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	01/08/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to implement their abuse policy with regards to allegations of abuse involving one resident (Resident #1-R1) in a sample of ten residents.The findings included:For R1, who was involved in several resident-to-resident altercations, the facility staff failed to report the incidents of/allegations of abuse to the Ombudsman in accordance with their abuse policy. On 1/7/26-1/8/26 a clinical record review was conducted of R1's chart. This review revealed a progress note dated 11/2/25 that read, Resident was witnessed telling another resident to move from in front of his door holding a butter knife. Resident yelled, 'move her from in front of my door.' Removed resident and attempted to take butterknife and resident refused to give to write [sic]. On 1/7/26, a review of facility documentation revealed that the facility failed to send the investigation summary to the ombudsman and Adult protective services. Further review of facility documentation revealed a facility investigation summary dated 9/12/25 that described an incident where R1 was . struck from behind and that he responded by striking her back. The facility had no credible evidence that the incident was reported to the Ombudsman in accordance with their abuse policy. On 1/7/26 at 4:12 PM, an interview was conducted with R1. R1 was difficult to keep focused on the questions asked when the surveyor inquired about the above incidents. R1 did report that he gets along with everyone and wasn't able to give any details about the incidents. The facility's policy titled, Reporting Requirements/Investigations with an effective date of 02/05/2023, was reviewed. The policy read in part, 1. Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. A. Notify the Adult Protective Services Agency, the local Ombudsman, and the appropriate local law enforcement authorities (police, sheriff's office, and/or medical examiner as deemed appropriate) for any incident of patient abuse, mistreatment, neglect, or misappropriation of personal property or other reasonable suspicion of a crime. On 1/7/26 at 4:55 PM, during an end of day meeting with the facility administrator, director of nursing, and regional director of clinical services the above findings were reviewed. On 1/8/26 at 8:23 AM, the facility administrator met with the surveyor and reported that she had come to the facility from another state and was not aware that incidents of abuse were reported to/sent to the Ombudsman. The administrator went on to state that she had received communication recently from the Ombudsman's office and was made aware of this requirement. The administrator stated she is now aware and would be reporting as required going forward. On 1/8/26 at 12:04 PM, during another meeting with the facility administrator, director of nursing and regional director of clinical services, the above findings were again reviewed.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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 resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to report incidents/allegations of abuse to the required agencies involving one resident (Resident #1-R1) in a survey sample of ten residents.The findings included:For R1, who was involved in several resident-to-resident altercations, the facility staff failed to report the incidents of/allegations of abuse to each of the required agencies and make reports of incidents of abuse within the required timeframes. On 1/7/26-1/8/26 a clinical record review was conducted of R1's chart. This review revealed a progress note dated 11/2/25 that read, Resident was witnessed telling another resident to move from in front of his door holding a butter knife. Resident yelled, 'move her from in front of my door.' Removed resident and attempted to take butterknife and resident refused to give to write [sic]. On 1/7/26, a review of facility documentation revealed that the facility failed to have credible evidence that the facility investigation summary was sent to Adult Protective services. Further review of facility documentation revealed a facility investigation summary dated 9/12/25 that described an incident where R1 was . struck from behind and that he responded by striking her back. The facility had no credible evidence that the incident was initially reported to the state survey agency or adult protective services when it occurred. On 1/7/26 at 4:12 PM, an interview was conducted with R1. R1 was difficult to keep focused on the questions asked when the surveyor inquired about the above incidents. R1 did report that he gets along with everyone and wasn't able to give any details about the incidents. The facility's policy titled, Reporting Requirements/Investigations with an effective date of 02/05/2023, was reviewed. The policy read in part, 1. Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. A. Notify the Adult Protective Services Agency, the local Ombudsman, and the appropriate local law enforcement authorities (police, sheriff's office, and/or medical examiner as deemed appropriate) for any incident of patient abuse, mistreatment, neglect, or misappropriation of personal property or other reasonable suspicion of a crime. On 1/7/26 at 4:55 PM, during an end of day meeting with the facility administrator, director of nursing, and regional director of clinical services the above findings were reviewed. On 1/8/26 at 8:23 AM, the facility administrator met with the surveyor and reported that she had come to the facility from another state and was not aware that incidents of abuse were reported to/sent to adult protective services in addition to the state survey agency. The administrator stated she is now aware and would be reporting as required going forward. On 1/8/26 at 12:04 PM, during another meeting with the facility administrator, director of nursing and regional director of clinical services, the above findings were again reviewed. No additional information was provided.

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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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to administer medications in accordance with physician orders and failed to notify the doctor when medications were not available for administration affecting one resident (Resident #8-R8) in a survey sample of ten residents.The findings included:For R8 the facility failed to administer medications in accordance with physician orders and failed to notify the doctor when medications were not available for administration. On 1/6/26, during a closed record review of R8's clinical record. Review of the medication administration record (MAR) for R8 revealed that on 5/4/25, Hydralazine HCL (used to treat blood pressure) was not administered. According to the nursing progress note it read, medication unavailable awaiting refill from pharmacy. According to the facility's Omnicell (medication dispensing/storage machine/supply maintained on-site) content listing the medication would have been available to facility staff to administer. On 5/30/25, R8 was not administered the physician ordered dose of diltiazem HCl ER beads (Cardizem, used to treat hypertension, high blood pressure, chest pain and other heart rhythm disorders). There were no associated nursing progress notes to indicate the provider was made aware of the medication not being given. On R8's June 2025 medication administration record, there was no documentation regarding the administration of pantoprazole sodium oral tablet (Protonix- a proton pump inhibitor, used to reduce stomach acid production), on 6/15/25. There were no progress note entries in R8's chart to explain why the medication was not administered nor any evidence that the doctor was notified. According to R8's physician orders, each of the above noted medications had an active physician order. On 1/7/26 at 3:28 PM, an interview was conducted with licensed practical nurse #3 (LPN #3). LPN #3 explained the protocol when medications are not available for administration. LPN #3 stated that she checks to see if the medication has been ordered, if it had not been ordered, she would order it. LPN #3 went on to report she would check the Omnicell [medication dispensing/storage machine/supply maintained on-site]. When asked what LPN #3 would do if the medication is not available in the Omnicell, LPN #3 said, I would call the pharmacy, if it is not STAT [medical term meaning immediately/without delay] you don't have to get it, you just wait for it to come in through the pharmacy. I make a note in the chart and let the nurse coming in to relieve me know and the administrator. When asked why it is important for residents to receive their medications, LPN #3 said, A lot of the medications they receive help with different co-morbidities they have. On 1/7/26 at 3:52 PM, an additional nurse was interviewed, LPN #4. LPN #4 explained when medications are not available how she responds. LPN #4 said, First I check the Omnicell and then I call the provider if it is not available and document the intervention the provider suggests. When asked why it is important for residents to receive their medications, LPN #4 said, for the continuation of care, medication compliance and to maintain therapeutic levels. On 1/7/26 at 3:57 PM, an interview was conducted with the assistant director of nursing (ADON), who was a registered nurse (RN #1). RN #1 explained that if a medication is not available, the staff let us know and let the doctor know. We get an order to actually put it on hold until we get the medication, we call the pharmacy to see when we will get it, if it is not in the Omnicell. We don't have a big problem, usually we have the medications in the Omnicell. On 1/7/26 at 4:55 PM, during an end of day meeting with the facility's administrator, director of nursing (DON), and regional director of clinical services (RDCS), the above findings were discussed. The DON explained that during medication administration if a medication is not available, they [the staff] are to check the Omnicell and if it is not available contact the provider to initiate an alternative medication. Review of the facility policy titled, General Guidelines for Medication Administration with an effective date of 09-2018, was conducted. The policy (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	read in part, . 11. If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g. other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit. No further information was provided.

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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 - Minimal harm or potential for 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** Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to conduct post fall assessment and monitoring following a fall with a head injury for one resident (Resident #9-R9) in a survey sample of ten residents.The findings included:For R9 who fell and sustained a laceration and hematoma to the back of the head and complained of pain, the facility staff failed to provide ongoing assessment and monitoring of the resident through neuro checks (neurological assessment/observations). On 1/6/26, a closed record review was conducted of R9's clinical record. According to a Fall Note dated 11/3/25 at 5:28 AM, it noted, During routine rounds, CNA found the resident on the floor and immediately notified the nurse. Upon arrival to the resident's room, writer observed the resident sitting on the floor on the side of the bed closest to door with both legs extended. Upon assessment, writer noted a hematoma with a small laceration to the occipital area with a small amount of blood present; no active bleeding observed. A small amount of blood was also noted on the floor and on the back of the resident's head. Vital signs obtained. Resident was assisted back to bed safely. Gauze applied to the site to maintain cleanliness and protect the area. Resident verbalized, 'I fell bad and my head hurt' and also reported bilateral leg pain. Resident was uncooperative with skin assessment. What new Interventions were implemented in response to the fall?: Neuro check initiated. head wound cleansed and gauze applied. Increased monitoring and safely checks implemented Was the Provider/resident and RP notified at the time of the fall?: Yes, NP notified; stated to monitor resident. A review of the Neurological Checklist in R9's chart dated 11/3/25, was conducted. It revealed that the first neurological check was initiated on 11/3/25 at 4:10 AM. The Resident reported a pain score of 8 on a sale of 1-10. The next three neuro checks were to be done in 15-minute intervals and were documented as done at 4:25 AM, 4:40 AM, and 4:55 AM. Following the 15-minute interval there were to be neuro checks done every 30 minutes for four occurrences. They were documented as having been done at 7:30 AM, 8AM, 8:30 AM and 9 AM. There was no documentation or evidence that R9 was assessed, monitored or evaluated from 4:55 AM until 7:30 AM. There was a nursing note entered into R9's chart on 11/3/25 at 7:08 AM, that read, Resident observed sitting upright on the bed, alert and in stable condition. No acute distress noted. Resident touched the back of her head and stated, the area feels sore. Report passed on 7-3pm nurse for continued monitoring. Writer followed with NP, who stated she will assess the resident upon arrival to the building this morning. DON notified on resident fall. RP contacted and no response. There was no documentation of an assessment of the resident at that encounter. On 11/3/25 at 17:27 (5:27 PM) the director of nursing made an entry in R9's chart that read, .During a follow-up assessment this afternoon, a laceration was noted on the occipital. The wound measured approximately 3 cm in length and 0.5 cm in width. The laceration appeared open, with visible tissue edges and minimal bleeding observed. The surrounding skin showed mild redness, but no signs of infection or swelling were noted. Given the depth and appearance of the wound, it was determined that the resident would require sutures for proper closure. The NP was notified and gave an order for the resident to be sent to the emergency room for evaluation and possible stitching. According to a progress note entry dated 11/4/25, the facility staff received a call from the hospital which reported that R9 was being admitted to the hospital for a Sub-[NAME] [sic] hematoma brain bleed. On 1/6/26 at 3:45 PM, during an end of day meeting, the facility administrator and director of nursing were asked to provide the facility policy regarding post-fall response and neurological evaluations. On 1/7/26 at 9:04 AM, an interview was conducted with the nurse practitioner (NP) for R9. The NP reported that R9 was one of her routine patients and she (NP) had seen R9 the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	day of the fall. The NP reported that R9 was ambulating and appeared to be at baseline. The NP went on to report that when a resident falls and hit their head or is suspected to have hit their head she will have them do neuro checks to make sure they don't have any changes from their baseline and to continue those and notify if there are any changes. The NP explained that neuro checks are important to monitor for changes and is the first indication that something is going on that we can't see. On 1/7/26 at 10:38 AM, an interview was conducted with licensed practical nurse #5 (LPN #5), who was the unit manager where R9 resided. LPN #5 explained that she went to see R9 when she arrived and another nurse identified as LPN #6 was in the room. The unit manager/LPN #5 explained the protocol for neuro checks and explained if a resident hit their head or had an unwitnessed fall they do neuro checks. Neuro checks are done every 15 min for first 4, then every 30 min for hour, then hour after that for four hours. The unit manager said neuro checks are important, because they can have change in level of consciousness, a total decline, blood pressure issues, and we want to keep an eye on that so we can send them out if something were to change. On 1/7/26 at 10:52 AM, an interview was conducted with LPN #6. LPN #6 stated she was the nurse that relieved the nurse assigned to R9 when the fall occurred. LPN #6 reported that her shift began at 7 AM and upon her arrival she was told that she needed to continue the neuro checks which she reported she did. LPN #6 explained that neuro checks are done every 15 minutes for four occasions, every 30 minutes for four occasions, every hour for four hours and then every shift. LPN #6 explained that neuro checks involve vital signs, pupil reaction, grip and range of motion. When asked why neuro checks are important, LPN #6 said, It is important because if there is a change in pupil reaction it can indicate a closed head injury. LPN #6 was asked about the gap in R9's neuro checks from 4:55 AM until 7:30 AM. LPN #6 said her shift started at 7AM and during report she was told to continue them, which she did and can't answer why they were not done prior to her shift starting. On 1/7/25 at 4:55 PM, during an end of day meeting with the facility administrator, director of nursing and regional director of clinical services the above findings were reviewed with regards to R9's lack of evaluation and neuro checks from 4:55 AM until 7:30 AM. On 1/8/26 at 6:01 AM, an interview was conducted with LPN #7, who was working when R9 fell on [DATE]. LPN #7 confirmed that R9 did fall in the early morning hours, hit her head, had bleeding and a bandage was applied. LPN #7 reported she did the neuro checks but said, it was in the middle of me passing medications and doing my other stuff. I don't know if I didn't finish putting them in there [the computer/clinical record]. On 1/8/26 at 11:24 AM, an interview was conducted with the director of nursing (DON). The DON confirmed that there was a gap in evidence of R9 being monitored and assessed the day of the incident from 4:55 AM until 7:30 AM. The DON went on to report that R9's vital signs were stable and for me, I didn't have a major concern until later when I saw the opening. I did the measurements, and I felt it needed sutures. According to the facility policy titled, Neurological Assessment with an effective date of 1/29/2024, it read, A neurological assessment will be completed by a licensed nurse in order to detect potential early signs of brain injury. The procedure went on to state: 1. Explain to the resident why neurological assessment is being performed. 2. Complete the Neurological Checklist Assessment in the medical record. Assess: a. vital signs, b. orientation, c. level of consciousness, d. pupillary response, e. verbal responses, f. pain, g. movement and sensation of extremities. 3. Complete assessment every 15 minutes for the first hour, every 30 minutes for the next two hours, and every hour for the next four hours. 4. Notify provider and responsible party of any abnormal findings. Document in the medical record and follow provider recommendations. No additional information was provided.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to have five medications available for administration for one resident (Resident #8-R8) in a survey sample of ten residents.The findings included:For R8 the facility failed to have give medications available to administer in accordance with physician orders on 5/4/25. On 1/6/26, during a closed record review of R8's clinical record it was noted on the census tab that R8 had discharged from the facility on 10/15/25. Review of the medication administration record (MAR) for May 2025 revealed that on 5/4/25, the following medications had a code 9- entered on the MAR. According to the chart codes (legend) at the bottom of the MAR, code 9 indicated other/see nurse notes. The medications with that code were: Fluticasone Propionate Nasal Suspension (Flonase nasal spray- used for allergic rhinitis), Vitron-C (a vitamin with Vitamin C and iron), Budesonide-Formoterol Fumarate inhaler (a corticosteroid used to treat inflammation in the lungs), Buspirone HCL (Buspar- used to treat anxiety) for two doses, and Hydralazine HCL (used to treat blood pressure). According to the MAR, R8's blood pressure on 5/4/25 was recorded as 197/103, which was elevated and the medication used to treat elevated blood pressure was not administered. According to R8's physician orders, each of the above noted medications had an active physician order on 5/4/25. According to the nursing progress note entries dated 5/4/25 regarding each of the medications not given, the entry read, medication not available. On 1/7/26 at 3:28 PM, an interview was conducted with licensed practical nurse #3 (LPN #3). LPN #3 explained the protocol when medications are not available for administration. LPN #3 stated that she checks to see if the medication has been ordered, if it had not been ordered, she would order it. LPN #3 went on to report she would check the Omnicell [medication dispensing/storage machine/supply maintained on-site]. When asked what LPN #3 would do if the medication is not available in the Omnicell, LPN #3 said, I would call the pharmacy, if it is not STAT [medical term meaning immediately/without delay] you don't have to get it, you just wait for it to come in through the pharmacy. I make a note in the chart and let the nurse coming in to relieve me know and the administrator. When asked why it is important for residents to receive their medications, LPN #3 said, A lot of the medications they receive help with different co-morbidities they have. On 1/7/26 at 3:52 PM, an additional nurse was interviewed, LPN #4. LPN #4 explained when medications are not available how she responds. LPN #4 said, First I check the Omnicell and then I call the provider if it is not available and document the intervention the provider suggests. When asked why it is important for residents to receive their medications, LPN #4 said, for the continuation of care, medication compliance and to maintain therapeutic levels. On 1/7/26 at 3:57 PM, an interview was conducted with the assistant director of nursing (ADON), who was a registered nurse (RN #1). RN #1 explained that if a medication is not available, the staff let us know and let the doctor know. We get an order to actually put it on hold until we get the medication, we call the pharmacy to see when we will get it, if it is not in the Omnicell. We don't have a big problem, usually we have the medications in the Omnicell. Review of the Omnicell contents listing provided by the facility revealed that of the five medications not administered to R8 on 5/4/25, only one was available in the Omnicell, which was Hydralazine 25 mg tablet. On 1/7/26 at 4:55 PM, during an end of day meeting with the facility's administrator, director of nursing (DON), and regional director of clinical services (RDCS), the above findings were discussed. The DON explained that during medication administration if a medication is not available, they [the staff] are to check the Omnicell and if it is not available contact the provider to initiate an alternative medication. Review of the facility policy titled, General Guidelines for Medication Administration with an effective date of 09-2018, was conducted. The policy (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	read in part, . 11. If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g. other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit. No further information was provided.