interview was conducted with OSM (other staff member) #34, staffing coordinator for nursing. OSM #34 stated that they staffed from five agencies currently and they handled the employee records from the agencies. She stated that prior to a staff member coming to work at the facility she had the agency send over a profile that had the license, background check, sworn disclosure and CPR (cardiopulmonary resuscitation) certification. She stated that if an agency staff member came in over the weekend, she would get the file the Monday afterwards. She stated that she was sure that she had files for all the agency staff requested and was not sure if they were taken out of the facility or not. She stated that they had contacted the agency to get the requested files, but they said that they did not have them. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility assessment, last reviewed on [DATE] documented in part, .Describe the staffing training/education and competencies that are necessary to provide the level and types of support and are needed for your resident population .Consider the following training topics (this is not an inclusive list): Communication- effective communications for direct care staff; Resident's rights and facility responsibilities - ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents; Abuse, neglect, and exploitation- training that at a minimum educates staff on- (1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; (2) Procedure for reporting incidents, of abuse, neglect, exploitation, or the misappropriation of resident property; and (3) Care/management for person with dementia and resident abuse prevention; Infection control- a facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program . Required in-service training for nurse aides. In-service training must: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. Include dementia management training and resident abuse prevention training For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired . On [DATE] at 5:35 p.m., ASM #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was presented prior to exit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 3. For Resident #21 (R21), the facility staff failed to obtain prescribed Hydromorphone (1) in a timely manner. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/18/24, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section J documented R21 receiving scheduled and as needed pain medications and having frequent pain. On 12/30/24 at 10:36 a.m., an interview was conducted with R21 who stated that the facility ran out of their pain medication over Christmas. She stated that she went five days with none of the as needed pain medication and she was told that there was no physician to sign a prescription for the medication. R21 stated that she was having neck and arm pain and was told that she had to wait for the physician to sign a new prescription. R21 stated that she was able to get her scheduled pain medications, but they did not work like the as needed pain medication. The physician order's for R21 documented in part, - Hydromorphone HCL Tablet 2mg Give 1 tablet by mouth every 4 hours as needed for pain. Order Date: 12/11/2024. - Hydromorphone HCL oral liquid 1mg/ml (hydromorphone HCL) Give 2 ml by mouth every 4 hours as needed for pain. Order Date: 12/27/2024. The eMAR (electronic medication administration record) for R21 dated 12/1/24-12/31/24 documented an order for Hydromorphone 1mg every 4 hours as needed for pain 4-10 from 10/14/24-12/11/24 administered as needed and an order for Hydromorphone 2mg every 4 hours as needed for pain beginning on 12/11/24. The eMAR documented R21 receiving as needed doses from 12/11/24-12/23/24 and then on 12/29/24. The eMAR further documented an order added on 12/27/24 for Hydromorphone liquid 1mg/ml 2ml every 4 hours as needed for pain with doses administered on 12/27/24-12/29/24. The eMAR documented no doses administered between 12/24/24-12/28/24. The progress notes for R21 documented in part, - 12/27/2024 03:30 (3:30 a.m.) Note Text: Per Pharm Script the residents Hydromorphone HCI is on back order and can only currently provide the medication in liquid form if the MD provides another prescription. This nurse reached out to MD and MD on call service with no response to obtain an order for Hydrocodone. Resident is aware of current situation. - 12/27/2024 10:10 (10:10 a.m.) Note Text: called made to pharmacy re Medication. new script was sent per pharmacy request however pill med pn [sic] back order. Liquid medication was available so new script was sent and will be available. Resident is claims she is 3/10 pain at this time and understand the delay. The progress notes failed to evidence any communication with the pharmacy prior to 12/27/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan for R21 documented in part, The resident has a risk for pain related to s/p (status post) spinal surgery, neuropathy, arthritis, bladder spasms. Created on: 10/14/2024. Revision on: 11/22/2024. Under Interventions it documented in part, administer medications as ordered. Date Initiated: 10/14/2024 . On 1/2/25 at 10:10 a.m., an interview was conducted with LPN (licensed practical nurse) #1 who stated that when a medication was not available, they checked the in-house inventory to see if it was available and if not available, they called the physician to put the medication on hold or find an alternative for the resident. Review of the in-house inventory failed to evidence stock of Hydromorphone. The facility policy, Medication Unavailability documented in part, 1. A licensed nurse will notify the provider of the unavailability of medication and discuss an alternative order, if necessary. 2. If alternate medication is ordered and is not available, the licensed nurse will activate the backup pharmacy process and procedures. 3. A licensed nurse will document notification of the provider of the unavailability in the medical record. A licensed nurse will notify the responsible party of any new orders and document notification in the medical record. On 1/3/25 at 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit. Reference: (1) Hydromorphone immediate-release tablets and oral solution are used as a short-term treatment to relieve severe pain (pain that begins suddenly, has a specific cause, and is expected to go away when the cause of the pain is healed) in people who are expected to need an opioid pain medication and whose pain cannot be controlled by the use of alternative pain medications. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682013.html Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure medications were available for administration for three (3) of 33 residents in the survey sample, Residents #1, #4, and #21. The findings include: 1. For Resident #1 (R1), the facility staff failed to ensure Paxlovid (1) was available for administration. It was not started until six days after the physician order. The physician order dated 8/30/24, documented, Paxlovid (150/100) oral tablet therapy pack 10 x 150 MG (milligrams) & 10 x 100 MG; give 1 tablet by mouth one time a day for antiviral for 10 days use as directed. The pharmacy delivery manifest documented the Paxlovid was delivered on 9/6/24 at 6:18 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The September 2024 MAR (medication administration record) documented the above order. On 9/1/24, 9/2/24, and 9/4/24 the nurses documented administering the dose at 8:00 a.m. On 9/3/24 and 9/5/24, there was a 9 documented. A 9 indicated, Other/See Progress note. The progress note dated, 9/3/24 at 2:13 p.m. documented, Awaiting pharmacy. The progress note dated, 9/5/24 at 1:51 p.m. documented, Medication not available. An interview was conducted with LPN (licensed practical nurse) #1 on 1/2/25 at 10:10 a.m. LPN #1 stated that if a medication is not available the nurse should check the Omnicell (back up pharmacy machine in the building). If the medication is not available in the Omnicell you call the doctor to put the medication on hold or find an alternative. It is documented in a progress note that the medication is not available, and that you contacted the doctor. The facility policy, Medication Unavailability documented in part, 1. A licensed nurse will notify the provider of the unavailability of medication and discuss an alternative order, if necessary. 2. If alternate medication is ordered and is not available, the licensed nurse will activate the backup pharmacy process and procedures. 3. A licensed nurse will document notification to the provider of the unavailability in the medical record. A licensed nurse will notify the responsible party of any new orders and document notification in the medical record. ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit. References: (1) Paxlovid - The combination of nirmatrelvir and ritonavir is used to treat coronavirus disease 2019 (COVID-19 infection) caused by the SARS-CoV-2 virus in adults who have mild to moderate symptoms and are at risk of severe disease that could result in hospitalization or death. This information was taken from the following website: https://medlineplus.gov/druginfo/meds/a622005.html 2. For Resident #5, the facility staff failed to ensure Lyrica (1) was available for administration. It was not started until 6 days after admission. The physician order dated 3/1/24 documented, Lyrica Capsule 100 MG; Give 1 capsule by mouth three times a day for Pain. May cause dizziness or drowsiness. Avoid alcohol. The pharmacy delivery manifest documented the Lyrica was delivered to the facility on 3/7/24 at 8:34 p.m. The March 2024 MAR documented the above order. The medication was ordered for 6:00 a.m., 2:00 p.m. and 10:00 p.m. On the following dates and times, a 5 was documented. A 5 indicates, Hold/see nurse note. 3/1/24 at 10:27 p.m. - nurse's note - awaiting arrival. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/2/24 at 6:46 a.m. - no nurse's note documented. 3/2/24 at 1:15 p.m. - no nurse's note documented. 3/3/24 at 6:41 a.m. - no nurse's note documented. 3/4/24 at 6:00 a.m. - no nurse's note documented. 3/7/24 at 6:20 a.m. - no nurse's note documented. On the following dates and times, a 9 was documented. A 9 indicates, Other/See progress notes. 3/2/24 at 9:51 p.m. - nurse's note - Medication not available. 3/4/24 at 1:09 p.m. - nurse's note - medication being ordered, called pharmacy to do a follow up on order. 3/4/24 at 9:16 p.m. - no nurse's note documented. 3/5/24 at 6:55 a.m. - nurse's note - awaiting delivery from pharmacy. 3/5/24 at 3:30 p.m. - nurse's note - resident oof (out of facility) to ER. 3/5/24 at 21:08 p.m. - no nurse's note documented. 3/6/24 at 5:17 a.m. - awaiting delivery from pharmacy. 3/6/24 at 3:06 p.m. - waiting on delivery. An interview was conducted with LPN (licensed practical nurse) #1 on 1/2/25 at 10:10 a.m. LPN #1 stated that if a medication is not available the nurse should check the Omnicell (back up pharmacy machine in the building). If the medication is ot available in the Omnicell you call the doctor to put the medication on hold or find an alternative. It is documented in a progress note that the medication is not available, and you contacted the doctor. ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit. (1) Pregabalin capsules, oral solution (liquid), and extended-release (long-acting) tablets are used to relieve neuropathic pain (pain from damaged nerves) that can occur in your arms, hands, fingers, legs, feet, or toes if you have diabetes and postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles). This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a605045.html.

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NAME OF PROVIDER OR SUPPLIER: Colonial Heights Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on staff interview, and clinical record review, and facility document review, it was determined that facility staff failed to obtain physician ordered laboratory tests for two of 33 residents in the survey sample, Residents #16 (R16) and R4. The findings include: 1. For R16, the facility staff failed to obtain physician ordered laboratory (lab) tests of CBC (complete blood count) (1), BMP (basic metabolic panel) (2) and CRP (C-Reactive protein) (3) on 10/07/2024, 10/14/2024, 10/21/2024 and 10/28/2024; a CBC on 11/21/2024; and a CBC and CMP (comprehensive metabolic panel) (4) ordered on 12/05/2024 for two days. R16 was admitted to the facility with diagnoses that included but were not limited to osteomyelitis (5) of vertebra (bone of the spine), sacral (bottom of the spine) and sacrococcygeal region (base of the spine) and sepsis (6). On the most recent comprehensive MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 10/10/2024, R16 scored 13 out of 15 on the BIMS (brief interview for mental status), indicating R16 was cognitively intact for making daily decisions. The POS (physician's order sheet) dated 10/01/2024 for R16 documented in part, CBC, BMP, CRP every night shift every Mon (Monday) for monitoring. Start Date: 08/05/2024. The POS dated 11/01/2024 for R16 documented in part, CBC, CMP, CRP one time only until 11/22/2024. Order Date: 11/21/2024. Start Date: 11/21/2024. End Date: 11/22/2024. The POS dated 12/01/2024 for R16 documented in part, CBC, CMP one time only for 2 (two days. Order Date: 12/05/2024. Start Date: 12/06/2024. End Date: 12/07/2024. The comprehensive care plan for R16 dated 08/05/2024 documented in part, Focus. CARDIAC: the resident is at risk for cardiac complications secondary to hypotension, anemia and sepsis. Created on: 08/05/2024. Under Interventions it documented in part, Labs as ordered. Date Initiated: 08/05/2024. On 12/30/2024 at approximately 4:30 p.m., ASM (administrative staff member) #3, director of nursing stated the facility was unable to locate the lab tests listed above for R16. On 01/03/2025 at approximately 9:38 a.m., an interview was conducted with LPN (licensed practical nurse) #27 regarding the process of obtaining physician ordered labs. LPN #27 stated when the nurse receives the order it is put into PCC (point click care - facility's electronic health record) to confirm the order, complete a lab sheet and place it in the lab book. She stated the lab technician comes in during the 11:00 p.m. - 7:00 a. m. shift, checks the lab book, draws the lab and if the lab cannot be obtained or the resident refuses, the lab technician has the nurse sign the lab sheet. LPN #27 further stated that the lab book and lab sheets should be checked to ensure the labs are done. (continued on next page)

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy Laboratory/Diagnostic Testing documented in part, Procedure: 1. A licensed nurse will obtain laboratory, radiology or other diagnostic services to meet the needs of its patients as ordered by the provider. 2. A licensed nurse will monitor and track all provider ordered laboratory, radiology or other diagnostic tests; ensure tests are completed as ordered and communicate results to the provider. 3. Lab Tracking Form will be completed for details. 4. The licensed nurse with notify the provider of critical results as soon as possible. 5. The licensed nurse will document the dates of the notification or critical results, the method of notification as well as any other necessary information related to the lab, radiology, or other diagnostic testing results in the patient's medical record. 7. Results are to be maintained in the medical record. On 01/03/2025 at approximately 12:09 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References: (1) is a group of blood tests that measure the number and size of the different cells in your blood. Obtained from the website: https://medlineplus.gov/lab-tests/complete-blood-count-cbc/. (2) measures eight different substances in your blood. It provides important information about your body's fluid balance, your metabolism (the process your body uses to make energy from food you eat), and how well your kidneys are working. Obtained from the website: https://medlineplus.gov/lab-tests/basic-metabolic-panel-bmp/. (3) measures the level of c-reactive protein (CRP) in a sample of your blood. CRP is a protein that your liver makes. Obtained from the website: https://medlineplus.gov/lab-tests/c-reactive-protein-crp-test/. (4) a routine blood test that measures 14 different substances in a sample of your blood. Obtained from the website: https://medlineplus.gov/lab-tests/comprehensive -metabolic-panel-cmp/. (5) Bone infection. Obtained from the website: https://medlineplus.gov/boneinfections.html. (6) Your body's overactive and extreme response to an infection. Sepsis is a life-threatening medical emergency. Without quick treatment, it can lead to tissue damage, organ failure, and even death. Obtained from the website: https://medlineplus.gov/sepsis.html. 4. For Resident #4, the facility staff failed to obtain the physician ordered Vancomycin (1) trough levels on 3/28/24 and 3/31/24. The physician ordered dated, 3/25/24, documented, Vanc trough to be collected Q72HR (every 72 hours) every night shift every 3 days for ABT (antibiotic) monitoring. Review of the clinical record, failed to evidence documentation of the physician ordered laboratory tests. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/31/24 at 4:19 p.m. ASM (administrative staff member) #5, the regional director of clinical services, stated they do not have the results of the Vancomycin levels for 3/28/24 and 3/31/24. An interview was conducted with LPN (licensed practical nurse) #1 on 1/2/25 at 10:10 a.m. LPN #1 stated that if the physician ordered laboratory tests are not obtained, she would call the doctor and get a STAT (right away) order and reenter the order into the system and call the lab (laboratory) for the STAT order. An interview was conducted with ASM (administrative staff member) #10, the medical director, on 1/2/25 at 12:52 p.m. ASM #10 stated the Vancomycin levels are to ensure the levels are in therapeutic range and not toxic. Vancomycin can become toxic, thus the monitoring of the levels. ASM #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit. References: (1) Vancomycin injection is used alone or in combination with other medications to treat certain serious infections such as endocarditis (infection of the heart lining and valves), peritonitis (inflammation of the lining of the abdomen), and infections of the lungs, skin, blood, and bones. Vancomycin injection is in a class of medications called glycopeptide antibiotics. It works by killing bacteria that cause infections. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601167.html.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, it was determined that the facility staff failed to serve palatable food for one of three facility units, [NAME] Unit. The findings include: On 12/18/2024 at t approximately 1:05 p.m. a test tray consisting of mixed vegetables, gravy, mashed potatoes, pasta with sauce and sliced turkey breast and were placed in a food cart, sent to the [NAME] unit. The cart was followed by this and another surveyor, OSM (other staff member) #35, kitchen supervisor. At approximately 1:25 p.m., the last lunch tray was served to a resident on the [NAME] unit and OSM #35 was asked to remove the test tray from the food cart, then proceeded to take the temperatures of the food. All the food was 140 degrees F (Fahrenheit) or greater. The test tray was sampled by two surveyors and OSM #35 for palatability, however, OSM #35 would not taste the turkey breast stating she did not like turkey. After tasting the turkey breast by the surveyors, it was agreed that it had a gelatinous taste. On 01/02/2025 at approximately 5:30 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility document review it was determined facility staff failed to store, prepare, and serve food in a sanitary manner in one of one facility kitchens. The findings include: On 12/18/2024 at approximately 9:00 a.m., an observation of the facility's kitchen revealed the following: 1. Observation of the inside of the walk-in refrigerator revealed a quarter of a whole ham sitting on the second shelf up from the floor partially uncovered. 2. Observation of the inside of the facility's reach-in refrigerator at approximately 9:00 a.m., located in the facility's kitchen, revealed containers of juice and iced teas. Observation of the thermometer inside the reach-in refrigerator indicated an internal temperature of 56 degrees. Another observation of the thermometer inside the reach-in refrigerator at 12:05 p.m., indicated an internal temperature of 51 degrees. 3. Observation of the tray line in the facility's kitchen revealed OSM (other staff member) #36, dietary aide, standing at the end of the tray line, checking the resident's meal trays for dietary accuracy and place the meals on the food carts. Further observations of OSM #36 revealed he was not wearing a beard cover while handling the resident's meals. On 12/18/2024 at approximately 11:45 a.m., an interview was conducted with OSM #36. When informed of the observation, #3, as stated above, OSM #36 stated agreed he was not wearing a beard guard and should have had one to prevent hair from falling into the resident's food. On 12/19/2024 at approximately 3:00 p.m., an interview was conducted with OSM #1, food service director. When informed of the observation of the ham not covered, she stated it should not have been exposed to the environment and was removed from the walk-in refrigerator and discarded. When informed of the observation of the temperatures for the reach-in refrigerator OSM #1 stated that it was not working correctly and was taken out of service. When informed of OSM #36 not wearing a beard guard while resident's food was being plated, she stated that all facial hair should be covered to prevent contamination of the resident's food. The facility policy's Food Storage documented in part, Policy: Sufficient storage facilities will be provided to keep food safe, wholesome and appetizing. Food will be stored in an area that is clean, dry and free from contaminants. Food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination. Procedure: 11. Leftover food will be stored in covered containers or wrapped carefully and securely. The facility's policy Employee Sanitary Practices documented in part, Policy: All food and nutrition services employees will practice good personal hygiene and safe food handling practices. Procedure: All employees will: 1. Wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/02/2025 at approximately 5:30 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit.

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, staff interview and facility document review, the facility staff failed to maintain three of three dumpsters in a sanitary manner. The findings include: On 12/18/2025 at approximately 9:20 a.m., an observation of the facility's dumpsters sitting side-by-side located in the back parking area behind the facility, was conducted. Observations of the dumpsters to the right and left, while facing them, revealed the tops of the dumpsters were open to the environment and the covers of the middle dumpster were crushed down inside the dumpster leaving the top open to the environment. Further observation revealed the side sliding doors on all three dumpsters were open to the environment. Observations of the area around the dumpsters revealed numerous pieces of debris, including but not limited to a variety of plastics and paper products. On 12/18/2025 at approximately 9:40 a.m., an observation of the facility's dumpsters was conducted with OSM (other staff member) #1, food service director. OSM #1 stated she agreed with the above findings and the dumpsters should be kept closed and the area cleaned to prevent the attraction of rodents. OSM #1 further stated that the kitchen department and the maintenance department alternate cleaning the dumpster area every other day. The facility's policy Equipment/Grounds Inspection documented in part, Maintenance Director will facilitate assistance from and/or collaborate with the weekend MOD (medical officer of the day) or other department heads to complete internal and external inspections and recorded checks when the maintenance director is not on site. 4. Inspect dumpsters, walkways, parking lot, curb sides, courtyards and grounds for damage and other areas to verify they are clean and clear of debris and safety hazards. On 01/02/2025 at approximately 5:30 p.m., ASM (administrative staff member) #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit.

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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 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.

Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to maintain an accurate clinical record for three (3) of 33 residents in the survey sample, Residents #1, #4 and #13.

The findings include:

1. For Resident #1, the facility staff documented the medication, Paxlovid, was given when the medication was not available from the pharmacy for administration.

The physician order dated 8/30/24, documented, Paxlovid (150/100) oral tablet therapy pack 10 x 150 MG (milligrams) & 10 x 100 MG; give 1 tablet by mouth one time a day for antiviral for 10 days use as directed.

The pharmacy delivery manifest documented the Paxlovid was delivered to the unit on 9/6/24 at 6:18 a.m.

The September 2024 MAR (medication administration record) documented the above order. On 9/1/24, 9/2/24, and 9/4/24 the nurses documented administering the dose at 8:00 a.m. when the medication had not been delivered to the facility.

An interview was conducted with LPN (licensed practical nurse) #1, on 1/2/25 at 10:10 a.m. When asked how a nurse confirms that they've given a medication, LPN #1 stated you click yes or no on the MAR. She further stated, A nurse should not sign off something that they didn't do because it's illegal to do that. LPN #1 had documented two of the three doses administered above. The MAR was reviewed with LPN #1. She made no comment.

ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m.

No further information was provided prior to exit.

References:

(1) Paxlovid - The combination of nirmatrelvir and ritonavir is used to treat coronavirus disease 2019 (COVID-19 infection) caused by the SARS-CoV-2 virus in adults who have mild to moderate symptoms and are at risk of severe disease that could result in hospitalization or death. This information was taken from the following website: https://medlineplus.gov/druginfo/meds/a622005.html.

2. For Resident #4, the facility staff documented the medication, Lyrica, was given when the medication was not available from the pharmacy for administration.

The physician order dated 3/1/24 documented, Lyrica Capsule 100 MG; Give 1 capsule by mouth three times a day for Pain. May cause dizziness or drowsiness. Avoid alcohol.

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

The pharmacy delivery manifest documented the Lyrica was delivered to the facility on 3/7/24 at 8:34 p.m.

The March 2024 MAR documented the above order. On 3/3/24 at 2:00 p.m., and at 10:00 p.m. and on 3/6/24 at 10:00 p.m. the Lyrica was documented as having been administered when the medication had not been delivered to the faciliy.

An interview was conducted with LPN (licensed practical nurse) #1, on 1/2/25 at 10:10 a.m. When asked how a nurse confirms that they've given a medication, LPN #1 stated you click yes or no on the MAR. She further stated, A nurse should not sign off something that they didn't do because it's illegal to do that.

ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m.

No further information was provided prior to exit.

(1) Pregabalin (Lyrica) capsules, oral solution (liquid), and extended-release (long-acting) tablets are used to relieve neuropathic pain (pain from damaged nerves) that can occur in your arms, hands, fingers, legs, feet, or toes if you have diabetes and postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles). This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a605045.html.

3. For Resident #13, the facility staff documented a treatment was completed when it had not been completed.

Observation was made on 12/30/24 at 1:45 p.m. of R13, accompanied by CNA (certified nursing assistant) #35. The dressing around the insertion site of the tube feeding tube was dated 12/28/24. This was verified by the CNA #35.

The physician order dated, 6/23/24, documented, Enteral Feed Order: Every day shift change split gauze.

The December 2024 TAR (treatment administration order) documented the above order. On 12/29/24, the nurse initialed that the treatment was completed.

An interview was conducted with LPN (licensed practical nurse) #1, on 1/2/25 at 10:10 a.m. When asked how a nurse confirms that they have completed a treatment, LPN #1 stated they label all their treatments with their initials and date; and sign it off on the TAR. LPN #1 stated they shouldn't sign off something they didn't do as it's illegal. LPN #1 stated the tube feeding dressings should be done every day.

The facility policy, Enteral Feeding Tubes documented in part, Gastrostomy/Jejunostomy Tubes .3. Provide peristomal site care and dressing, if indicated, per provider order.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ASM (administrative staff member) #2, the assistant administrator, ASM #3, the director of nursing, ASM #5, the regional director of clinical services, ASM #1, the interim administrator, and ASM #4, the regional vice president of operations, were made aware of the above concern on 1/2/25 at 5:36 p.m. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, clinical record reviews, and facility documentation, the facility staff failed to ensure the facility was free of pests. The findings included: During the lunch meal on 12/23/24, room [ROOM NUMBER]'s B bed Cove Base Molding was observed from the hallway to have fallen entirely from the wall and floor transition with prominent crumbled sheetrock on the floor along the entire length of the Cove Base Molding. The resident in the B bed (R#26) sat in a wheelchair, eating lunch next to the outside back wall with the dismantled sheetrock to his right side and in the pathway of his wheelchair. Resident #26 did not respond verbally when asked what he thought about the condition of the wall he was sitting next to; he just smiled and placed his hands in the air. An unidentified light brown bug approximately three inches long with too numerous to count legs on each side and long tentacles was observed crawling on the crumbled sheetrock. Resident #26 was admitted on [DATE] with a significant diagnosis of right-sided weakness. The Brief Interview for Mental Status (BIMS) coded the resident a 10 out of a possible score of 15, indicating he was moderately impaired in his cognitive skills for daily decision-making. During the continued observation of the [NAME] Unit, Resident #29, the resident in room [ROOM NUMBER] A bed, voluntarily stated, That wall has been like that for a while, and no one has bothered to fix it. He (referring to R#26) doesn't talk much about anything but has to see it. When asked if he had ever seen a centepede crawling along the edges of the room, he stated, Not only that but plenty of roaches too. Resident #29 said, Before you leave please take a long look at my bathroom. It is nasty-looking, and there is a hole in the wall. I hate going in there to use it. I see the housekeeping slopping water on the floor, but it never seems to change how it looks. The toilet needs to be replaced with all that dark stuff all over it. It probably can't get clean. The resident also highlighted the dark substance on the roommate's privacy curtain and stated he sees it every time the nursing staff pulls it, but they seem like they don't see it, I guess. These are the newer curtains, too. Resident #29 added that he can see his roommate when it is pulled. The privacy curtain was validated as short when pulled, allowing visualization of the roommate. On 12/23/24 at approximately 12:45 A.M., this writer was joined by Administrative Staff Member #12 (ASM #12), who identified himself as an Administrator from another sister facility. ASM #12 was shown the condition of the resident rooms and bathrooms, as well as duct tape on the floor at the entrance of every room of [NAME] and [NAME] Units. In passing room [ROOM NUMBER], the previously observed brown bug was again identified as crawling on the baseboard of the entranceway of the resident's room. ASM #12 was asked to retrieve it, and he started using a long-handled dustpan and broom. When it appeared the bug was recessing into the gap between the baseboard and wall, this writer hollered to kill it. ASM #12 stepped on the bug and said, I have never seen anything like that; it looks like a centipede, but we got it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Shortly after this observation, the Administrative Staff Member (ASM) #11 (Vice President of Operations) was shown the condition of some of the rooms and the duct tape on the floor to the entrance of the resident's rooms. He was shown the Cove Base Molding that fell away from the wall with crumbled sheetrock and the centipede's sighting. ASM #12 lightheartedly responded that the bug had a couple of legs on each side, and the crumbling wall and detached Cove Base Molding in room [ROOM NUMBER] probably just happened because the Administration/Leadership conducts daily room rounds. On 12/23/24 at approximately 1:15 P.M. , ASM #12 was asked why he minimized the appearance of the centipede; there was no response, as he retreated down the hallway where the administrative offices were located. On 1/2/25 at approximately 3:15 p.m., the Administrative Staff Member (ASM) #1 (Interim Administrator as of 12/30/24) provided the building's pest control logs to and service invoices to date. A review of the pest control logs to date identified multiple pests-centipedes on 9/30/24 from resident (room not listed on the log), whole building. This entry did not specify the identity of all the multiple pests but did specify centipede(s) sighting. According to ASM#1, it was her expectation and that of the pest control company that all pest sightings be entered in the pest control logs by all staff. Thus, the pest control company would address any need to treat specific areas or rooms; otherwise, they would perform monthly routine pest control maintenance throughout the facility. She stated that the company could be called for any need apart from the monthly service. The log did not list the centipede sightings shared by this writer nor the one identified by ASM #12 on 12/23/24. During the exit briefing on 1/2/25 at 4:30 p.m., ASM#1 said she called the ASM #11 and validated all the environmental issues and the centipede sightings that were brought to his attention on 12/23/24. ASM#1 stated, All the issues brought forth during this survey were not under me, and I am glad of that, but I care about the residents and vow to get everything corrected for them.