STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonnades Health Care Center	100 Colonnades Hill Drive Charlottesville, VA 22901

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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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. 41449 Based on staff interview and facility documentation review, the facility staff failed to respond timely to a clinical record request for 1 resident of 20 residents, resident #26 (R26). The findings included: For R26, whose power of attorney requested copies of the resident's clinical record, the facility staff failed to fulfil the request for over six weeks. On 11/1/24, a closed clinical record review was conducted of R26's chart. This review revealed no information with regards to a request for clinical records being made. On 11/1/24 at 9:49 a.m., an interview was conducted with the medical records employee. The medical records employee reported that the process when a person requests medical records is that they fill out a form, it is forwarded to the records management team and documents are uploaded for them to review. Once approval is received from the records management team, she releases the requested records. The medical records employee reported she had only been in the role about two months and therefore had no knowledge of a request for records involving R26. On 11/1/24 at approximately 10:15 a.m., the medical records employee reported to the surveyor that the social worker had handled the request for records involving R26. On 11/1/24 at approximately 10:30 a.m., an interview was conducted with the social worker. The social worker was able to go through her emails and confirmed that a request for records involving R26 was made 12/21/2023. The social worker also provided copies to the survey team where the records were shipped to R26 and received on 2/3/24. When asked about the timing of such requests the social worker said that the process of the request going through the records management and the legal team but we try to do it within a 2-week period. The Social worker confirmed that R26's family member who requested the records was the power of attorney and provided the surveyor with a copy of the power of attorney. On 11/1/24, the facility's policy regarding medical record requests was requested. The policy titled; Record Requests was reviewed. According to the policy as part of a foot note, it read, 42 CFR [code of federal regulation] 483.10(b)(2) states that access to records must be provided within 24 hours (excluding weekends and holidays) and copies within two business days. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/1/24 at 1:45 p.m., during an end of day meeting held with the facility administrator, acting director of nursing and corporate staff, the above findings were reviewed. No additional information was received.

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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 - Immediate jeopardy to resident health or safety 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** 49456 Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to protect the residents' right to be free from mental abuse/verbal abuse/ and physical abuse by a staff member for four residents, (Resident #5 (R5), Resident #7 (R7) Resident #20 (R20) and Resident #177 (R177)) out of a survey sample of 20 residents, which resulted in psychosocial harm for R20. Immediate jeopardy (IJ) and substandard quality of care in the area of abuse was identified. The findings included: 1. For R5 and R20, the facility staff failed to protect the resident's right to be free from physical abuse, mental abuse and verbal abuse. On 10/29/24, a clinical record review was conducted of R5's chart, which noted she had been discharged and was no longer a resident of the facility. Therefore, an interview could not be conducted with R5. On 10/29/24 at 9:08 a.m., an interview was conducted with R20. R20 said, [Certified nursing assistant #1 (CNA 1)'s name redacted] treated me like slapping the pigs. I reported it to the social worker and talked with her about it. R20 said, The aide was rough with me, and I didn't like it. R20 stated they [facility staff] were responsive to her concern, and she never saw CNA1 again after the incident. R20 said, I am limited to what I can do due to my broken leg. On 10/30/24 at 11:00 a.m. an interview was conducted with the social service director (SSD). The SSD stated she had interviewed R5 and R20, who were roommates. SSD stated that R20 had stated that CNA1 was rough with her during daily care and in the shower room. The SSD stated that R5's complaint was that CNA1 was being rough with her during morning care while applying her back brace. The SSD said, [R5's name redacted] and [R20's name redacted] verbalized that they were not scared or nervous, just didn't want [CNA1's name redacted] as an aide anymore. On 10/31/24 at 8:40 a.m. another interview was conducted with the SSD. The SSD stated she documented her interviews with R5 and R20 in a word document but was unable to locate the document. When asked if other residents had complained about CNA1, the SSD stated she was unable to recall the names of the other residents, but others had complained previously about CNA1 and reported the residents were on the same hallway as R5 and R20. The SSD had no evidence of any interviews she conducted with any of the residents nor a record of their concerns and confirmed she had not documented any of the information in the resident's clinical record. The SSD said, [Administrator name redacted] asked me to interview the other residents who had complained about [CNA1's name redacted] being rough with them with care. The SSD stated that she reported the interviews to the administrator, and she was unaware of what was done about the additional complaints. The SSD stated that the complaints and interviews with other residents were prior to the complaints received about R5 and R20's incident. On 10/30/24, the facility administrator was asked to provide all information/evidence they had with regards to R5 and R20's allegation of abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/31/24 at 9:15 a.m. an interview with the administrator was conducted. The administrator was questioned about the facility documentation provided to the survey team with regards to R5 and R20's allegations of abuse. Included in the documents was evidence of staff education with regards to customer service, not abuse. The administrator said, Not all nursing staff is on the in-service, we are missing two part-time college students and some from the third shift that's not on this education. The administrator stated that after she came into work on 10/1/24, a dayshift aide, CNA#7 (CNA7) approached her and reported the allegation of abuse. The administrator stated CNA7 was a new aide and was scared and tearful over the incident. The administrator then stated that CNA7 came to her after breakfast to report the allegation of abuse. The administrator stated that she discussed the allegation with her supervisor and then CNA1 was pulled off the nursing unit. The administrator said, [CNA1's name redacted] could be abrupt with communication when she is upset. [CNA1's name redacted] was terminated for her behavior toward us [staff/administration]. When [CNA1's name redacted] was leaving, she was disruptive in the hallway on the nursing unit and in front of the residents. ***On 10/31/24 a clinical record review was conducted of R5 and R20's charts. There was no documentation within the clinical records with regards to the resident's allegation of abuse or having been interviewed. According to the activity of daily living (ADL) documentation, it indicated that CNA1 continued to provide care and documented in R5 and R20's charts on 9/30/24 and on 10/1/24 until 10:00a.m. According to CNA1's timecard she clocked out at 10:45 a.m. on 10/1/24. On 10/31/24 at 11:30 a.m. an interview was conducted with the MDS (minimum data set) coordinator, who was a registered nurse. The MDS coordinator had written a witness statement on 10/1/24 that read, While reviewing baseline care plan with resident, [R5's name redacted] on 9/30/24, she told me that her nurse's aide that morning had been rough with her. She stated that while putting her TLSO (thoracic-lumbar-sacral orthosis) brace on, she was rough. When asked, the MDS coordinator identified the CNA as CNA1. The MDS coordinator said, I told her I would talk to the person who supervises the CNAs about it, and she expressed fear of retribution from the CNA. I assured her that she was safe. The MDS coordinator stated that she reported this to the administrator on 9/30/24. According to the facility documentation and fax confirmations, R5 and R20's allegation of abuse was not reported to the regulatory agencies and adult protective services until 10/1/24 at 3:34 p.m. On 10/31/24 at 5:00 p.m. a follow-up interview was conducted with R20. R20 said, Early morning I like to go out and watch things come to life and [CNA1's name redacted] came out stood by me just looking at me and never spoke to me and I did feel intimidated by her. Then R20 said, During the bed bath [CNA1's name redacted] took a washcloth and slapped me, like you would take a mop and sling it down. I have dogs and would not wash them like that. Then R20 said, When she hit me with this washcloth, I felt I wasn't human, subhuman and I cannot understand anyone doing this to someone! This verbiage you can tell is coming from a teacher. R20 stated that the acting DON did complete a skin assessment and found two small bruises on her legs and back. Then R20 said, I cried and was trying to catch my breath. I was appalled that someone would be that way. The social worker let me talk and I reported it and thought it would end there, but the social worker said no. I wish the aide still had a job but not with humans. I cried when I told the social worker the story and didn't see any reason for this, over a bath. It was like a nightmare. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/31/24 a review of witness statements in CNA1's personnel file about the allegation of abuse was conducted. The first witness statement was from CNA7. CNA7's witness statement read in part, .this morning two residents stated to me that [CNA1's name redacted] has been very rough and hurting them during her care. The two residents were [R20's name redacted] and [R5's name redacted]. I brought [R5's name redacted] to the dining table for breakfast she was trying to talk to me about [CNA1's name redacted] and [CNA1 name redacted] said to the resident Do you have something you need to say to me, in a smart tone. The administrator had written a witness statement on 10/1/24 that read in part, .This writer had to suspend [CNA1's name redacted], pending an investigation after complaints from two separate residents regarding her care for them. The SSD wrote a statement and read, This writer spoke with [R5's name redacted] and [R20's name redacted]. [R5's name redacted] reported that [CNA1 name redacted] was 'rough' with her during morning care yesterday morning. She had to have a brace on while lying down and [CNA1's name redacted] wouldn't put it on, getting her dressed instead and was rough with her. [R20's name redacted] reported that [CNA1's name redacted] was rough with her during shower care, not gentle, slapping the washcloth on her and she felt intimidated by her standing there. On 10/31/24, CNA1's personnel file was reviewed. According to the document titled, Performance Counseling and Improvement Plan for Correction Action, read in part, .Termination Written. Reason for Counseling 1. Policy/company rules not followed: Abuse or neglect of a resident, Date and Time: [DATE]. 2. Policy/company rules not followed: Failure to work in a cooperative manner. Date and Time: 9/26/24 . This document was signed by the administrator, the general manager and a witness on 10/7/24. On 11/1/24 at 9:09 a.m. another interview was conducted with the SSD. The SSD said, The resident [R20] was tearful when telling me the story about what happened with the aide. The SSD stated that she never asked R20 how the actions from CNA1 made her feel. On 11/1/14 at 10:28 a.m. an interview was conducted with a physical therapist. The physical therapist said, [R5's name redacted] was more subjective and was guarded with her language. She [R5] stated to me that her roommate was upset about being struck in the shower which indicated physical contact to me. The physical therapist stated she questioned R5 about R20 striking the aide and R5 stated no, it was the other way around, the aide struck her. The physical therapist said, I told [R5's name redacted] I needed to report this to my supervisor, and she may want to speak with you to get your feedback. Facility documentation also revealed that on 10/1/24, Resident #20 (R20) and Resident #5 (R5) reported to facility staff, that CNA #1 was rough and hurting them during care. Following this, the administrator suspended CNA #1 at 10:45 am, reported the incident to regulatory agencies that afternoon, and initiated an investigation. The investigation included staff witness statements that confirmed that CNA #1 was verbally abusive, and statements from both R20 & R5 that alleged physical abuse by CNA#1. On 10/31/24 a review of facility documentation was conducted. The incident summary read in part, .based on the assessments and investigation, the allegations were unsubstantiated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility administrator failed to complete a thorough investigation, no additional resident or staff interviews were conducted, and concluded that the allegation of abuse had been unfounded. 2. The facility staff failed to report an allegation of abuse for R7, after it was reported by a surveyor to the acting director of nursing. On 10/29/24 at 10:47 a.m., during an interview with R7 she reported the staff are rough when they help you to stand up or change your diaper. When R7 was asked about the bruising to her right wrist, the resident said, they are very rough. On 10/29/24 at 10:51 a.m., following the above interview with R7, the surveyor was unable to locate the facility administrator to report the allegation. The surveyor then made the acting director of nursing (DON) aware of the allegation. On the evening of 10/29/24, a clinical record review was conducted of R7's chart. There was no documentation with regards to the bruising on the interior of R7's right wrist and the bruising noted. There was a progress note entry dated 10/29/24 at 11:14 a.m., by the DON that read, ADNS [acting director of nursing services] was asked to follow up on resident statement that when she was asked how she got the bruise on her wrist, she stated staff was sometimes rough with her during care. ADNS approached resident in her room; she was observed lying in bed with eyes closed. I asked her how she was feeling and she responded sleepy. When I asked her how she got the bruise on her wrist, she hesitated to answer and said, I don't know . I asked her if she wanted any covers and she said, No. I just want to rest. I ensured bed was in low position, fall mat on floor beside bed, wheelchair in locked position, and call bell within reach prior to leaving the room. Will follow up with resident when she is awake. On 10/30/24 at 11:12 a.m., a follow-up interview was conducted with the DON. When asked about any follow-up with regards to R7 and the allegation reported by the surveyor, the DON said, I think I put a note in, I went in and she had put herself to bed, I was trying to make sure she was centered on the bed better, she is very hard of hearing, I asked if felt ok, she said yes, I asked if she was sleepy she said yes. I asked her, can you tell me how you got that bruise? She said, I don't know, she was very tired and very lethargic, I left it alone, I lowered the bed and put the fall mat down. I went and checked on her later and she was in a meal. I talked to her, she was up this morning, she wasn't answering questions appropriately, she had a fall again last night, they are talking to hospice to see what else we can do to help her . On 10/30/24 at 3:17 p.m., an interview was conducted with the administrator. The surveyor asked the administrator if she was aware of the allegation reported by the surveyor to the DON involving R7, the administrator said, She [the DON] did say you [the surveyor] had talked to her about an area on [R7's name redacted]'s wrist or hand and she went and talked to [R7] and got a very different answer. I believe she went back and talked to her again and she had no complaints of staff. She brought all that to me. The administrator acknowledged that nothing involving R7 had been reported to the required agencies and nothing was in process. On 10/31/24 at 11:30 a.m., the survey team reviewed facility documentation, which indicated R7's report of an allegation of abuse was reported as an injury of unknown origin following the surveyor questioning the facility administrator about reporting the allegation of abuse involving R7 on 10/30/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. The facility staff failed to respond to and report an injury of unknown origin for R177's skin tear to her left hand. On 10/31/24 at 11:13 a.m. an interview was conducted with a staff member who expressed a desire to remain anonymous. The anonymous staff (AS1) verbalized that she was called into R177's room by certified nursing assistant, CNA1. AS1 stated, I reported an incident with a resident to the Administrator, the resident had two skin tears to her left extremity. AS1 then stated, the skin tears were new. AS1 said, [CNA1's name redacted] said to the resident, I don't want to hear that apology, and the resident began to cry. On 10/31/24 at approximately 3:00 p.m. a clinical record review was completed. On 7/28/24 a physician order for treatment was noted. The order read, clean skin tear to left elbow and left hand with normal saline pat dry apply border gauze until healed. On 7/28/24 a skilled note was written and there was no mention of an incident or the skin tears. On 7/30/24 a weekly skin note was completed by RN1 and read in part, .skin tear to left hand steri strips applied and foam dressing applied. On 7/30/24 a doctor's progress note was written. The note read in part, the skin tear on the left elbow happened by rubbing on the arm of the wheelchair. The note did not mention the skin tear to the left hand. On 10/31/24 an employee that wanted to remain anonymous showed the surveyor a text message that was sent to the administrator on 7/28/24 and the text message read, I really need to talk to you. The anonymous employee stated, I reported the incident of [R177's name redacted] skin tears and of her complaining that CNA1 was rough with her. The employee stated that the administrator response was, to be careful of what you are saying and accusing people of. The anonymous employee then stated, I never heard anything else about the incident and assumed nothing was done. On 10/31/24 and again on 11/1/24 a request was made by the surveyor for the facility to provide evidence of an investigation for the skin tear that R177 obtained, or how the facility determined it was caused. On 11/1/24 the surveyor had not received any information. Another request for it was made to the administrator. Prior to the survey team's departure from the facility, no information was provided to the survey team. On 10/31/24, prior to calling IJ, the skilled nursing staff members were interviewed, and three out of six staff members interviewed knew who the abuse coordinator for the facility was. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/31/24, a facility document was reviewed. The titled document was, Abuse, Neglect and Exploitation-Prevention, Reporting and Investigation, read in part, .It is the policy of the community that: a) each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Team members must not engage in, nor permit anyone else to engage in, abuse, neglect, or exploitation of any resident. b) team members of the community are mandated reporters and have a duty to report known or suspected abuse, neglect and/or exploitation to local, state, and/or federal authorities in accordance with applicable law and regulations. c) in addition, team members who know of or suspect abuse, neglect, or exploitation of any resident must immediately notify the Executive Director/designee, to ensure appropriate action is timely taken for the safety of the resident and those potentially impacted . Training, the department coordinator/designee educates team members, through on-boarding and on-going training sessions on the prevention, reporting, and documentation of abuse, neglect, and exploitation. Training includes a) all team members are mandated reporters and are required to report allegations or known episode of abuse, neglect, and/or exploitation to applicable state authorities within the time frame established by law. h) steps to take to ensure the safety and protection of residents in situations of known or suspected abuse, neglect and/or exploitation, including escalation to the Executive Director/designee .Duty to report. Every team member is a mandated reporter and has a duty to report known or suspected abuse, neglect, and/or exploitation to local and state authorities in accordance with applicable law and regulation. a) these authorities may include law enforcement, the licensing regulator, the ling term care ombudsman, and/or adult protective services. The report of abuse, neglect or exploitation must be made within the timeframes and through the format required by applicable law and regulation. b) allegations of or suspicions of abuse, neglect and/or exploitation are to be reported .Protecting the resident. In addition, to initial Mandatory reporting, to ensure the safety and protection of residents, any team member who know of or suspect abuse, neglect or exploitation of a resident must also immediately notify the ED/SNA/designee. The SNA/designee: a) upon receiving notification of any known or suspected abuse, neglect, or exploitation of a resident contacts the licensed nurse who evaluates the resident and provides the necessary intervention, for example, calls 911 if emergent. b) Removes the individual alleged to be involved in the abuse, neglect or exploitation from the area. i. ensure that any team member alleged to be involved in the abuse, neglect or exploitation is placed on administrative leave, pending the results of the investigation. ii. Ensures that non-team members alleged to be involved in the abuse, neglect or exploitation will be asked to leave the resident area and await further instructions. c) ensures that the resident's (i) physician, (ii) legal representative and (iii) family member or other individual regularly involved in the residents day to day care are notified as soon as practicable within timeframes established within laws/regulations .Investigation: The SNA/designee: Validates that the mandatory report of known or suspected abuse, neglect or exploitation has been made to the applicable authorities in accordance with state/federal requirements. The SNA/designee manage and directs the investigation of all abuse, neglect and/or exploitation. The SNA/designee implements corrective actions as indicated by the results of the investigation. If a written report of the investigation 1findings is required by applicable law or regulation, the SNA completes such report and ensures that it is submitted timely. On 10/31/24 at 4:30 p.m., the survey team identified the facility was in immediate jeopardy (IJ) in the care area of Freedom from Abuse, Neglect, and Exploitation. The facility staff failed to implement interventions to prevent, protect, and respond to allegations of physical and verbal abuse. The survey team met with the facility administrator, acting director of nursing, social service director, the general manager and the regional director of resident care and reviewed the IJ findings and a copy of the IJ template was provided to the facility administrator. (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 - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility staff were notified of the concern about the skin assessments and that the survey team would be unable to abate the IJ. The facility staff conducted new skin assessments on non interviewable residents. No new areas were noted, and all assessments had the initial date of identification. The survey team reviewed the revised skin assessments and confirmed that no new skin issues were identified. A sample of 20% of the skin assessment findings were verified through clinical record reviews to ensure skin impairments had been previously documented by the facility staff. The survey team reviewed and confirmed that the family of non interviewable residents were interviewed with no abuse related concerns noted. The survey team reviewed resident interviews, and no new areas of concern were identified. The survey team confirmed that the facility completed and reported R7's allegation of abuse. On 11/1/24 at 1:30 p.m. the survey team was able to confirm that the immediacy had been removed and IJ was abated. Following the removal of immediate jeopardy, the scope and severity was lowered to a level three isolated. No additional information was provided prior to exit.

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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. 28106 Based on resident interview, staff interview, clinical record review, and facility document review, the facility failed to implement Quality Assurance and Performance Improvement (QAPI) policy for abuse and failed to implement abuse policy regarding an allegation of abuse and injury of unknown origin for one of 20 residents (Resident #7). The Findings Include: 1. The facility did not communicate or monitor feedback of allegations of abuse during QAPI meetings as directed in the QAPI policy. Review of facility reported incidents indicated that the facility reported an allegation of abuse between a staff member and two residents on 10/2/24. Review of the facility QAPI policy read in part 4. The SNA/designee [skilled nursing administrator] will maintain documentation and demonstrate evidence of its ongoing QAPI program. Documentation may include. but is not limited to: b. Systems and reports demonstrating systematic identification, reporting, investigation,analysis, and prevention of adverse events. [.] The community maintains procedures for feedback,data collection systems, and monitoring, including adverse event monitoring [.] Date sources may include, but not limited to: viii. Reportable events, including reports of adverse events or abuse, neglect, or exploitation. On 11/1/24, review of the facility QAPI meeting minutes conducted on 10/23/24 did not indicate abuse allegations were monitored or discussed during the meeting. On 11/1/24 at 10:50 a.m. the administrator was interviewed regarding the above finding. The administrator reviewed the QAPI meeting minutes and agreed there was no documentation evidencing communication or monitoring of abuse. No there information was provided prior to exit conference on 11/1/24. 41449 For resident #7 (R7) who reported an allegation of abuse, the facility staff failed to implement their abuse policy as evidenced by failure to report the allegation timely to the required regulatory agencies and other agencies, and to initiate an investigation. On 10/29/24 at 10:47 a.m., during an interview with R7 she reported the staff are rough when they help you to stand up or change your diaper. When R7 was asked about the bruising to her right wrist, the resident said, they are very rough. On 10/29/24 at 10:51 a.m., following the above interview with R7, the surveyor was unable to locate the facility administrator to report the allegation. The surveyor then made the acting director of nursing (DON) aware of the allegation. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the evening of 10/29/24, a clinical record review was conducted of R7's chart. There was no documentation with regards to the bruising on the interior of R7's right wrist and the bruising noted. There was a progress note entry dated 10/29/24 at 11:14 a.m., by the DON that read, ADNS [acting director of nursing services] was asked to follow up on resident statement that when she was asked how she got the bruise on her wrist, she stated staff was sometimes rough with her during care. ADNS approached resident in her room; she was observed lying in bed with eyes closed. I asked her how she was feeling and she responded sleepy. When I asked her how she got the bruise on her wrist, she hesitated to answer and said, I don't know . I asked her if she wanted any covers and she said, no. I just want to rest. I ensured bed was in low position, fall mat on floor beside bed, wheelchair in locked position, and call bell within reach prior to leaving the room. Will follow up with resident when she is awake. On 10/30/24 at 11:12 a.m., a follow-up interview was conducted with the DON. When asked about any follow-up with regards to R7 and the allegation reported by the surveyor, the DON said, I think I put a note in, I went in and she had put herself to bed, I was trying to make sure she was centered on the bed better, she is very hard of hearing, I asked if felt ok, she said yes, I asked if she was sleepy she said yes. I asked her, can you tell me how you got that bruise? She said, I don't know, she was very tired and very lethargic, I left it alone, I lowered the bed and put the fall mat down. I went and checked on her later and she was in a meal. I talked to her, she was up this morning, she wasn't answering questions appropriately . During the above interview with the DON, she was asked how they handle abuse allegations. The DON said, we investigate, we ask, we talk to the resident and then talk to whomever it involved and just kind of evidence based, if it was, they were rough with me, we would do a skin assessment as well. The DON asked, was that done for her [R7]? The DON said, yeah, she has had recent skin assessments. I looked at her yesterday and she has had the something there it wasn't anything new. On 10/30/24 at 3:17 p.m., an interview was conducted with the administrator. When asked how they respond to allegations of abuse, the administrator stated, As soon as we are notified, we begin the questioning. When asked, what if the resident doesn't repeat what was reported? The administrator said, I would ask other residents if they had any issues, talk to team members. We can talk to their family and see if they mentioned it to them. When asked if any of this is reported, the administrator said, It should be because it is an allegation of abuse. When asked if she had any abuse reports in process, the administrator said, I do not. The surveyor asked the administrator if she was aware of the allegation reported by the surveyor to the DON involving R7, the administrator said, She [the DON] did say you [the surveyor] had talked to her about an area on [R7's name redacted]'s wrist or hand and she went and talked to [R7] and got a very different answer. I believe she went back and talked to her again and she had no complaints of staff. She brought all that to me. The administrator acknowledged that R7's allegation had not been reported to the required agencies and nothing was in process. On 10/31/24 at 11:30 a.m., the survey team reviewed facility documentation, which indicated R7's report of an allegation of abuse was reported as an injury of unknown origin following the surveyor questioning the facility administrator about reporting the allegation of abuse involving R7 on 10/30/24. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24, following identification of immediate jeopardy in another tag, the facility administrator reported R7's report of staff being rough as an allegation of abuse. Review of the facility's policy titled, Abuse, Neglect & Exploitation- Prevention, Reporting and Investigation was conducted. The policy read in part, . 4. Every team member is a mandated reporter and has the duty to report known or suspected abuse, neglect and/or exploitation to local and state authorities in accordance with applicable law and regulation. a. These authorities may include law enforcement, the licensing regulator, the long-term Care Ombudsman and/or adult protective services. The report of abuse, neglect or exploitation must be made within the time frames and through the format required by applicable law and regulation. b. Allegations of or suspicions of abuse, neglect and/or exploitation are to be reported . On 10/31/24 at 4:30 p.m., when the facility administrator, director of nursing and corporate staff was notified of the failure to implement their abuse policy with regards to R7. On 11/1/24, the survey team was provided evidence that the facility reported R7's allegation of abuse to the appropriate agencies to include the state survey agency and adult protective services. No further information was provided.

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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. 41449 For Resident #7 (R7) who made an allegation of abuse/mistreatment, the facility staff failed to report the abuse allegation to the required agencies timely. On 10/29/24 at 10:47 a.m., during an interview with R7 she reported the staff are rough when they help you to stand up or change your diaper. When R7 was asked about the bruising to her right wrist, the resident said, they are very rough. On 10/29/24 at 10:51 a.m., following the above interview with R7, the surveyor was unable to locate the facility administrator to report the allegation. The surveyor then made the acting director of nursing (DON) aware of the allegation. On the evening of 10/29/24, a clinical record review was conducted of R7's chart. There was no documentation with regards to the bruising on the interior of R7's right wrist and the bruising noted. There was a progress note entry dated 10/29/24 at 11:14 a.m., by the DON that read, ADNS [acting director of nursing services] was asked to follow up on resident statement that when she was asked how she got the bruise on her wrist, she stated staff was sometimes rough with her during care. ADNS approached resident in her room; she was observed lying in bed with eyes closed. I asked her how she was feeling and she responded sleepy. When I asked her how she got the bruise on her wrist, she hesitated to answer and said, I don't know . I asked her if she wanted any covers and she said, no. I just want to rest. I ensured bed was in low position, fall mat on floor beside bed, wheelchair in locked position, and call bell within reach prior to leaving the room. Will follow up with resident when she is awake. On 10/30/24 at 11:12 a.m., a follow-up interview was conducted with the DON. When asked about any follow-up with regards to R7 and the allegation reported by the surveyor, the DON said, I think I put a note in, I went in and she had put herself to bed, I was trying to make sure she was centered on the bed better, she is very hard of hearing, I asked if felt ok, she said yes, I asked if she was sleepy she said yes. I asked her, can you tell me how you got that bruise? She said, I don't know, she was very tired and very lethargic, I left it alone, I lowered the bed and put the fall mat down. I went and checked on her later and she was in a meal. I talked to her, she was up this morning, she wasn't answering questions appropriately, she had a fall again last night, they are talking to hospice to see what else we can do to help her, she sustained a laceration on the back of her head, right wrist had an old bruise that had separated from the skin, asked how she got that and she didn't answer appropriate to the question. She mentioned something off the wall, I don't know what it was. During the above interview with the DON, she was asked how they handle abuse allegations. The DON said, we investigate, we ask, we talk to the resident and then talk to whomever it involved and just kind of evidence based, if it was, they were rough with me, we would do a skin assessment as well. The DON asked, was that done for her [R7]? The DON said, yeah, she has had recent skin assessments. I looked at her yesterday and she has had the something there it wasn't anything new. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24, an additional clinical record review was conducted of R7's medical record. This review revealed a note dated 10/24/24, that was titled, Weekly Skin Check Note. The note read, Multiple bruising noted on face and head. Several staples noted on right side of head. Guest is currently resting in her room with no distress. Another skin check note dated 10/17/24 read, no new areas of concern to skin, has bruising to face from previous fall as well as skin tear with steri- strips to left hand from previous fall, skin otherwise intact, uncooperative with skin checks. There was no mention to a bruise to the interior of the right wrist. On 10/30/24 at 3:17 p.m., an interview was conducted with the administrator. When asked to define abuse, the administrator stated, anything that is physical, allegations of abuse can be physical, if being verbally talked down to or in a negative way. Of course there would be the misappropriation of funds. It is the resident's perception of anything negative that happens to them. When asked how they respond to such allegations, the administrator said, we initially go talk to the resident and ask them to define rough, it depends on their definition of rough. If their definition is rough, we talk to the team member, talk to other residents. Depending on the severity we may suspend them pending investigation. As soon as we are notified, we begin the questioning. When asked, what if the resident doesn't repeat what was reported? The administrator said, I would ask other residents if they had any issues, talk to team members. We can talk to their family and see if they mentioned it to them. When asked if any of this is reported, the administrator said, It should be because it is an allegation of abuse. When asked if she had any abuse reports in process, the administrator said, I do not. The surveyor asked the administrator if she was aware of the allegation reported by the surveyor to the DON involving R7, the administrator said, She [the DON] did say you [the surveyor] had talked to her about an area on [R7's name redacted]'s wrist or hand and she went and talked to [R7] and got a very different answer. I believe she went back and talked to her again and she had no complaints of staff. She brought all that to me. The administrator acknowledged that nothing involving R7 had been reported to the required agencies and nothing was in process. On 10/31/24 at 11:30 a.m., the survey team reviewed facility documentation, which indicated R7's report of an allegation of abuse was reported as an injury of unknown origin following the surveyor questioning the facility administrator, about reporting the allegation of abuse, involving R7 on 10/30/24. On 10/31/24 in the afternoon, following identification of immediate jeopardy in another tag, the facility administrator reported R7's report of staff being rough as an allegation of abuse. Review of the facility's policy titled, Abuse, Neglect & Exploitation- Prevention, Reporting and Investigation was conducted. The policy read in part, . 4. Every team member is a mandated reporter and has the duty to report known or suspected abuse, neglect and/or exploitation to local and state authorities in accordance with applicable law and regulation. a. These authorities may include law enforcement, the licensing regulator, the long-term Care Ombudsman and/or adult protective services. The report of abuse, neglect or exploitation must be made within the time frames and through the format required by applicable law and regulation. b. Allegations of or suspicions of abuse, neglect and/or exploitation are to be reported . On 10/31/24 at 4:30 p.m., when the facility administrator, director of nursing and corporate staff was notified of the failure to report R7's allegation of abuse timely and accurately. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/1/24, the survey team was provided evidence that the facility reported R7's allegation of abuse to the appropriate agencies to include the state survey agency and adult protective services. No further information was provided. 49456 Based on resident interviews, staff interviews, clinical record review, and facility documentation review, the facility staff failed to report an allegation of abuse and injuries of unknown origin involving two residents, Resident #177 (R177) and Resident #7 (R7), in a survey sample of 20 residents. 1. The facility staff failed to report a skin tear to R177's left hand, which was an injury of unknown origin. On 10/31/24 R177 was no longer a resident on the skill nursing unit, she had been discharged , so no interview was able to be conducted with her. On 10/31/24 at 9:15 a.m. an interview was conducted with the administrator. The administrator verbalized that all staff should know to report abuse immediately. The administrator was unable to recall any allegations reported to her pertaining to abuse prior to 10/1/24. The administrator did also state that injuries of unknown origin have to be reported and could be an indication that abuse has occurred. On 10/31/24 at 11:13 a.m. an interview was conducted with a staff member who expressed a desire to remain anonymous. The anonymous staff (AS1) verbalized that she was called into R177's room by certified nursing assistant, CNA1. AS1 stated, I reported an incident with a resident to the Administrator, the resident had two skin tears to her left extremity. AS1 then stated, the skin tears were new. AS1 said, [CNA1's name redacted] said to the resident, I don't want to hear that apology, and the resident began to cry. On 10/31/24 at 2:20 p.m. an interview was conducted with LPN1. LPN1 verbalized that when there was an allegation of abuse made, that they find out who was abusing them, would separate them, and if a staff member was the abuser, they would send the staff member home. LPN1 stated, I would report it to the administrator, or the acting director of nursing and that the administrator was the abuse coordinator. On 10/31/24 at 2:28 an interview was conducted with CNA#3 (CNA3). CNA3 verbalized that if she needed to report abuse that she would report to the charge nurse and to the administrator. CNA3 verbalized that if the administrator is not in the building that she would report it to the acting director of nursing. On 10/31/24 at 2:26 p.m. an interview was conducted with LPN1. LPN1 verbalized that when an incident was reported that you ask the staff and resident what happened, notify the family and doctor, put the incident in the risk connect, obtain an order for treatment, treat the area, and do a health note in the clinical record. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 2:51 p.m. an interview was conducted with the administrator and with the regional director of resident care. The administrator stated, we do our incidents in a separate portal, and it is not like a incident report. The regional director of resident care stated, we review all our incidents, falls, behaviors, medication errors, pressure ulcers and skin tears. The administrator verbalized that the incidents cannot be printed out from this portal. The regional director of resident care verbalized that we follow a process, and it is managed by our legal team. She stated, The legal team is our second QAPI [quality assurance and performance improvement] and monitor to make sure we do everything. The surveyor then requested proof of an investigation being conducted for the skin tear on R177's left hand. On 10/31/24 an employee that wanted to remain anonymous showed the surveyor a text message that was sent to the administrator on 7/28/24 and the text message read, I really need to talk to you. The employee stated, I reported the incident of [R177's name redacted] skin tears and of her complaining that CNA1 was rough with her. The employee stated that the administrator response was, to be careful of what you are saying and accusing people of. The employee then stated, I never heard anything else about the incident and assumed nothing was done. On 10/31/24 at approximately 3:00 p.m. a clinical record review was completed. On 7/23/24 a weekly skin check note was completed and had no mention of any skin tears to R177's left hand or elbow. On 7/28/24 an order for treatment was completed. The order read, clean skin tear to left elbow and left hand with normal saline pat dry apply border gauze until healed. On 7/28/24 a skilled note was written and there was no mention of an incident with the skin tears. On 7/30/24 a weekly skin note was completed by RN1, and it read in part, .skin tear to left hand steri strips applied and foam dressing applied. On 7/30/24 a doctor's progress note was written. The doctor's note read in part, .the skin tear on the left elbow happened by rubbing on the arm of the wheelchair . The note did not mention the skin tear to the left hand. On 11/1/24 at 10:00 a.m. an interview was conducted with the administrator. The administrator verbalized that she was never made aware of the allegation of abuse that happened on 7/28/24. The administrator stated, No one called me and made me aware. The general manager was manager on duty that day. Staff will contact me when I am not the manager on duty. On 11/1/24 at 10:37 a.m. an interview was conducted with LPN#3 (LPN3). LPN3 stated, If an allegation of abuse needed to be reported I would report it to the administrator, acting director of nursing and the social worker. If it is a weekend when they are off, I would call or text them to report it to them. On 10/31/24 and 11/1/24 a request was made by the surveyor for the facility to provide evidence that an investigation was conducted for the skin tear that R177 obtained. On 11/1/24, mid-morning, the surveyor had not received any information, so another request for it was made to the administrator. Upon departure of the facility, no evidence of an investigation was provided to the surveyor. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 a facility document was reviewed. The facility documentation was titled, Abuse, Neglect, and Exploitation-Prevention, Reporting and Investigation, read in part, Duty to report. Every team member is a mandated reporter and has a duty to report known or suspected abuse, neglect, and/or exploitation to local and state authorities in accordance with applicable law and regulation. a) these authorities may include law enforcement, the licensing regulator, the ling term care ombudsman, and/or adult protective services. The report of abuse, neglect or exploitation must be made within the timeframes and through the format required by applicable law and regulation. b) allegations of or suspicions of abuse, neglect and/or exploitation are to be reported. On 11/01/24 at approximately 1:45 p.m. an end of day meeting was conducted with the administrator, the acting director of nursing, the general manager and the social worker. The above concerns were discussed. No additional information was provided.

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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** 49456 Based on resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to complete a thorough investigation for an allegation of abuse for three residents, Resident #5 (R5), Resident #20 (R20), and Resident #177 (R177), in a survey sample of 20 residents. The findings included: 1. For R5 and R20 who reported an allegation of abuse, the facility staff failed to provide evidence that a thorough investigation to include interviews with other residents to determine if they may have been affected. According to the personnel records, the alleged perpetrator was terminated for abuse, but the facility administrator noted that the allegation of abuse was unsubstantiated. Following the abuse report, some facility staff were educated on customer service. On 10/29/24, a clinical record review was conducted of R5's chart, which noted the resident had discharged and was no longer a resident of the facility. Therefore, an interview could not be conducted with R5. On 10/29/24 at 9:08 a.m., an interview was conducted with R20. R20 said, [Certified nursing assistant #1's name redacted] treated me like slapping the pigs. I reported it to the social worker and talked with her about it. R20 said, The aide was rough with me and I didn't like it. R20 stated she was at the facility until her leg heals and she can get back to her home. R20 stated they [facility staff] were responsive to her concern, and she never saw CNA1 again after the incident. R20 said, I am limited to what I can do due to my broken leg. On 10/30/24 at 11:00 a.m., an interview was conducted with the social service director (SSD). The SSD stated she had interviewed R5 and R20, who were roommates. SSD stated that R20 had stated that CNA1 was rough with her during daily care and in the shower room. The SSD stated that R5's complaint was that CNA1 was being rough with her during morning care and in applying her brace. The SSD said, [R5's name redacted] and [R20's name redacted] verbalized that they were not scared or nervous, just didn't want [CNA1's name redacted] as an aide anymore. The SSD said, More residents complained about this aide over time, but not that specific day. On 10/30/24 at 11:15 a.m., an interview was conducted with the acting director of nursing (DON). The acting DON stated that she was not involved in the interview process with the residents. The acting DON stated that she completed a skin assessment on R5 and R20 and found no changes with their skin assessments. When asked about other residents to whom CNA1 had provided care, the acting DON stated that she only did skin checks on those two residents on the nursing unit. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 2:50 p.m. an interview was conducted with the administrator. When asked about the abuse allegations against CNA1, the administrator stated that an employee from third shift had reported the abuse allegation to her as soon as she entered the building on 10/1/24, adding that she arrives to work between 8:00 a.m. to 8:15 a.m. every morning. The administrator stated that she could not recall the identity of the third shift staff member that reported the allegation of abuse to her. The administrator stated, It was such an ordeal with CNA1. She was calling me all kinds of names. The administrator stated that she discussed the allegation of abuse with the administrative staff, so they would know what happened, and then sent CNA1 home, pending the results of the abuse investigation. The administrator that stated she had the acting DON to do skin checks on the two residents, provide education to staff, and had the SSD talk with R5 and R20 about the incident. On 10/31/24 at 8:40 a.m., another interview was conducted with the SSD. The SSD stated that she documented her interviews with R5 and R20 in a word document but was unable to locate the document. The SSD stated she was unable to recall the names of the other residents that had complained about CNA1, but that the residents were on the same hallway as R5 and R20. The SSD said, [Administrator name redacted] asked me to interview the other residents who had complaints about [CNA1's name redacted] being rough with them with care. The SSD stated that she reported the interviews to the administrator, and that she was unaware of what was done about those additional complaints. The SSD stated that the complaints and interviews with other residents were performed prior to the complaints received from R5 and R20's. The SSD was unable to recall who the residents were that had complained about CNA1 and had no evidence of the interviews she conducted with them nor any record of their concerns. On 10/31/24 at 9:15 a.m., an interview with the administrator was conducted. Providing requested facility documentation, the administrator said, Not all nursing staff is on this in-service; we are missing two part-time college students and some from the third shift that's not on this education. The administrator stated that after she came into work on 10/1/24, a dayshift aide, CNA#7 (CNA7) approached her and reported the allegation of abuse. The administrator stated CNA7 was a new aide and was scared and tearful over the incident. The administrator stated that CNA7 came to her after breakfast to report the allegation of abuse. The administrator stated that she discussed the allegation with her supervisor and then CNA1 was pulled off the nursing unit. CNA1's timecard was reviewed and showed that CNA1 clocked out of the facility at 10:45 a.m. on 10/1/24. The administrator said, [CNA1's name redacted] could be abrupt with communication when she is upset. [CNA1's name redacted] was terminated for her behavior toward us [staff/administration]. When [CNA1's name redacted] was leaving, she was disruptive in the hallway on the nursing unit and in front of the residents. On 10/31/24 at 11:30 a.m., an interview was conducted with the MDS (minimum data set) coordinator, who was a registered nurse. The MDS coordinator had written a witness statement on 10/1/24 that read, While reviewing baseline care plan with resident, [R5's name redacted] on 9/30/24, she told me that her nurse's aide that morning had been rough with her. She stated that while putting her TLSO (thoracic-lumbar-sacral orthosis) brace on, she was rough. When asked, the MDS coordinator identified the CNA as being CNA1. The MDS coordinator said, I told her I would talk to the person who supervises the CNAs about it, and she expressed fear of retribution from the CNA. I assured her that she was safe. The MDS coordinator stated that she reported this to the administrator on 9/30/24. No report was made for R5 and R20's allegation of abuse until 10/1/24 at 3:34 p.m. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonnades Health Care Center	100 Colonnades Hill Drive Charlottesville, VA 22901

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 5:00 p.m., a follow-up interview was conducted with R20. R20 said, Early morning, I like to go out and watch things come to life and [CNA1's name redacted] came out stood by me just looking at me and never spoke to me. I did feel intimidated by her. Then R20 said, During the bed bath [CNA1's name redacted] took a washcloth and slapped me, like you would take a mop and sling it down. I have dogs and would not wash them like that. Then R20 said, When she hit me with this washcloth, I felt I wasn't human, subhuman, and I cannot understand anyone doing this to someone! This verbiage, you can tell, is coming from a teacher. R20 stated that the acting DON did complete a skin assessment and found two small bruises on her legs and back. Then R20 said, I cried and was trying to catch my breath. I was appalled that someone would be that way. The social worker let me talk. I reported it and thought it would end there, but the social worker said no. I wish the aide still had a job but not with humans. I cried when I told the social worker the story and didn't see any reason for this, over a bath. It was like a nightmare. On 10/31/24, a review of facility documentation was conducted. The incident summary of these allegations of abuse perpetrated by CNA1 read in part, .based on the assessments and investigation, the allegations were unsubstantiated. On 10/31/24, a review of witness statements in CNA1's personnel file about the allegations of abuse was conducted. The first witness statement was from CNA7. Dated 10/1/24, CNA7's witness statement read in part, .this morning two residents stated to me that [CNA1's name redacted] has been very rough and hurting them during her care. The two residents were [R20's name redacted] and [R5's name redacted]. I brought [R5's name redacted] to the dining table for breakfast she was trying to talk to me about [CNA1's name redacted] and [CNA1 name redacted] said to the resident, Do you have something you need to say to me, in a smart tone. The second witness statement was written by the administrator on 10/1/24 and read in part, .This writer had to suspend [CNA1's name redacted], pending an investigation after complaints from 2 separate residents regarding her care for them. The SSD also wrote a witness statement, which read, This writer spoke with [R5's name redacted] and [R20's name redacted]. [R5's name redacted] reported that [CNA1 name redacted] was 'rough' with her during morning care yesterday morning. She had to have a brace on while lying down and [CNA1's name redacted] wouldn't put it on, getting her dressed instead and was rough with her. [R20's name redacted] reported that [CNA1's name redacted] was rough with her during shower care, . not gentle, slapping the washcloth on her and she felt intimidated by her standing there. On 10/31/24, CNA1's personnel file was reviewed. The facility document titled, Performance Counseling and Improvement Plan for Correction Action, read in part, .Termination Written. Reason for Counseling 1. Policy/company rules not followed: Abuse or neglect of a resident, Date and Time: [DATE]. 2. Policy/company rules not followed: Failure to work in a cooperative manner. Date and Time: 9/26/24 . This document was signed by the administrator, the general manager, and a witness on 10/7/24. On 11/1/24 at 9:09 a.m., another interview was conducted with the SSD. The SSD said, The resident [R20] was tearful when telling me the story about what happened with the aide. The SSD stated that she never asked R20 how the actions from CNA1 made her feel. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/1/14 at 10:28 a.m., an interview was conducted with a physical therapist. The physical therapist said, [R5's name redacted] was more subjective and was guarded with her language. She [R5] stated to me that her roommate was upset about being struck in the shower, which indicated physical contact to me. The physical therapist stated that she questioned R5 about R20 striking the aide and R5 stated no, it was the other way around, the aide struck her. The physical therapist said, I told [R5's name redacted] I needed to report this to my supervisor, and she may want to speak with you to get your feedback. 2. The facility staff failed to investigate an injury of unknown origin for R177's skin tear to her left hand. On 10/31/24 at 11:13 a.m., an interview was conducted with a staff member who expressed a desire to remain anonymous. The anonymous staff (AS1) verbalized that she was called into R177's room by certified nursing assistant, CNA1. AS1 stated, I reported an incident with a resident to the Administrator, the resident had two skin tears to her left extremity. AS1 then stated, The skin tears were new. AS1 said, [CNA1's name redacted] said to the resident, I don't want to hear that apology, and the resident began to cry. On 10/31/24 at approximately 3:00 p.m., a closed record review was conducted. Documentation included a physician's order for R177, dated 7/28/24, for treatment which read, Clean skin tear to left elbow and left hand with normal saline pat dry apply border gauze until healed. Also dated 7/28/24, a skilled nursing note was documented, but there was no mention of an incident or the skin tears that R177 had suffered. Documented on 7/30/24, a weekly skin note was completed by RN1 and read in part, .skin tear to left hand steri strips applied and foam dressing applied. Dated 7/30/24, a doctor's progress note read in part, the skin tear on the left elbow happened by rubbing on the arm of the wheelchair. The note did not mention the skin tear to the left hand. On 10/31/24, an employee (AS1) that wanted to remain anonymous showed the surveyor a text message that was sent to the administrator on 7/28/24, which read, I really need to talk to you. AS1 stated, I reported the incident of [R177's name redacted] skin tears and of her complaining that CNA1 was rough with her. AS1 stated that the administrator's response was to be careful of what you are saying and accusing people of. AS1 then stated, I never heard anything else about the incident and assumed nothing was done. On 10/31/24, a request was made for the facility to provide evidence of an investigation for the skin tears that R177 had suffered, or how the facility determined it had been caused. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24, a review of facility documentation was conducted. The facility document titled, Abuse, Neglect and Exploitation - Prevention, Reporting and Investigation, read in part, .Protecting the resident. In addition, to initial Mandatory reporting, to ensure the safety and protection of residents, any team member who know of or suspect abuse, neglect or exploitation of a resident must also immediately notify the ED/SNA/designee. The SNA/designee: a) upon receiving notification of any known or suspected abuse, neglect, or exploitation of a resident contacts the licensed nurse who evaluates the resident and provides the necessary intervention, for example, calls 911 if emergent. b) Removes the individual alleged to be involved in the abuse, neglect or exploitation from the area. i. ensure that any team member alleged to be involved in the abuse, neglect or exploitation is placed on administrative leave, pending the results of the investigation. ii. Ensures that non-team members alleged to be involved in the abuse, neglect or exploitation will be asked to leave the resident area and await further instructions. c) ensures that the resident's (i) physician, (ii) legal representative and (iii) family member or other individual regularly involved in the residents day to day care are notified as soon as practicable within timeframes established within laws/regulations .Investigation: The SNA/designee: Validates that the mandatory report of known or suspected abuse, neglect or exploitation has been made to the applicable authorities in accordance with state/federal requirements. The SNA/designee manage and directs the investigation of all abuse, neglect and/or exploitation. The SNA/designee implements corrective actions as indicated by the results of the investigation. If a written report of the investigation findings is required by applicable law or regulation, the SNA completes such report and ensures that it is submitted timely. On the morning of 11/1/24, the evidence was again requested from the administrator to indicate that that an abuse investigation had been conducted or that the cause of R177's multiple injuries had been determined, but no documentation of either was provided. On 11/01/24 at approximately 1:45 p.m., an end of day meeting was conducted with the administrator, the acting director of nursing, the general manager, and the social worker, during which the above concerns were discussed. No additional information was provided prior to survey exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41449 Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to adequately develop a comprehensive care plan to address the behavioral health care needs for one resident (Resident #7 - R7), in a survey sample of 20 residents. The findings included: For R7, who had a diagnosis of dementia, had documented behaviors, and was given psychotropic medications on a scheduled/routine basis, the facility staff failed to develop a comprehensive care plan to include the routine use of psychotropic medication with the targeted behaviors being treated, as well as how facility staff were to provide routine care in the presence of behaviors. On 10/29/24 at 10:47 a.m., R7 was visited and interviewed in her room. R7 was noted to be very hard of hearing but was able to engage in conversation and interview appropriately. R7 displayed no behaviors during the interview. On 10/29/24-10/30/24, a clinical record review was conducted. This review revealed that R7 had a diagnosis of dementia and an active order, that read, Haloperidol Lactate Oral Concentrate, give 0.5 mg by mouth two times a day for restlessness. Prior to that order, documentation indicated that R7 had the Haloperidol ordered to be given every 4 hours as needed for anxiety. According to R7's comprehensive care plan, there was a focused care area that was developed 8/2/24 and last revised on 9/3/24, which indicated R7 was on a psychotropic medication, but there was no indication for the reason the psychotropic medication was being used, nor for what behaviors or side effects that staff should be monitoring. Neither did the care plan include measurable goals or projected reduction/endpoint for the psychotropic medication. The only care area of R7's care plan noting behaviors was labeled as an elopement risk/wanderer that read, The resident is/has potential to be verbally aggressive, verbally refusing care, calling staff names stupid r/t [related to] dementia. The two interventions listed for this focus areas read as Wonder guard to left ankle and Offer resident choice during care and activities. (SIC) This comprehensive care plan did not include any clear documentation of R7's behaviors that required management by psychotropic medication, nor were any non-pharmocological interventions listed on how staff were to approach and provide daily care in the presence of behaviors. On 10/31/24 at 6:13 p.m., an interview was conducted with the acting director of nursing (DON). When asked about the targeted behaviors for R7, the acting DON stated that staff should be monitoring for behaviors and documenting as such. On 10/31/24 at 7:31 p.m., another interview was conducted with the acting DON. When again asked about R7's behaviors, the acting DON stated that R7 had agitation and aggression. She stated that R7's behaviors included, Hallucinations, delusions, and she is always bending down in the wheelchair. She [R7] is almost blind and doesn't see very well. She will say where did my husband go, he was right here. She is normally very calm, but she was pushing away the aide trying to deliver care; very unusual behavior. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility policy titled, Individualized Care Plan which read in part, . 4. The IDT [interdisciplinary team] develops comprehensive care plan addressing the resident's most acute problems. The comprehensive care plan will include a. services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing . d. Support the behavioral health care needs, identified in the comprehensive assessment . On 11/1/24, during an end of day meeting, the facility administrator and other management staff in attendance, were made aware of the above findings. No additional information was provided prior to the conclusion of the survey.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on resident interview, staff interview, and clinical record review, the facility staff failed to follow professional standards of nursing practice for one resident (Resident #102-R102) in a survey sample of nine residents. The findings included: For R102 the facility nursing staff failed to clarify a physician order for insulin, where the number of units to be administered had two different values within the administration directions. On 1/7/25, during a clinical record review, it was noted that R102 was admitted to the facility on [DATE], following an acute care hospitalization . Discharge orders from the hospital indicated that R102 was to receive Tresiba FlexTouch U-100, 100 unit/mL (3 mL) Insulin Pen. This medication order read, Inject 86 units beneath the skin every night at bedtime. R102's admission orders which were signed by the attending physician and medical director of this facility on 1/3/25, indicated that the 86 units of Tresiba were to be given nightly at bedtime. According to R102's medication administration record (MAR), Lantus Solostar was being administered at 88 units nightly at bedtime, since 1/3/25. Review of R102's paper clinical record revealed a faxed paper from the pharmacy, received on 1/3/25 at 11:23 a.m., that indicated a therapeutic interchange was being recommended and had a note that read, Please adjust your MAR for an approved therapeutic interchange to Lantus Solostar 86 units at bedtime. On the afternoon of 1/7/25, an interview was conducted with the Assistant Director of Nursing Services (ADNS). The above findings were brought to her attention. The ADNS stated that the therapeutic interchange orders switching medicaions are entered into the electronic health record of residents by the pharmacy. No explanation was provided as to why this discrepancy was not questioned. On 1/7/25 at approximately 3 p.m., during a meeting with the facility's interim administrator, interim director of nursing, and general manager were made aware of the above concerns regarding the discrepancy of R102's insulin orders. On 1/8/25 at 8:15 a.m., an interview was conducted with the attending physician/medical director (MD). The doctor was shown the above information regarding R102's discharge orders from the hospital, signed admission orders to this facility, and faxed paper in the clinical record for the therapeutic interchange from Tresiba to Lantus. The MD confirmed that the dosage should have been 86 units and not 88 units. The doctor went on to state that when given at such large doses the difference of a few units doesn't pose a significant risk to the resident and noted that R102's blood sugars have not been adversely affected as a result. On 1/8/25, in the afternoon, a telephone interview was conducted with a pharmacist and pharmacy manager with the facility's contracted pharmacy. The pharmacist confirmed that the interchange for this medication would not have changed the dosage and that 88 units was a typographical error on the pharmacy's part. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at approximately 2:40 p.m., R102 was visited in his room. When asked about the insulin, R102 was able to indicate he receives insulin but was unsure of the exact dosing and stated that his wife manages his medications. On 1/9/25, at approximately 9:30 a.m., licensed practical nurse #2 (LPN #2) was asked to show the surveyor the medication administration record information on the computer that the nurse would see when the medication is being administered. According to the medication administration record information available to the nurse, it read, Lantus Solostar 100 unit/ml. Inject 88 unit subcutaneously at bedtime for dm2 [type 2 diabetes]. Dispensed supply: Lantus Solostar 100 unit/ml. Inject 86 units sub-q at bedtime for diabetes mellites. LPN #2 read the order and was asked what she would give if this medication was due on her shift. LPN #2 stated, The order has two different things. I would have to call the doctor to get clarification before I administer anything. On 1/9/25, in the afternoon, during a meeting with the facility administrator and director of nursing the above was again discussed and both confirmed that the nurses should have followed professional nursing standards and clarified the insulin order prior to administering the injections. According to the Lippincott Manual of Nursing Practice, Eighth Edition, on page18, it noted Common Legal Claims for Departure from Standards of Care. This section read in part, .Following medical orders which should not have been followed such as medication dosage errors. Failure to act as a patient advocate, such as not questioning illegible or incomplete medical orders . No additional information was provided.

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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. 28106 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to follow physician orders for two of twenty residents in the survey sample (Residents #14 and #26). The findings include: 1. License practical nurse (LPN #2) pulled one vitamin D3 25 mcg (micrograms) for Resident #14 (R14) when the physician's order required two tablets of vitamin D3 mcg. A medication pass observations was conducted on 10/30/24 at 8:20 a.m. with LPN #2 administering medications to R14. Among the medications administered was one tablet of vitamin D3 25 mcg. The label of the medication was reviewed and indicated R14 was to receive two vitamin D3 25 mcg tablets. LPN #2 continued to pull medications for R14 and place them into a medication cup. LPN #2 then put all medications cards back into the cart, closed and locked the cart and started to step away from the cart to distribute the medications in the cup. LPN #2 was questioned regarding the vitamin D3. LPN #2 observed one vitamin D3 in the cup then reviewed the physicians order and verbalized not realizing R14 was ordered two vitamin D3 tablets. R14's clinical record documented a physician's order dated 9/17/24 for vitamin D3 25 mcg with instructions to give two tablets daily. This finding was reviewed with the administrator, director of nursing and regional nurse consultants during a meeting on 10/30/24 at 5:01 p.m. with no further information presented prior to the end of the survey. 41449 For Resident #26 (R26), the facility staff failed to carry out physician orders and administer medications in accordance with physician orders. On 10/29/24, a closed record review was conducted of R26's clinical record. The record included a physician progress note dated 11/20/23, that read, Brief Update: Met with patient's daughter who requested home medications be restarted: Tramadol 50mg q6h prn [every 6 hours as needed], KDUR 20meq BID [twice a day], Fibercon BID, and nighttime O2 [oxygen]. Plan to start as requested. On 10/30/24 at 8:18 a.m., an interview was conducted with the physician and medical director, who was the author of the note dated 11/20/23, referenced above. When asked about the process that he gives/writes orders, the physician explained that he doesn't have the ability to enter orders into the electronic health record at this facility like he does at other facilities, so he writes the orders on an order sheet, puts it in the chart, and flags it for the nurses. The doctor was shown the progress note in R26's chart that was written on 11/20/23 and asked what his intention was. The physician said, When I put in a brief update note, that is my reminder to do the orders. Usually I do orders the same day, but at times I will wait on labs or cultures before giving orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24, a review of R26's closed paper chart was conducted. Included was a physician order dated 11/20/23, that read, Tramadol 50 mg q 6 prn, KDur 20 meq q d [every day], Fibercon 2-tab BID [twice a day], no orange juice per daughter. According to the medication administration record and physician orders for R26, the Tramadol order was never carried out, therefore was not available for administration if needed. The order for KDur was replaced with Klor-Con, which was not started until 12/13/23. The order for Fibercon was replaced with Metamucil and that did not start until 11/30/23. On 10/30/24 at 5:01 p.m., during an end of day meeting held with the facility administrator and director of nursing, the above concerns were shared. They were given copies of the physician order dated 11/20/23, as noted above and asked to see if they could determine why the orders were not implemented and initiated timely. On 10/31/24 at 7:24 p.m., a meeting was held with the director of nursing (DON). When asked if she had found out any information with regards to the R26's delayed medication orders, the DON stated that she had been the nurse that signed the order and said, He [the doctor] may have told me to wait and hold off for him to review lab work because labs indicated she didn't need it. When asked if there was any indication of this conversation or if labs were drawn, the DON said that she had nothing to provide. When asked to provide the facility policy regarding physician orders, the facility administrator reported to the survey team that they had no such policy. No further information was provided prior to conclusion of the survey.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 41449 Based on observation, resident interview, staff interviews, clinical record review, and facility documentation review, the facility staff failed to ensure the environment was free of accident hazards and failed to assess residents to determine who was at risk, having the potential to affect multiple residents on one of one nursing units. Two residents (Resident #105 and Resident #109) spilled coffee onto their lap, which resulted in R105 requiring first aide intervention, which constituted harm. Immediate Jeopardy (IJ) and substandard care was identified. Once IJ was abated, the scope and severity was lowered to a level three, isolated. The findings included: For all of the residents residing on the one nursing unit in the facility, the facility staff had not assessed the residents ability to manage hot liquids, when hot coffee was available and accessible to residents in the lobby, and the facility failed to maintain a consistent system in place to monitor temperatures of hot liquids being served in the dining room, which resulted in two residents spilling coffee and one resident (Resident #105) sustaining redness that required first aide treatment. On 1/7/25 at 2:30 p.m., during a review of facility documentation, it was noted that on 12/22/24, Resident #105 (R105) spilled hot coffee onto her lap, which required medical treatment to include first aide (application of cold compress). According to the nursing note dated 12/22/24 at 12:37 p.m., it read, It was reported to writer that patient spilled hot coffee on her lap during lunch. Assessed guest skin and redness noted to thighs. Cold compress applied. Resident denies pain/discomfort when asked. Resident's son [name redacted] notified and Dr. [physician's name redacted] is made aware. Will continue to assess patient for any blister s/sx [signs and symptoms] of skin irritation. Patient is now to have cup with lid for all meals. According to R105's physician orders, the physician ordered occupational therapy to evaluate for upper extremity strengthening. On 12/24/24, occupational therapy (OT) initiated therapy for R105 to work on self-feeding and alternate cup options. According to a dietary employee (Other Employee #2-OE2), the dietary manager (Other Employee #6-OE6) and a registered nurse (RN #3), R105 had been previously identified with issues/concerns in her ability to feed herself. According to the dietary manager/OE6 and R105's clinical record, the previously identified concern prompted on 8/10/24, a physician order that R105 was to have light weight mugs at meals. On 1/7/25 at 2:40 p.m., an observation was conducted of the kitchenette where the coffee is prepared. The dietary aide (other employee #1- OE1) said that the coffee temperature is checked once it's prepared, but they let the coffee sit and cool down before serving it. The dietary aide also stated that sometimes ice must be added, prior to serving. As requested, the dietary aide measured the temperature of the coffee from the dispensing machine, and it was observed that the temperature measured 173 degrees Fahrenheit. The dietary aide then said that the service technician had just come and turned it down, as it previously was around 179 degrees. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER Colonnades Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Colonnades Hill Drive Charlottesville, VA 22901	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	According to the meal service temperature logs from 12/30/24-1/7/25, there were multiple omissions that demonstrated that the temperature of the hot liquids was not recorded during each meal. When questioned about the prior temperature logs on 1/8/25, the dietary manager and dining director stated that the prior monitoring form did not include beverages, and they had not been recording or monitoring the temperature of hot liquids. On 1/8/25, approximately 8:15 am, an interview with a licensed practical nurse (LPN #2), it was identified that Resident #109 had also had an incident where she spilled coffee. Review of the clinical record revealed that on 12/27/24, R109 spilled lukewarm coffee into her lap and sustained no injury. On 1/8/25, interviews were conducted with LPN #2 and a certified nursing assistant (CNA #1), both of whom stated that if residents want coffee between meals, they obtain it from the lobby coffee station. On 1/8/25 at approximately 8:50 a.m., the dietary manager measured the temperature of the coffee in the lobby, which was noted to be 156 degrees Fahrenheit. On 1/8/25 at 3:20 p.m., an interview was conducted with two dietary staff (OE#1 and OE #2). Both of whom stated when they arrive, they obtain coffee from the coffee machine, fill the coffee dispensers, and take them to the front lobby around 7:30 a.m. Both dietary staff stated that they do not take the temperature of the coffee that is placed in the lobby, and it is not cooled down prior to placing in the lobby. At this time, the temperature of the coffee was again obtained, directly from the coffee machine as it would be put into the dispensers in the lobby and was measured at 165 degrees Fahrenheit. Both the dietary aides and dietary managers confirmed that the repair technician was onsite and had decreased the temperature of the machine on 1/7/25. On the afternoon of 1/8/25, an interview was conducted with the facility's interim administrator, interim Director of Nursing (DON), and general manager, to identify the facility response to the spilled coffee incidents. The facility DON reported that they had initiated a PIP (performance improvement plan) which included that all residents with a BIMs (brief interview for mental status score) of 12 or less, and those who are visually impaired, were evaluated by therapy for hot liquids and were actively working to develop an assessment tool to be used to assess resident's ability to safely manage hot liquids. The DON stated that the PIP was still in process and had not been completed. On 1/8/25, in the afternoon, an interview was conducted with the therapy director (Other Employee #9- OE #9). As of 1/8/25, there were three residents with a BIMs of 12 or less, that had not yet been evaluated for their ability to handle hot liquids safely. There was no evidence that the facility made any attempt to identify residents at risk with causative factors, other than cognitive or visual impairments, were evaluated for their ability to manage hot liquids safely. On 1/8/25 at 5:15 p.m., Immediate Jeopardy was identified and was noted to have begun on 12/22/2024, when R105 spilled her coffee, and first aid had to be provided. A meeting was held with the facility's interim administrator, interim director of nursing, and general manager to notify of the immediate jeopardy. On 1/8/25 at 7:40 p.m., the facility submitted an accepted IJ removal plan. The plan read as follows: Residents #105 and #109 were assessed for hot liquid safety and referred to Occupational Therapy. On 1/8/25 the Director of Nursing will conduct an assessment of all current residents for accident hazards such as risk of burns from hot liquids. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Residents identified at risk; nursing will initiate a care plan with interventions to mitigate hazards such as risk of burns from hot liquids. Residents identified at risk will be evaluated by occupational therapy. Director of Nursing will educate all current team members on hazards such as the risk of burns from hot liquids and appropriate serving temperature prior to being permitted to work. Dietary manager will educate dietary team members on the importance of completing and documenting temperatures on hot liquids during each meal prior to being permitted to work. New admissions will be assessed for hazards such as risk of burns from hot liquids, with interventions initiated and a referral to occupational therapy. Hot beverage station located at the concierge's desk will be removed. Any concerns identified will be addressed as per our policy and procedures. Completion Date: 1/9/25 11:00 a.m. On 1/9/25 at 11:05 a.m., interviews were conducted with both certified nursing assistants (CNA #1 and CNA #2) working, the licensed practical nurse (LPN #2), a registered nurse (RN #3), the activity assistant, a housekeeper, the medical records employee, two therapy staff, and the two dietary employees. Each of the employees were able to verify they had received education and were able to answer questions with regards to the serving temperature of hot liquids, how to obtain coffee for a resident outside of mealtimes, and how to know what precautions had to be taken for residents identified to be at risk for burns from hot liquids. The two nurses were also able to verbalize knowledge of when and how the assessment of residents with regards to hot liquids would be completed. An audit was conducted which included comparison of the daily census, to ensure that 100% of residents had been screened/assessed for the risk of injury from hot liquids. The care plan was reviewed for the eleven residents identified to be at risk to ensure interventions had been implemented in the care plan. The therapy evaluation for each of the eleven residents noted to be at risk was reviewed to ensure that therapy had assessed the residents. The staff education was reviewed and the sign in sheet was compared to the as worked schedule to ensure that all staff were trained. Interviews were conducted with various staff to confirm they received education and had knowledge of the risks, interventions, etc. The education for the dietary staff was reviewed and compared to the as worked schedule to ensure that the dietary staff working had been educated. The temperature logs for breakfast were reviewed to ensure that that temperatures had been taken and were noted to be in the facility's acceptable serving range of 140-155 degrees Farenheight. The dietary staff were then interviewed to confirm receipt of the education and to verify their knowledge of the risk, importance of ensuring appropriate temperatures and the interventions for residents identified to be at risk. The census was reviewed to identify if any new admissions had been admitted since IJ was identified. No admissions had been received at the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/9/25 at 12:10 p.m., observations were conducted in the kitchenette. Dietary staff were observed to obtain the temperature of all food items to include hot water and coffee. All temperatures were verified by the surveyor to ensure they were within appropriate serving temperature. Observations were conducted of the entire meal delivery to residents in the dining room. It was noted that none of the residents in the dining room received any hot liquids. The meal set-up and delivery of meals to residents eating in their rooms was observed. It was noted that Resident #106 (R106) was served hot coffee in a disposable cup with a lid. According to R106's meal ticket which was on the tray and accompanied the food into the resident's room was observed and was noted to read, . Preferences: Handled cup & lid for hot [NAME] [beverage] . At 1:30 p. m., R106 was served the meal which included the coffee in the disposable cup. The surveyor then returned to the Administrator's office, reviewed R106's hot liquid assessment which indicated that the resident was at risk and the care plan intervention read, Handled cup with lid for hot beverages. The facility administrator and director of nursing services (DON) were asked to accompany the surveyor to R106's room. The surveyor notified them of the observations and findings. The DON then entered R106's room and confirmed the observation. The facility administrator and DON were made aware at 1:40 p.m., they had been unable to abate IJ. The facility then presented the surveyor with notification that they had re-educated all the staff and were ready for the surveyor to attempt to verify IJ removal as of 3 p.m. on 1/9/25. On 1/9/25 at the evening meal, observations were again made. The observations included dietary staff obtaining temperatures of the foods and hot liquids and verification that they were within appropriate temperature for service. The dietary staff were observed to record the temperatures obtained. Meal service/delivery to residents was observed. One resident, R106 received coffee at the meal, and it was served in a mug with a handle and a lid. IJ was abated at 5:40 p.m. on 1/9/25, and the scope and severity was lowered to a level three, isolated. No additional information was provided.

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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. 28106 Based on staff interview, clinical record review, and facility document review, the facility staff failed to implement non-pharmacological interventions for pain for one of twenty residents in the survey sample (Residents #14, R14). The findings include: Diagnoses for R14 included; post surgical hip repair, chronic kidney disease, major depression, and chronic pain. The most current MDS (minimum data set) was a five day assessment with an ARD (assessment reference date) of 9/22/24. R14 was assessed with a cognitive score of 12 out of 15, indicating cognitively intact. Review of Physician orders indicated an order dated 9/16/24 for Oxycodone 10 mg [milligrams] give 2 tablets by mouth every 6 hours for severe pain. Review of R14's medication administration record (MAR) for September and October 2024 indicated R14 received Oxycodone on 9/19/24, 9/28/24, and 10/10/24. Review of R14's progress notes surrounding the dates Oxycodone was given were reviewed and did not indicate non-pharmacological interventions were performed. On 10/31/24 at 6:12 PM the director of nursing (DON) was interviewed regarding using non-pharmacological interventions prior to administering pain medication. The DON verbalized that staff should be using and documenting non-pharmacological interventions prior to giving pain medication. The DON verbalized review of progress notes did not show evidence of using other interventions prior to giving pain medication. The facilities Pain Management Program was reviewed and read in part D. Non-Pharmacological Interventions [.] Consider using multiple nondrug therapies to better meet resident's individual needs. All interventions are evaluated and documented in the same way as medication therapy [.]. The above finding was presented to the administrator and general manager on 11/1/24 at 1:30 p.m. no other information was presented prior to exit conference on 11/1/24.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 41449 Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure appropriate dementia care with individualized interventions was in place for one resident (Resident #7 - R7), in a survey sample of 20 residents. The findings included: For R7, who had dementia, the facility staff failed to develop resident specific interventions to ensure the resident received appropriate treatment to maintain the resident's highest practicable well-being. On 10/29/24 at 10:47 a.m., R7 was interviewed in her room. R7 was noted to be very hard of hearing but was able to engage in conversation/interview appropriately. R7 displayed no behaviors during this interview. On 10/29/24-10/30/24, a clinical record review was conducted. This review revealed that R7 had a diagnosis to include, unspecified dementia, unspecified severity, without behavioral disturbances, psychotic disturbance, mood disturbance and anxiety. According to R7's care plan, there was a focused care area devised on 4/11/24, that read, The resident has impaired cognitive function d/t [due to] dementia. There were no resident specific goals or individualized approaches to guide direct care staff in how to approach R7 for care. The interventions listed read, Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion, Present just one thought, idea, question or command at a time, Cue, reorient and supervise as needed. There was also a care plan that noted R7 had the potential to be verbally aggressive r/t [related to] dementia. The only intervention listed for that focus area read, Offer resident choice during care and activities. The care plan did not address any internal or external triggers for behaviors, related to R7's impaired vision, hard of hearing, disease symptomology, or need for environmental accomodation. According to the progress notes, R7 had sustained 11 falls in 2024, several of which resulted in significant head injuries that required visits to the hospital for treatment. There was no intervention within R7's care plan to include routine guidance for dementia care delivery, or meaningful activities based on the resident's customary routine and preferences, or non-pharmocological interventions on how to respond to or redirect R7's behaviors. On 10/31/24 at approximately 4:45 p.m., an interview was conducted with licensed practical nurse #1 (LPN #1). When asked about R7's Haldol order, LPN #1 said, She started on Haldol by hospice. Haldol was for restlessness and diagnosis of anxiety; she was reaching out for things. When asked if R7 was reaching out for things prior to Haldol being started, LPN #1 said, Yes it was. LPN #1 went on to say, It [Haldol] was prn [as needed] at one point, with the increase in reaching out, they made it standing [scheduled] . The care plan did not indicate that R7 had visual hallucinations or how facility staff were to respond. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 5:02 p.m., an interview was conducted with a licensed practical nurse (LPN #4). When asked about R7, LPN #4 said, She doesn't have any combative behaviors but has behaviors of being uncooperative if you can't get her to understand what you are going to do. When we have to do skin assessments, she doesn't understand what we are going to do, and she will pull away from you. Her main behavior is standing up, which causes her to fall or reaching down for items on the floor that are not present, hallucinations. When asked if R7's impaired hearing was a factor with her behavior, LPN #4 said, I think everything plays a role in it. She doesn't see well, doesn't hear well, and it is easy for her to get confused . On 10/31/24 at 6:13 p.m., an interview was conducted with the acting director of nursing (DON). When asked about the monitoring of behaviors and resident specific approaches to dementia care, the DON said, It needs to be, and we usually should. We put a schedule in for it to be routinely monitored, every shift. When shown R7's physician orders and MAR (medication administration record), the DON confirmed there was no evidence of the facility staff monitoring for behaviors, side effects or any other individualized interventions with regards to R7's dementia care. On 10/31/24, the facility staff was asked to provide their policy regarding dementia care. When it had not been received, the facility policy regarding dementia care was again requested on 11/1/24, to which the facility administrator stated that they had no such policy. On 11/1/24 at 1:45 p.m., during an end of day meeting, the facility administrator and other management staff were made aware of the above findings. No other information was provided prior to survey exit.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to respond to a medication regime review and recommendations from the pharmacy for 1 resident (Resident #11-R11) in a survey sample of 20 residents. The findings included: For R11, who was receiving two psychotropic medications, the facility's medical provider failed to respond to the pharmacy recommendation for a gradual dose reduction. On 10/29/24 at 11:45 a.m., during an interview with R11, the resident was observed to have constant lip smacking while talking to the surveyor, which could be indicative of tardive dyskinesia, which is a chronic condition that causes involuntary, repetitive movements in the body. On 10/30/24, during a clinical record review of R11's chart. According to the physician orders, R11 was receiving Buspirone HCl 15 mg tablet three times daily for anxiety since 12/16/2022. There was no indication that R11 had a dose change in the Buspirone. The physician orders also indicated R11 received Remeron 45 mg at bedtime for major depressive disorder, which started 2/13/24. The physician orders and progress notes were reviewed, which revealed no indication that R11 had any attempted gradual dose reductions of the Buspirone, nor any documented contraindication to why a gradual dose reduction should not be attempted. According to a pharmacy progress note, a recommendation was made to the provider on 5/16/24 and 6/24/24, to consider a dose reduction. According to the pharmacy recommendations dated 5/16/24, the pharmacists noted, The resident receives buspirone 15 mg TID for anxiety. **annual documentation if clinically appropriate, please consider a dose reduction (GDR), perhaps decreasing to 10 mg TID, or consider documenting dose reduction as contraindicated at this time. The form was blank with no physician response noted. There was a second pharmacy Note to Attending Physician/Prescriber that read, This resident is receiving Remeron 45 mg at bedtime with the off-label diagnosis of appetite stimulation. Although there is evidence to support that this medication, at low doses, can cause weight gain and improve appetite please comment on the risk benefit of continuing the use of this agent. The remainder of the form was blank with no response noted from the physician. According to the pharmacy Note to Attending Physician/Prescriber dated 6/24/24, it noted, This resident receives mirtazapine 45 mg and buspirone 15 mg TID for anxiety. **annual documentation if clinically appropriate, please consider a dose reduction (GDR), perhaps decreasing buspirone to 10 mg TID and/or decreasing mirtazapine to 30 mg or consider documenting dose reduction as contraindicated at this time. Again, the form was blank with no response from the provider. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 2:51 p.m., an interview was conducted with the acting director of nursing (DON/DNS). When asked about pharmacy recommendations, the DON said, Normally we give them to the doctor to sign off on. We are still working through that process, as acting DNS I am still working my way around that. When asked if there was any way to know if the doctor saw the recommendations from the pharmacy, the DON said, They should be in the hard chart. On 11/1/24 at 8:39 a.m., an interview was conducted with the physician/medical director. When asked about dose reductions and pharmacy recommendations, the doctor stated that he felt like R11 hadn't tolerated dose reductions and was hesitant to decrease the dose. When asked if that rationale was documented, the doctor said, I can't say I have charted that. The surveyor explained that in the absence of a gradual dose reduction the expectation would be to have clinical indications as to why the dose reductions was felt to be contra indicated. The doctor said, I can't say I've done that. I do know it is best practice for sure. When it was discussed that the pharmacy recommendations suggesting GDR's [gradual dose reductions] be conducted of R11's medications, the doctor stated that he had not received the forms, as he always responds to them. According to the facility policy titled, Medication Monitoring Medication Regimen Review and Reporting, which read in part, . 2. The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each residents receives are clinically indicated .6. Resident specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician . 8. The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days or per facility specific protocols . On 11/1/24 at 1:45 p.m., during an end of day meeting held with the facility administrator, and other management staff, the above findings were discussed. No additional information was provided.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 41449 Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure a gradual dose reduction was performed for one resident (Resident #11- R11), failed to ensure one resident (Resident #7- R7) was free from unnecessary psychotropic medications, and failed to document assessment and monitoring of psychotropic medications effect on two residents (Resident #14-R14 and Resident #7-R7) in a survey sample of 20 residents. The findings included: 1. For Resident #11, who was on a psychotropic medication for 22 consecutive months, the facility staff failed to attempt a gradual dose reduction or have documentation from the doctor why a reduction was contraindicated. On 10/29/24 at 11:45 a.m., during an interview with R11, the resident was observed to have constant lip smacking while talking to the surveyor, which could be indicative of tardive dyskinesia, which is a chronic condition that causes involuntary, repetitive movements in the body. This prompted further investigation of R11's medications. On 10/30/24, during a clinical record review of R11's chart. According to the physician orders, R11 was receiving Buspirone HCl 15 mg tablet three times daily for anxiety since 12/16/2022. There was no indication that R11 had a dose change in the Buspirone. The physician orders also indicated R11 received Remeron 45 mg at bedtime for major depressive disorder, which started 2/13/24. The physician orders and progress notes were reviewed, which revealed no indication that R11 had any attempted gradual dose reductions of the Buspirone, nor any documented contraindication to why a gradual dose reduction should not be attempted. According to the most recent physician progress note, dated 9/23/24, it indicated that R11 received Buspirone 10 mg tablets three times daily. According to a pharmacy progress note, a recommendation was made to the provider on 5/16/24 and 6/24/24, to consider a dose reduction. There was no evidence that the recommendations were received or reviewed by the physician. On 10/30/24 at 2:51 p.m., an interview was conducted with the acting director of nursing (DON/DNS). When asked about pharmacy recommendations, the DON said, Normally we give them to the doctor to sign off on. We are still working through that process, as acting DNS I am still working my way around that. When asked if there was any way to know if the doctor saw the recommendations from the pharmacy, the DON said, They should be in the hard chart. On 10/30/24, a review of the paper chart for R11 was reviewed. There was no evidence of the pharmacy recommendation being addressed. The recommendation forms from the pharmacy were not in the chart. The DON did provide the surveyor with copies of the pharmacy recommendations, which were blank with no response. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/1/24 at 8:39 a.m., an interview was conducted with the physician/medical director. When asked about R11's progress notes written by the doctor indicating that the resident was on 10 mg tablets of buspirone three times daily, but the orders indicated the dose was 15 mg three times daily. The physician indicated that the progress note was an error, they pull information from prior notes and the orders in the computer are accurate. When asked about dose reductions and pharmacy recommendations, the doctor stated that he felt like the resident hadn't tolerated dose reductions and was hesitant to decrease the dose. When asked if that rationale was documented, the doctor said, I can't say I have charted that. The surveyor explained that in the absence of a gradual dose reduction the expectation would be to have clinical indications as to why the dose reductions was felt to be contra indicated. The doctor said, I can't say I've done that; I do know it is best practice for sure. According to the facility policy titled, Medication Monitoring Medication Management, which read in part, . Based on a comprehensive assessment of a resident, the facility must insure: . Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs . The intent of this requirement is that: . the facility implements gradual dose reductions (GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication . On 11/1/24 at 1:45 p.m., during an end of day meeting held with the facility administrator, and other management staff, the above findings were discussed. No additional information was provided. 2. For R7, who was ordered to receive Haldol, an antipsychotic medication, the order exceeded the 14-day duration for prn [as needed] doses and there was a lack of appropriate clinical indication documented to support the use of the Haldol, therefore it was deemed unnecessary. For R7 the facility staff also failed to have evidence of behavioral interventions and/or monitoring when psychotropic medications were in use. On 10/29/24 at 10:47 a.m., an interview was conducted with R7 in her room. During the interview, the surveyor noted numerous areas of discoloration/bruising to R7's arms, wrists, and above her right eye. R7 was noted to be visually impaired and very hard of hearing. On 10/30/24, a clinical record review was conducted of R7's chart. According to the physician orders, R7 had an order dated 8/6/24 that read, Haloperidol Lactate oral concentrate. Give 0.5 mg by mouth every 4 hours as needed for anxiety. The order was discontinued on 10/24/24, at which another order was written that read, Haloperidol Lactate oral concentrate. Give 0.5 mg by mouth two times a day for restlessness. According to a physician progress note dated 8/6/24, it read in part, .Patient seen today for follow-up due to increased agitation and restlessness. Patient had a fall due to her increased restlessness. Discussed plan with hospice who recommended starting Haldol. Will discontinue the risperidone and start Haldol in its place . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonnades Health Care Center	100 Colonnades Hill Drive Charlottesville, VA 22901

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24, the physician wrote a progress note that read in part, .Patient seen today for follow-up. Patient returns from the ER after suffering a fall with a scalp laceration. 3 sutures were placed, and patient returned. CT imaging was negative for any acute findings . The progress notes by nursing nor the physician made mention of the order change with regards to the Haldol being discontinued from an as needed dosing to being scheduled twice daily. There was no documentation within the clinical record of R7's paper or electronic chart from hospice other than the hospice plan of care. There was a separate notebook/3-ring binder in the nursing station that held hospice information. According to the [Hospice company name redacted] facility visit log R7 did not have any hospice representatives visit her on 10/24/24, and there was no information with regards to the recommendation of Haldol being scheduled to be given twice daily. According to the progress notes, R7 sustained 11 falls. Of the eleven falls only four caused no injury. On several occasions, R7 sustained lacerations to her head, hematoma's and required to be sent to the emergency room for further treatment on several occasions which resulted in sutures and staples to the lacerations to R7's head. On 10/31/24 at 11:30 a.m., a telephone interview was conducted with the hospice medical director (HMD). When asked about R7 and the indication for use of Haldol, the HMD said, This patient has senile degeneration of her brain and with that can come behavioral disturbance. In hospice the first line of medication with terminal agitation is Haldol. When asked by the surveyor, Haldol is the preferred medication despite the black box warning for Haldol use in the elderly? The HMD said, in our hospice practice it is our first line and one of the most effective medications with benzodiazepine use for behaviors. The HMS went on to say, the hospice interdisciplinary team reviews medications bi-weekly and it was found to be necessary. The HMD was asked, What the facility staff should be monitoring for as an indication of when to administer the Haldol when it is ordered as needed? The HMD said, the staff look for distress, fearfulness, restlessness and agitation. The HMD was asked about the side effects of Haldol, by the surveyor. The HMD said, It is a first generation antipsychotic and is generally very well tolerated. They should look for excessive sedation, dystonic reactions and akathisia, but should be monitoring for any changes in the patient. The HMD went on to report that, because she is terminal we expect progression. When asked if any of this information to include the interdisciplinary discussion and review of medications as well as the hospice medical provider's rational for use of psychotropic medications is documented, the HMD said, the medical provider documents in their documentation and we don't have a practice of having doctor notes sent to the facility. We try to work well with facilities and collaborate while meeting the needs of the resident. We have it in our documentation and can look at when it was changed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the above interview with the HMD, the surveyor asked if she [the HMD] was aware of the regulatory requirements for long-term care with regards to the use of psychotropic medications regardless of if a resident is on hospice care, the HMD stated she was aware of the 14-day limit on as needed orders and gradual dose reductions or documentation of the rationale of why it is clinically contraindicated. The HMD said, gradual tapering would not be in line with goals for things like the 14-day rule for medications, we can do one of two things, we can issue a letter stating that the patient needs the medication for greater than 30 days or we can re-prescribe every 14 days. I would be happy to provide a letter if that would be helpful. When asked if this is not something that hospice does when they have residents in long-term care facilities, the HMD stated, Usually the facility has to request it. The HMD was asked if she was aware that R7 had multiple falls, several of which she sustained significant injuries that required hospital care for sutures due to head lacerations. The HMD stated she was aware but didn't feel the Haldol was a contributing factor and added, it is very hard to say for sure. What our data shows is that effective symptom management of agitation can decrease incidents of falls and more likely is explained that the patient is in the process of slowly declining. I would not attribute it to Haldol use. On 11/1/24 at 8:39 a.m., an interview was conducted with R7's attending physician at the facility, who was also the medical director of the facility. The doctor was asked about R7's orders for Haldol and that the order indicated it was being used for agitation. It was also discussed that there is no documentation to support the medication going from an as needed dosing to being scheduled twice a day. The doctor said, I have struggled with that with hospice patients. He said, I tend to defer to hospice when they are consulted. [R7's name redacted] is not imminent although she is declining. On 10/31/24 at approximately 4:45 p.m., an interview was conducted with licensed practical nurse #1 (LPN #1). LPN #1 was asked about R7's Haldol order. LPN #1 said, She started on Haldol by hospice. Haldol was for restlessness and diagnosis of anxiety; she was reaching out for things. When asked if the resident was reaching out for things prior to Haldol starting? LPN #1 said, Yes it was. LPN #1 went on to say, it [Haldol] was prn [as needed] at one point, with the increase in reaching out, they made it standing [scheduled]. At one point it was morphine and Ativan we were giving. She was worse than she is now, and we thought she was dying. On 10/31/24 at 5:02 p.m., an interview was conducted with a licensed practical nurse (LPN #4). When asked about R7, LPN #4 said, she doesn't have any combative behaviors but has behaviors of being uncooperative if you can't get her to understand what you are going to do, when we have to do skin assessments, she doesn't understand what we are going to do, she will pull away from you. Her main behavior is standing up which causes her to fall or reaching down for items on the floor that are not present, hallucinations. When asked if she felt R7's impaired hearing was a factor in her agitation, LPN #4 said, I think everything plays a role in it, she doesn't see well, doesn't hear well and it is easy for her to get confused. When asked about the Haldol use, LPN #4 said, whenever she continued to stand up and slip out of chair or do things unsafe is when she would get Haldol. When asked, do you think that helped? LPN #4 said, Sometimes it seemed to and sometimes it did not, it depended if she was agitated with it. I think that she can't always understand. When asked if there are anything she has to monitor for with R7 having an antipsychotic medication, LPN #4 said, I think there are some on her MAR [medication administration record], I monitor if over sedated or anything that is not her norm [normal]. If notice a change, [the physician's name redacted] is very responsive to us, we notify him of anything. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 6:13 p.m., an interview was conducted with the acting director of nursing (DON). When asked about the monitoring of behaviors and side effects when psychotropic medications are ordered, the DON said, It needs to be, and we usually should. We put a schedule in for it to be routinely monitored, every shift. The DON was shown R7's physician orders and MAR and confirmed there was no evidence of the facility staff monitoring for behaviors, side effects or any other factors with regards to R7's use of Haldol. On 10/31/24 at 7:31 p.m., another follow-up interview was conducted with the DON. When asked why R7 was receiving Haldol, the DON said, I think what started it was agitation and aggression. They had tried Ativan in the past and she had an opposite reaction. They have it scheduled now because they felt like she could have benefited from having it administered appropriately. They [hospice] were thinking that it may even out her behaviors. When asked what R7's behaviors were, the DON said, Hallucinations, delusions, she is always bending down in the wheelchair. She [R7] is almost blind and doesn't see very well. She will say where did my husband go, he was right here. She is normally very calm, but she was pushing away the aide trying to deliver care, very unusual behavior. When asked if agitation or aggression is an appropriate indication for antipsychotic use, the DON said, In the hospice world yes, they initially had it for anxiety, but she doesn't have an anxiety diagnosis. When asked if she was aware of the regulatory requirements with regards to as needed orders for psychotropic medications, the DON said, Yes, to watch for side effects and 2 weeks [duration]. According to the facility policy titled, Medication Monitoring Medication Management, it read in part, Each resident's drug regimen is reviewed to ensure it is free from unnecessary drugs. This includes any drug in excessive dose; for excessive duration; without adequate monitoring; without adequate indications for its use . It went on to read, . Based on a comprehensive assessment of a resident, the facility must insure: Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. PRN orders for psychotropic drugs are limited to 14 days. Exception: If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication . On 11/1/24 at 9:38 a.m., the director of nursing provided the survey team with a letter that she stated they had just received via fax. The letter was from the hospice agency and was dated 10/31/24. It read in part, [R7's name redacted] is a patient under hospice services with [hospice company name redacted] with a primary diagnosis of Senile Degeneration of the Brain. [R7's name redacted] symptoms are currently being managed with Haloperidol lactate 2mg/ml oral concentrate PO [by mouth] or SL [sublingual] 0.25 ml (0.5 mg) twice daily for agitation and restlessness. The patient's care plan, including medication regimen, is re-evaluated on a regular basis by the hospice interdisciplinary team to review medication necessity and appropriateness. The document was signed by the Associate Medical Director for hospice. On 11/1/24 at 1:45 p.m., during an end of day meeting, the facility administrator and other management staff were made aware of the above findings. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided. 28106 3. Facility failed to document assessment and monitoring of Duloxetine (antidepressant) for R14. The findings Include: Diagnoses for R14 included; post surgical hip repair, chronic kidney disease, major depression, and chronic pain. The most current MDS (minimum data set) was a five day assessment with an ARD (assessment reference date) of 9/22/24. R14 was assessed with a cognitive score of 12 indicating cognitively intact. Review of physician orders for R14 included an antidepressant Duloxetine 60 mg (milligrams) delayed release daily start date was 9/16/24. Another physicians order dated 9/16/24 directed staff to monitor for side effects, mood and behavior for the antidepressant and document Y if no concerns, N if any concerns observed and select code other/see nurses notes. Review of R14's care plan also indicated that staff was to monitor and document side effects and effectiveness of the antidepressant each shift. Review of R14's medication administration record (MAR) and treatment administration record (TAR) for the the month of October 2024 did not show any evidence that side effects, behavior, or mood was being documented, nor did it indicate a place to document any assessments of the antidepressant. On 10/31/24 at 6:12 PM the DON was interviewed regarding the above findings. The DON reviewed R14's monitoring and assessment order and verbalized the nurse that entered the order did not complete the necessary scheduling details as routine in order for the assessment and monitoring to populate to the MAR so that documentation could be completed each shift by the nurses, resulting in not being assessed. On 11/1/24 at 1:30 p.m. the above finding was presented to the administrator and the facilities general manager. No other information was presented prior to exit conference on 11/1/24.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on staff interview, clinical record review and facility documentation review, the facility staff failed to ensure residents were free from a significant medication error for one resident (Resident #7-R7) in a survey sample of 20 residents. The findings included: For R7, the facility staff failed to administer an antibiotic resulting in a two-day delay in the order being carried out and then resulting in multiple missed doses. On 10/29 and 10/30/24 a clinical record review was conducted of R7's chart. This review revealed R7 had a visit to the hospital on 10/25/24, following a fall where she sustained a laceration to the back of her head which required medical attention. R7 returned to the facility on [DATE]. According to the hospital records within R7's paper chart, the ED [emergency department] After Visit Summary dated 10/25/24, noted Reason for Visit: Fall. Diagnoses: Fall, initial encounter, Hematoma of scalp, initial encounter, Cystitis, Traumatic tear of thoracic aorta, initial encounter. That same form noted, Your medications have changed. Start taking: Cephalexin (Keflex). Pick up these medications from any pharmacy with your printed prescription. The actual prescription was in the chart and read, Cephalexin (Keflex) 250 mg/5ML suspension. Take 3 mL by mouth 4 times daily for 5 days. According to R7's medication administration record (MAR), the order was entered with a start date of 10/26/24. Two doses of the antibiotic on 10/26/24, were noted as not administered and had the code MD noted before the order was discontinued at 3:56 p.m. According to the Chart Codes/Follow Up Codes noted on the MAR, MD indicated medication pending delivery. According to the MAR and physician orders, the order for Cephalexin was entered again on 10/27/24, and indicated a stop date of 10/30/24 at 6:07 p.m., which indicated the antibiotic would be stopped after the resident received only 11 of the 20 scheduled doses. According to the MAR all four scheduled doses on 10/27/24, were coded as not given with the reason code medication pending delivery noted. On 10/25/24, there was a progress note entered by the medical director and attending physician of R7. According to the note, it read in part, .admitted to the hospital and treated for sepsis due to Staph epidermidis bacteremia. Patient was found to be hypothermic while hospitalized . Blood cultures were positive patient was started on vancomycin. Other etiologies of hypothermia were ruled out. Infectious disease was consulted who recommended 14-day course versus 6-week course of antibiotics. After goals of care discussion patient decided complete a 2- week course with PICC line placement . Patient seen today for follow-up . Additional Assessment and Plan: Patient is an [AGE] year-old female with past medical history of Parkinson's, MVC, recurrent falls, SAH, anemia, and osteoporosis who was admitted to the hospital and treated for sepsis due to Staph epidermidis bacteremia #. Sepsis due to staph bacteremia, - Complete antibiotics, - Monitor for symptoms . On 10/29/24 at 5:05 p.m., an interview was conducted with the acting director of nursing (DON). When asked what MD on the MAR indicated, the DON said, this means medication waiting for delivery. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 at 5:10 p.m., an interview was conducted with the registered nurse #3. When asked to explain the process when a resident returns from the emergency room or hospital, RN #3 said, a discharge summary comes with them, we call the doctor and go over it with him, we enter the orders in the computer. When we put the orders in the computer it sends to the pharmacy to be filled. When asked about the pharmacy, RN #3 stated that they send the discharge summary to the pharmacy via fax. The pharmacy has a STAT [urgent] run if you need them then, otherwise they deliver nightly, we have a box here that we can get some medications out of. RN #3 went on to say that we mark medicine pending delivery but when it comes, we go back and give it especially if it is a critical medicine, like an antibiotic, pain med or blood thinner. RN #3 was asked about R7's antibiotic for Cephalexin. LPN #1 explained that R7, was unresponsive when she first came back. During the above interview with RN #3, licensed practical nurse #1 (LPN #1) was present. LPN #1 went on to say, she [R7] was almost unresponsive when she left out of here, when she comes back, she is on puree diet, when arouses back up she wants her regular food. If medication is not available, we notify doctor it is not available, sometimes he will change to something we have, especially if antibiotic he will ask what you have available? LPN #1 went on to say that since R7 was ordered liquid antibiotics that would not be available in the on-site back-up supply of medications. The two nurses went on to report, [local retail pharmacy name redacted] didn't deliver it, so [facility contracted out of town pharmacy] was later getting it [the order]. We hate this pharmacy because they aren't local. On a good day they come twice a day, but if they don't have a driver, we get one delivery, on the weekends it is one delivery. We get the delivery about 6-7 p.m. and then night shift gets one around 12 midnight -1 am. On 10/30/24 at 8:26 a.m., an interview was conducted with the medical director/doctor (MD), who was also the attending physician for R7. When it was discussed that R7 had a delay in receiving the antibiotics, the MD said, the hospital ordered the antibiotic and sent it to [local retail pharmacy name redacted], they were waiting for it to be received. The surveyor discussed with the physician that due to the delay in starting the antibiotic the resident would not receive all ordered doses as the order was scheduled to end after only 11 of the 20 scheduled doses had been administered The MD said, I will have to extend the duration so that the resident receives all doses. On 10/30/24 at 5 p.m., during the end of day meeting, the facility administrator and DON were made aware of the above findings. The facility policy with regards to physician orders was requested. The DON went on to report that when the order for the antibiotic for R7 was entered into the electronic health record, the [local retail pharmacy name redacted] was selected as the pharmacy, so the order never actually made it to their pharmacy to fill. The DON stated that she had previously noticed that for some reason when some orders are entered, the system automatically defaults to the retail pharmacy versus the facility's contracted pharmacy. The DON stated that she has educated all nursing staff to be very mindful of this. When asked about the facility process to verify and/or review orders, the DON stated she reviewed them daily when she worked. On 10/31/24, the facility administration reported they had no policy regarding physician orders. The DON confirmed that the expectation would be that orders be carried out when given by the doctor. No additional information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41449 Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to ensure medications were securely stored in 1 of 2 medication carts and for 1 resident (resident #128) in a survey sample of 20 residents. The facility staff also failed to ensure that expired medications were not available for use in 1 of 1 medication rooms. The findings included: 1. For R128, the facility staff permitted the resident to have eye drops at the bedside which were not secured. On 10/29/24 at 9:49 a.m., observations were conducted in R128's room and an interview conducted with the resident. On R128's over bed table the surveyor noted a bottle with a prescription label. When asked, R128 said it was eye drops and I use them when my eyes get dry or itchy. R128 reported that he had received them when he was in the hospital. R128 handed the surveyor the bottle and it was noted to be Carboxymethylcellulose Refresh 1% a 15 ml container of ophthalmic gel. The instructions read, 1 drop both eyes. It had a hospital pharmacy label with a date 10/17/24. On 10/30/24 at 1:16 p.m., an interview was conducted with licensed practical nurse #1 (LPN #1), who was assigned as R128's nurse. LPN #1 said, [registered nurse #1- RN #1 name redacted] gave it to me [referring to the eye drops]. I let doctor [doctor's name redacted] know we have a patient who wants to self-administer. I've called the doctor, and I am waiting for him to respond back to me. LPN #1 said, all medications have to be locked up. On 10/30/24 at 1:18 p.m., an interview was conducted with RN #1. When asked about the eye drops, she found at R128's bedside, RN #1 said, my understanding is we have to talk to the physician and there is an evaluation that the nurses do to see if they understand the medication, are capable of administering, etc. When asked how she came to notice the eye drops, RN #1 she said, . I went in his room to ask him about something and found them in his belongings. I asked his permission to take them and told him why. He said yes I could take them. RN #1 was asked where mediations get stored if they can self-administer? RN #1 said, let me ask. When asked what the risk is of medications being left in the open and not secured, RN #1 said, someone who shouldn't have them could take them. On 10/30/24, a clinical record review was conducted of R128's chart. There was no indication that R128 was able to self-administer medications and keep medications stored at the bedside. Within the care plan for R128 was a focus area dated 10/19/24, which read, The resident is unable to self-administer their own medication. 2. The facility staff failed to ensure one medication cart, which contained over 75 cards of medications containing approximately 20-30 pills per card, was secured to prevent unauthorized access to medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 at 12:25 p.m., the surveyor arrived at the nursing station and noted no nursing staff were in sight. There was a medication cart in the hallway and the lock was protruding, which was an indication the cart was not locked. The surveyor talked with two maintenance staff that were at the nursing station and maintained eye contact of the medication cart. The surveyor then walked to the medication cart and was able to open each drawer. During the duration of observations of the unattended medication cart, the surveyor had noted numerous staff and residents pass by, who could have potentially accessed the medications. There were the two-maintenance staff that were just steps away at the nursing station, a housekeeper, activity staff member, laundry worker and certified nursing assistant. Two residents walked by the cart and another resident was pushed in a wheelchair by a staff member. On 10/29/24 at 1:13 p.m., another surveyor went to retrieve the nurse. When the licensed practical nurse #2 (LPN #2) arrived at the cart they surveyor showed her that she was able to open each drawer of the medication cart. The cart was observed to contain approximately 50 bottles of over-the-counter medications, which included pain medication such as Tylenol, vitamins, stool softeners, etc. There was another drawer which contained syringes with needles attached, lancets, eight lovenox injections and another drawer with approximately 75 cards of medications. Each of the cards contained 20-30 pills. The nurse stated she was sure she had locked the cart and didn't know what happened. The nurse also confirmed that no one else had keys and would have been able to unlock the medication cart. When asked why it is important to lock the cart, LPN #2 said, so no one can go in them, and it is a risk someone taking out of it. 3. Within the medication storage room, the facility staff failed to discard a box of tuberculin purified protein vial that was past the open date, making it expired, but available for use/administration. On 10/29/24 at 3:43 p.m., an inspection of the medication room was conducted with LPN #2 being present. The surveyor noted that within the refrigerator was two multi-dose vials of Tuberculin Purified Protein, both of which had been opened and accessed. The outer box of one had an open date of 4/30/24, and the second vial had an open date of 9/20/24, on the box. Following the above observation LPN #2 was asked about the dating of medication. LPN #2 explained that mediations are dated when opened because it determines the date of how long the product is good for. When asked about the tuberculin purified protein specifically, LPN #2 said, so you know when it is opened, and it is only good for 45 days. Review of the facility's policy titled; Storage of Medication was conducted. It read in part, . 3. In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended to by persons with authorized access . 14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal . The facility policy and information provided titled, Abridged List of Medications with Shortened Expiration Dates was reviewed and did not address the use by date of the Tuberculin Purified Protein vials that had been opened. According to the Food and Drug Administration (FDA), the Tuberculin Purified Protein Derivative (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Colonnades Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 Colonnades Hill Drive Charlottesville, VA 22901	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Mantoux) TUBERSOL(R) package insert obtained online at: https://www.fda.gov/media/74866/download, was reviewed. It read in part, .A vial of TUBERSOL which has been entered and in use for 30 days should be discarded . On 10/30/24 at 5:01 p.m., during an end of day meeting, the facility administrator and director of nursing were made aware of the above concerns. No additional information was provided.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28106 2. Four food bins containing rice, flour, sugar, and bread crumbs were labeled as expired and were accessible for distribution in the main kitchen. The findings included: On [DATE] at 8:40 a.m. during the initial tour of the main kitchen with dietary manager (other staff, OS #1) four large food bins containing rice, flour, sugar, and bread crumbs all with an expiration date of [DATE] were accessible for distribution. OS #1 also observed the food bins and verbalized that either a staff member had not relabeled the food bins when new food was added or the food is out of date, verbalizing the food will be removed and replaced along with new expiration dates. A policy titled Food Storage, Preparation and Service was obtained and read in part: General Food Handling [.] d. All food items are labeled, dated and rotated to maintain a system of First In First Out. e. Expired food is discarded. On ,d+[DATE] at 5:01 p.m. the administrator and director of nursing (DON) were notified of the above finding. No other information was provided prior to exit conference on [DATE]. 49456 Based on observations, staff interviews and facility documentation the facility staff failed to store, prepare, and distribute food in a sanitary manner in the main kitchen and in the dining room. The findings included: 1. The facility staff wore the same pair of gloves in the main dining room while serving food and assisting residents with feeding and other activity of daily living needs. On [DATE] at 12:52 p.m. to 1:00 p.m. a certified nursing assistant, CNA#2 (CNA2), was observed with the same pair of gloves on in the main dining room, assisting a residents with repositioning in the wheelchairs., rearranging the chairs in the dining room, touching the cabinets, had his hand on the wall, removed a cup from the cabinet and served food to several residents without changing his gloves or using hand hygiene. CNA2 then sat down and was observed assisting a resident with feeding wearing the same gloves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:04 p.m. an interview with CNA2 was conducted. CNA2 was asked why he wore gloves in the dining room and he stated, I feel it is more sanitary and I don't want to catch anything I try to stay clean. CNA2 was made aware about being observed with assisting the resident with positioning in the wheelchair, opening the cabinets to get a cup, handling food and then began assisting with feeding a resident with the same gloves on the entire time and he was never observed changing the gloves or performing hand hygiene. CNA2 stated, I have never changed them but technically I should, and I will keep that in mind for the future. On [DATE] at 1:15 p.m. an observation of CNA2 was conducted. CNA2 was observed on the nursing unit hallway assisting residents back to their rooms and was wearing a different colored pair of gloves. He assisted several residents to their rooms and never changed the pair of gloves he was wearing in the hallways. On [DATE] at approximately 3:00 p.m. a review of facility documentation was completed. The document titled, Infection Prevention and Control Program for Skilled Communities, read in part, .hand hygiene -one of the most effective ways to prevent the spread of infection. Gloves: wearing gloves is not a substitute for hand hygiene. Dirty gloves can soil hands. Always clean your hands after removing gloves. Remove gloves after contact with a resident and/or the surrounding environment. Failure to remove gloves after caring for a resident may lead to the spread of potentially deadly germs from one resident to another. Do not wear the same pair of gloves for the care of more than one resident. On [DATE] at approximately 5:15 p.m. an end of day meeting was conducted with the administrator, the acting director of nursing and the regional director of resident care services was conducted. The above concerns were discussed. No additional information was provided.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 41449 Based on staff interview, clinical record review and facility documentation review, the facility staff failed to provide physician ordered rehab therapy services to three residents in a survey sample of nine residents. The findings included: On 1/8/25, clinical record reviews were conducted of a sample of residents residing at the facility to identify residents with a BIMS (brief interview for mental status) score of 12 or less. Several residents (Resident #101-R101, Resident #102- R102, and Resident #103- R103) were all noted with a BIMS of 12 or less. Each of the residents were noted to have active physician orders for therapy to evaluate, dating as far back as 12/23/24. On 1/8/25, in the afternoon, an interview was conducted with the rehab/therapy director. The therapy director reviewed clinical records and stated that none of the three residents had been evaluated by therapy as of 1/8/25. When the therapy director was asked about the delay in treatment, the therapy manager stated that they have been busy with out-patient case load. On the evening of 1/8/25, the facility's interim administrator, interim director of nursing and general manager was made aware of the above concerns. On the morning of 1/9/25, the facility's administrator reported that all residents on the unit were being evaluated by therapy in accordance with physician orders and disciplinary action was being performed. On 1/9/25 at approximately 9 a.m., an interview was conducted with licensed practical nurse #2 (LPN #2). When asked about physician orders, LPN #2 explained that if an order for therapy came in she calls the therapy department to let them know of the new order. LPN #2 stated that physician orders should be carried out the same day the order is given. On 1/9/25 at approximately 10 a.m., a follow-up interview was conducted with the therapy director. When asked about the process when a physician orders for therapy to evaluate a resident, the therapy director stated, she has always put them on the list based on when the physician order was written. The therapy director stated that they have a large case load of out-patients and had not gotten to the skilled care residents. The therapy director went on to state that going forward the skilled care residents would be priority and would be moved to top of the list. No further information was provided.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on resident interviews, staff interviews, clinical record reviews, and facility documentation review, the facility staff failed to effectively administer the facility for residents to maintain their highest practicable well-being, which had the potential to affect all residents residing in the facility. The findings included: For the resident's residing in the facility, the facility administration failed to effectively and efficiently administer the facility to ensure residents were free from and protected from abuse. The facility administrator, who was the abuse coordinator, failed to implement the facility's abuse policy to ensure residents were protected, allegations were reported and investigated timely, and residents were free from abuse, which resulted in the identification of immediate jeopardy and substandard quality of care. 1. On 10/29/24 at 9:08 a.m., an interview was conducted with resident #20 (R20). R20 said, [Certified nursing assistant #1 (CNA 1)'s name redacted] treated me like slapping the pigs. I reported it to the social worker and talked with her about it. R20 said, The aide was rough with me, and I didn't like it. R20 stated they [facility staff] were responsive to her concern, and she never saw CNA1 again after the incident. R20 said, I am limited to what I can do due to my broken leg. On the evening of 10/29/24, a clinical record review was conducted of R20's chart, which revealed no information with regards to her allegation of abuse. On 10/30/24 at 11:00 a.m. an interview was conducted with the social service director (SSD). The SSD stated she had interviewed R5 and resident #20 (R20), who were roommates. SSD stated that R20 had stated that CNA1 was rough with her during daily care and in the shower room. The SSD stated that R5's complaint was that CNA1 was being rough with her during morning care while applying her back brace. The SSD said, [R5's name redacted] and [R20's name redacted] verbalized that they were not scared or nervous, just didn't want [CNA1's name redacted] as an aide anymore. On 10/31/24 at 9:15 a.m. an interview with the administrator was conducted. The administrator was questioned about the facility documentation provided to the survey team with regards to R5 and R20's allegations of abuse. Included in the documents was evidence of staff education with regards to customer service, not abuse. The administrator said, Not all nursing staff is on the in-service, we are missing two part-time college students and some from the third shift that's not on this education. The administrator stated that after she came into work on 10/1/24, a dayshift aide, CNA#7 (CNA7) approached her and reported the allegation of abuse. The administrator stated CNA7 was a new aide and was scared and tearful over the incident. The administrator then stated that CNA7 came to her after breakfast to report the allegation of abuse. The administrator stated that she discussed the allegation with her supervisor and then CNA1 was pulled off the nursing unit (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/31/24 at 11:30 a.m. an interview was conducted with the MDS (minimum data set) coordinator, who was a registered nurse. The MDS coordinator had written a witness statement on 10/1/24 that read, While reviewing baseline care plan with resident, [R5's name redacted] on 9/30/24, she told me that her nurse's aide that morning had been rough with her. She stated that while putting her TLSO (thoracic-lumbar-sacral orthosis) brace on, she was rough. When asked, the MDS coordinator identified the CNA as CNA1. The MDS coordinator said, I told her I would talk to the person who supervises the CNAs about it, and she expressed fear of retribution from the CNA. I assured her that she was safe. The MDS coordinator stated that she reported this to the administrator on 9/30/24. According to the facility documentation and fax confirmations, R5 and R20's allegation of abuse was not reported to the regulatory agencies and adult protective services until 10/1/24 at 3:34 p.m. According to the activity of daily living (ADL) documentation, it indicated that CNA1 continued to provide care and documented in R5 and R20's charts on 9/30/24 and on 10/1/24 until 10:00a.m. According to CNA1's timecard she clocked out at 10:45 a.m. on 10/1/24. Therefore, following the administrator being made aware of the allegations on 9/30/24 by the MDS Coordinator, the facility administrator failed to take measures to protect the resident and initiate an investigation into the allegations. By failure to remove the alleged perpetrator CNA1 following the initial report, CNA1 was permitted to continue working with the residents and had the opportunity to further abuse the residents. On 10/31/24 a review was conducted of witness statements in CNA1's personnel file. The first witness statement was from CNA7. CNA7's witness statement read in part, .this morning two residents stated to me that [CNA1's name redacted] has been very rough and hurting them during her care. The two residents were [R20's name redacted] and [R5's name redacted]. I brought [R5's name redacted] to the dining table for breakfast she was trying to talk to me about [CNA1's name redacted] and [CNA1 name redacted] said to the resident Do you have something you need to say to me, in a smart tone. The administrator had written a witness statement on 10/1/24 that read in part, .This writer had to suspend [CNA1's name redacted], pending an investigation after complaints from two separate residents regarding her care for them. According to the document titled, Performance Counseling and Improvement Plan for Correction Action, which was in CNA1's personnel file, it read in part, .Termination Written. Reason for Counseling 1. Policy/company rules not followed: Abuse or neglect of a resident, Date and Time: [DATE] This document was signed by the administrator, the general manager and a witness on 10/7/24. 2. On 10/29/24 at 10:47 a.m., during an interview with resident #7 (R7), the resident reported facility staff are rough. When asked about bruises to the resident's right arm, the resident repeated, Staff are very rough! The allegation was immediately reported by the surveyor, to the facility's acting director of nursing when the administrator was not able to be located. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On the evening of 10/29/24, a clinical record review was conducted of R7's chart. There was no documentation with regards to the bruising on the interior of R7's right wrist and the bruising noted. There was a progress note entry dated 10/29/24 at 11:14 a.m., by the DON that read, ADNS [acting director of nursing services] was asked to follow up on resident statement that when she was asked how she got the bruise on her wrist, she stated staff was sometimes rough with her during care. ADNS approached resident in her room; she was observed lying in bed with eyes closed. I asked her how she was feeling and she responded sleepy. When I asked her how she got the bruise on her wrist, she hesitated to answer and said, I don't know . I asked her if she wanted any covers and she said, no. I just want to rest. I ensured bed was in low position, fall mat on floor beside bed, wheelchair in locked position, and call bell within reach prior to leaving the room. Will follow up with resident when she is awake. On 10/30/24 at 11:12 a.m., a follow-up interview was conducted with the director of nursing (DON). When asked about any follow-up regarding R7's allegation, the DON stated that she had talked to R7 but she was sleepy and so she ensured the resident was centered in the bed, lowered the bed and put the fall mat in place. The DON stated she went back later to talk with R7, but she was in a meal and didn't interview the resident. On 10/30/24 at 3:17 p.m., an interview was conducted with the administrator. The administrator confirmed that she was the facility's abuse coordinator and stated, As soon as we are notified, we begin the questioning. When asked, what if the resident doesn't repeat what was reported? The administrator said, I would ask other residents if they had any issues, talk to team members. We can talk to their family and see if they mentioned it to them. When asked if any of this is reported, the administrator said, It should be because it is an allegation of abuse. When asked if she had any abuse reports in process, the administrator said, I do not. The administrator confirmed she was aware of R7's allegation that was reported to the director of nursing, but that she thought the DON had talked with the resident and no further action had been taken. According to facility documentation, the administrator reported R7's allegations to the state survey agency and adult protective services as an injury of unknown origin, following the surveyor's questioning of the administrator if any reports had been made. On 10/31/24, observations within the facility noted that postings were in place that indicated the administrator was the abuse coordinator. On 10/31/24 at 4:30 p.m., the survey team identified the facility was in immediate jeopardy within the care are of Free from Abuse, Neglect, and Exploitation, and substandard quality of care was identified. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/01/24 at 8:39 a.m., an interview was conducted with the attending physician and medical director of the facility. When asked about his role as medical director, the doctor said, I am responsible for overseeing the coordination of care and helping develop policies, provide education with staff on care, and dementia precautions. When asked, who the abuse coordinator is for the facility, the medical director stated the administrator. When asked, As medical director what are your expectation of what she would do? The medical director said, She covers a lot of different roles. I would expect her to gather the details and do a good investigation and report it up further. As far as the policy, she would coordinate gathering the information and doing the investigation. When asked if he would expect the administrator to take measures to protect the resident? He said, it depends on what the allegations are, it should be immediate if there is concern of mistreatment of a patient here. According to the Skilled Nursing Administrator (SNA) job description, it read in part, . Essential Duties: Skilled Nursing Center and Program Oversight. Plans, organizes, develops and leads the overall operation of the skilled nursing center in accordance with current federal, state, local laws and [company name redacted] standards, guidelines and regulations . Reviews and acts upon any complaint or concern as they arise . A review of the facility's policy titled, Abuse, Neglect & Exploitation- Prevention, Reporting and Investigation was conducted. The policy read in part, . team members who know of or suspect abuse, neglect, or exploitation of any resident must immediately notify the Executive Director /designee, to ensure appropriate action is timely taken for the safety of the resident and those potentially impacted . 8. The SNA/designee: a. Upon receiving notification of any known or suspected abuse, neglect or exploitation of a resident contacts the licensed nurse who evaluates the resident and provides the necessary interventions, for example, calls 911 if emergent. b. Removes the individual alleged to be involved in the abuse, neglect or exploitation from the area . 9. The SNA/designee: a. Validates that the mandatory report of known or suspected abuse, neglect or exploitation has been made to the applicable authorities in accordance with state/federal requirements. 10. The SNA/designee manages and directs the investigation of all abuse, neglect and/or exploitation . On 11/1/24 at 1:45 p.m., during a meeting with the facility administrator and other management staff, the above concerns were discussed. No additional information was provided.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 41449 Based on staff interview and facility documentation review, the facility staff failed to ensure that the facility assessment involved the appropriate participants, which had the potential to affect all operations and residents within the facility. The findings included: The facility staff failed to ensure the active involvement of direct care staff and solicit input from residents, resident representatives and family members in the development of the facility assessment. On 10/31/24, a review of the facility assessment was conducted. This review revealed no evidence of direct care staff, residents, resident representatives or family members being involved and/or their input being solicited for the development of and/or review of the resident assessment. The facility assessment was updated 5/23/24 and reviewed with the governing body on 5/16/24. According to the persons involved in completing assessment it included the administrator, director of nursing, governing body representative, medical director, social services coordinator, resident assessment coordinator and dietary services manager. On 11/1/24 at 10:56 a.m., an interview was conducted with the facility administrator. When asked if there was any involvement of direct care staff in the development, the administrator stated, it is more so like the DON [director of nursing] and assistant director of nursing. When asked, are residents and families involved in the process or their input solicited? The administrator stated, we only have a few long-term residents and most of them are cognitively impaired. I would say no. On 11/1/24 at 1:45 p.m., during an end of day meeting, the facility administrator, management team and corporate staff were made aware of the recent regulatory changes that require direct care staff, resident and family involvement in the development of the facility assessment. The facility policy regarding facility assessment was requested. The facility policy titled, Facility Assessment Process was received and reviewed. The document read in part, . How do we collect the necessary information? We utilize the facility assessment tool to collect the necessary information in three important areas. The tool basically asks three questions: Who are our residents? What are their needs? and What do we have that meets their needs? Or what do we need to get or work to improve . No additional information was provided.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 3. For R12, who had multiple falls and sustained a significant head injury, the facility failed to maintain a complete and accurate clinical record to include the details of the fall and the facility's response. On 10/29/24 at 11:03 a.m., during an interview with R12 and his spouse, the spouse reported, He had several falls here, which resulted in a head injury. The first one they called me, he hit his head badly and was bleeding and had to have some surgery on his brain. On the evening of 10/30/24, during a clinical record review, the following was noted. R12 had a fall on 6/10/24. The Fall Progress Note read, Fall was unwitnessed in residents room [ROOM NUMBER]/10/2024 8:00 PM. Residents description of event and how they were feeling: Guest stated that he was going to bed. He stated that he was ok before he fell .No injury noted at time of fall. [R12's spouse's name redacted] Your husband fell . He is ok. was notified on 06/10/2024 11:00 PM [Doctor's name redacted], MD was notified on 06/10/2024 9:00 PM with new orders received and entered in orders tab of record. Response: Care plan has been reviewed and updated. Guest requires extensive assistance for transfers and adls [activities of daily living]. On 6/23/24, R12 fell again. According to the fall progress note, it read, Fall was unwitnessed in residents room [ROOM NUMBER]/23/2024 8:00 PM. Resident unable to describe the event and how they felt just prior to falling .Fall resulted in an injury to the resident: guest noted to have bleeding from his right ear, right side of face reddened from fall with minor scrapes [R12's spouse's name redacted] was notified on 06/23/2024 8:15 PM [physician's name redacted] was notified on 06/23/2024 8:15 PM with new orders received and entered in orders tab of record. Response: Care plan has been reviewed; no updates needed at this time. There was a note entered at 1:30 a.m. on 6/24/24, that read, Received call from [hospital name redacted] ICU [intensive care unit] staff reporting that Guest has been admitted to the ICU. DX [diagnosis] Subarachnoid Hemorrhage and Parietal fracture. Medications reviewed with ICU nurse. On 9/9/24, R12 sustained another fall according to the progress notes. The fall progress note read in part, Fall event details: Fall was witnessed in hallway 09/09/2024 6:00 PM. Resident unable to describe the event and how they felt just prior to falling . Fall resulted in an injury to the resident: Left face laceration Our husband had a fall in front dining room door. was notified on 09/09/2024 6:15 PM [physician name redacted], MD was notified on 09/09/2024 6:30 PM with new orders received and entered in orders tab of record. Response: Care plan has been reviewed; no updates needed at this time. On 9/30/24, another fall progress note read in part, Fall event details: Fall was unwitnessed in residents' room [ROOM NUMBER]/29/2024 9:35 PM. Resident unable to describe the event and how they felt just prior to falling. Post fall evaluation: . [vital sign information redacted] .No injury noted at time of fall. wife was notified on 09/29/2024 9:40 PM Dr [name redacted] was notified on 09/29/2024 9:40 PM with no new orders received. Response: Care plan has been reviewed; no updates needed at this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonnades Health Care Center	100 Colonnades Hill Drive Charlottesville, VA 22901

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24, a fall progress note was entered into R12's chart that read in part, Fall event details: Fall was witnessed in residents room [ROOM NUMBER]/16/2024 10:00 PM Resident unable to describe the event and how they felt just prior to falling. Post fall evaluation: . [vital sign information redacted] .No injury noted at time of fall. [R12's wife's name redacted] was notified on 10/16/2024 10:00 PM [doctor's name redacted] was notified on 10/16/2024 10:00 PM with no new orders received. Response: Care plan has been reviewed and updated. Guest requires maximum assistance with his adls, bed mobility and transfers. On 10/25/24, another fall progress note was entered into R12's clinical record, which read in part, Fall event details: Fall was witnessed in residents room [ROOM NUMBER]/25/2024 12:00 AM. Resident unable to describe the event and how they felt just prior to falling. Post fall evaluation: .No injury noted at time of fall. [R12's wife's name redacted] was notified on 10/25/2024 9:30PM [doctor's name redacted], MD was notified on 10/25/2024 9:30 PM with no new orders received. Response: Care plan has been reviewed and updated. Guest requires maximum assistance with his adls. He limited assistance with bed mobility and ambulation. For each of the falls the clinical record failed to indicate the situational details of the fall, how the resident was found, and what the facility did in response to the falls. On 10/31/24, the facility staff were asked to provide the survey team with details of R12's falls and what was done in response to the falls. On the morning of 11/1/24, the survey team was provided with copies of R12's fall progress notes as noted above. The surveyor again asked for evidence to include the details of the falls and what interventions were put in place following the fall. On 11/1/24, in the early afternoon the survey team was provided with information and a document that had been typed to include the details of each fall and copies of the care plan which indicated appropriate interventions were put into place to prevent reoccurrence of falls following each incident. The resident assessment coordinator, who was a registered nurse was who had prepared the information with regards to R12's falls. When interviewed and asked if she had found the details within R12's clinical record, she said no. When asked if she would have expected such details to be part of the clinical record, she stated it should have been. On 11/1/24, in the afternoon an interview was conducted with the director of nursing (DON) and the surveyor shared the concern that R12's chart did not include the details of falls and the facility's response to show a clear picture of the events and the facility's response. The DON verbalized that she agreed, the details were not in the clinical record and should have been. The DON went on to state that she had provided education to nursing staff that they needed to be more descriptive and put the details of the falls/incidents in the clinical record of residents. On 11/1/24, about mid-afternoon, the administrator was made aware of the above findings. No additional information was provided. 4. For R7, who had eleven falls, some resulting in injury requiring transfer to the emergency room , the facility staff failed to document in the clinical record the details of the fall, how resident was found, and any contributing factors to the falls. (continued on next page)

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	495254	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonnades Health Care Center	100 Colonnades Hill Drive Charlottesville, VA 22901

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 at 10:47 a.m., during an interview with R7, the resident was observed to have bruising above her right eye and multiple bruises on her arms. On 10/30/24, during a clinical record review, it was noted that R7 had multiple falls and sustained significant injury on several occasions. The falls were noted to have occurred on 7/29/24, two on 8/5/24, 8/6/24, 10/4/24, 10/10/24, two on 10/14/24, 10/24/24, 10/25/24, and again on 10/30/24. Each of the falls documented that the fall was either witnessed or unwitnessed and the location of the fall such as living room, resident room, and dining room. The incidents gave no details as to contributing factors such as if the resident had shoes on, if the call bell had been engaged, or any interventions put in place to prevent reoccurrence. On 10/31/24, the facility administration was asked to provide the survey team with a timeline of R7's falls and the interventions implemented following each incident. On the morning of 11/1/24, the survey team was provided with copies of R7's fall progress notes, which noted no details. The surveyor again asked for evidence to include the details of the falls and what interventions were put in place following the falls. On 11/1/24, in the early afternoon, the resident assessment coordinator, who was a registered nurse, provided the survey team with a typed timeline of R7's falls. The information gave more detail to the incidents and provided R7's care plan with the associated interventions highlighted. The resident assessment coordinator, was asked if she had found the details within R7's clinical record, she said no. When asked if she would have expected such details to be part of the clinical record, she stated it should have been. On 11/1/24, in the afternoon an interview was conducted with the director of nursing (DON) and the surveyor shared the concern that R7's chart did not include the details of falls and the facility's response to show a clear picture of the events and the facility's response. The DON verbalized that she agreed, the details were not in the clinical record and should have been. The DON went on to state that she had provided education to nursing staff that they needed to be more descriptive and put the details of the falls/incidents in the clinical record of residents. On 11/1/24, about mid-afternoon, the administrator was made aware of the above findings. No additional information was provided. 49456 Based on resident interview, staff interview, clinical record review and facility documentation review the facility staff failed to ensure an accurate clinical record for 4 residents, Resident #20 (R20), Resident #177 (R177), Resident #7 (R7), and Resident #12 (R12), in a survey sample of 20 residents. The findings included: 1. The facility staff failed to complete an accurate care plan for Resident #20 (R20). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/30/24 in the evening, a review of the clinical record was conducted. During the review R20's care plan was to use a mechanical lift with bed mobility and transfers. R20's care plan also had that the resident could bear weight and transfer with the right boot on her lower extremity. On 10/31/24 at 10:31 a.m. an interview was conducted with R20. R20 stated, a mechanical lift had never been used here at this facility. On 10/31/24 at 10:32 a.m. an interview was conducted with the MDS (minimum data set) coordinator, RN#1 (RN1). RN1 accessed R20's care plan, reviewed it and verbalized that the care plan for R20 was not accurate with the transfer and bed mobility sections. RN1 stated, that this was not accurate and resolved the issue. On 10/31/24 at approximately 2:00 p.m. a review of the facility documentation was completed. The facility document titled, Individualized Care Plan, was read in part, .It is the policy of the community to develop a comprehensive, person-centered plan of care for each resident utilizing the information gathered during each assessment. The comprehensive care plan will include services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 2. The facility staff failed to document an injury of unknown origin in R177's clinical record. On 10/31/24 R177 was no longer a resident on the skill nursing unit, she had been discharged , so no interview was able to be conducted with her. On 10/31/24 at 11:13 a.m. an interview was conducted with licensed practical nurse #1 (LPN1). LPN1 verbalized that she was called into R177's room by certified nursing assistant #1 (CNA1). LPN1 stated, I reported an incident with a resident to the Administrator, the resident had two skin tears to her left extremity. LPN1 then stated, the skin tears were new. [name redacted] (CNA1) put in her notice and was cussing and yelling in front of the residents. LPN1 then verbalized that R177 said CNA1 was rough with her and the skin tears were fresh. LPN verbalized that CNA1 appeared mad at R177 about something and R177 apologized to CNA1. LPN1 stated, [name redacted] (CNA1) said to the resident, I don't want to hear that apology, and the resident began to cry. On 10/31/24 at 2:26 p.m. an interview was conducted with LPN1. LPN1 verbalized that when an incident was reported that you ask the staff and resident what happened, notify the family and doctor, put the incident in the risk connect, obtain an order for treatment, treat the area and do a health note in the clinical record. On 10/31/24 at 2:50 p.m. an interview was conducted with the acting director of nursing. The acting director of nursing stated, I expected all incidents to be charted in the clinical record by the nursing staff. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/31/24 at approximately 3:00 p.m. a clinical record review was completed. On 7/23/24 a weekly skin check note was completed and had no mention of any skin tears to left hand or elbow. On 7/28/24 an order for treatment was completed. The order reads, clean skin tear to left elbow and left hand with normal saline pat dry apply border gauze until healed. On 7/28/24 a skilled note was written by LPN1 and there was no mention of an incident with the skin tears. On 7/30/24 a weekly skin note was completed by RN1 and reads in part, .skin tear to left hand steri strips applied and foam dressing applied. On 7/30/24 a doctor's progress note was written. The note read in part, the skin tear on the left elbow happened by rubbing on the arm of the wheelchair. The note did not mention the skin tear to the left hand. On 11/01/24 at approximately 1:45 p.m. an end of day meeting was conducted with the administrator, the acting director of nursing, the general manager and the social worker. The above concerns were discussed. No additional information was provided.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on staff interview, clinical record review and facility documentation review, the facility staff failed to provide education and offer COVID immunizations, to 4 of 5 residents (resident #7-R7, resident #17-R17, resident #76- R76 and Resident #20-R20) sampled for immunizations and failed to have evidence of having provided staff education regarding COVID immunizations for 3 (licensed practical nurse #1- LPN #1, certified nursing assistant #6- CNA #6, and other employee #5- OE#5) of 3 staff sampled. The findings included: On 10/30/24, a sample of five residents was selected for review of immunizations. Review of the clinical records for each resident revealed the following: 1. R7 had no information noted with regards to the status of her COVID immunizations. There was no indication that the facility had offered any education with regards to COVID immunizations. 2. For R17, the clinical record indicated that the resident was eligible for the spike vaccination of COVID-19. 3. R76's clinical record indicated no information with regards to the COVID immunization status or that any offering or education had been provided. 4. R20's clinical record had no information with regards to immunizations. On 10/31/24 at 9:53 a.m., a meeting was held with the acting director of nursing (DON) in the presence of the regional director of resident care. The DON confirmed that she oversaw and oversaw the facilities immunization program and infection control. When asked about immunizations, the DON said, we offer flu, covid, and RSV. When asked about pneumonia, the DON said, we can. The DON was asked to explain the process for residents with regards to immunizations. The DON said, usually social work will ask them, they start the process and ask if they want the immunizations and get consents. Right now it is flu season, we did flu clinic last week, we get the consent and ordered from the pharmacy, get the orders, give the vaccines and do follow-up and documentation. When the DON was asked, why is important for residents to get immunized? The DON said, its personal preference to help with infection control and better for their health. The DON went on to explain that the social worker will give her, [the DON] the consent form and she will look into their record to see what they have had and when they received it. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the above interview the DON and Regional director of resident care were asked to access each resident's clinical record. They reported immunizations should be documented under the immunization tab and confirmed the above findings. The DON reported they attempt to get information regarding the resident's immunizations from the hospital. When asked how they know if the resident has received immunizations outside of the hospital and if they use the VIIS [Virginia Immunization Information System] portal, the DON stated, I know nothing about that and have never heard of it. The DON stated she had some consent forms in her office and obtained the following: 1. R7 had a signed consent to receive the COVID immunization dated 10/18/24. The DON confirmed it had not been administered as of 10/31/24. 2. R17 had a signed consent form for COVID, which was signed and dated 10/17/24. However, neither box had been checked to identify if the resident wanted the flu or pneumonia vaccine. The DON stated R17 wanted the COVID immunization, and she had failed to check the box. The DON also confirmed despite having the consent on file, the resident had not been immunized. 3. R76 had no information on file that the resident's COVID immunization status was known other than according to hospital records the last dose received was 10/20/21, which would make the resident eligible for the spike vaccination. There was no evidence that R76 had been educated or offered the vaccine. 4. R20 had signed a consent form indicating the desire to receive the COVID immunization on 10/17/24. The DON confirmed that as of 10/31/24, the immunization had not been given. When asked about the immunizations being signed 10/17-10/18 and had not been administered, the DON said, This is my first time doing any of this. It is a work in progress. When we were getting consent for the flu shots, we got consents for everything. The Regional Director of resident services stated, If they sign wanting it, we should schedule it immediately to prevent the spread of infection. On 10/31/24, in the early afternoon, the facility administrative staff were asked to provide evidence of COVID immunization status and education regarding COVID immunizations for the three staff being sampled, LPN #1, CNA #6 and OE #5. On 11/1/24 at 10:25 a.m., the general manager reported to the survey team, Costco comes in to provide education. We no longer require them [staff] to provide COVID immunization cards. The surveyor asked if they had any evidence of the staff being provided the education regarding immurations, such as a signed form, as the regulation continues to require evidence of staff education. The general manager said, they don't sign a copy, no and had no further information to provide. On 11/1/24 at 10:42 a.m., an interview was conducted with the social worker. The social worker was asked about consent forms for immunizations and reported when reviewing admission paperwork she had consent forms for flu, pneumonia and RSV vaccinations. The social worker stated that they get the hospital's immunization records for residents, she asks the residents and said, if they tell me I put it on the consent form and give it to [the DON's name redacted]. When asked about COVID immunizations, the social worker said, We did COVID this year when we asked about flu shots. It is not in my contract, and we just started it in October because it is flu season. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, COVID-19: Education & Offering of Vaccine- Resident & Team Members was conducted. The policy read in part, . The skilled nursing administrator (SNA)/executive director (ED)/director of nursing (DNS)/designee will facilitate the education of residents or resident representatives and team members regarding the benefits and potential side effects associated with the COVID-19 vaccine in a manner they can understand . 2. It is the responsibility of the SNA/ED/DNS/designee to facilitate a. Vaccination, which will be conducted in accordance with CDC, ACIP, FDA, and manufacturer guidelines .b. Screening individuals prior immunization prior to offering the vaccination . d. Each resident and team member will be offered the COVID-19 vaccine unless the immunization is medically contraindicated as determined by a physician, or the resident or team member has already been immunized . 9. It is the responsibility of the SNA/ED/designee that the facility maintain documentation related to team member COVID-19 vaccination that includes at a minimum, the following: a. That team members were provided education regarding the benefits and potential risks associated with COVID-19 vaccine . The FDA (Food and Drug Administration) gives information about the 2023-2024 spike vaccine on their website, accessed at: https://www.fda.gov/vaccines-blood-biologics/coronavirus-covid-19-cber-regulated-biologics/novavax-covid-19-vaccine-adjuvanted. The guidance read, On October 3, 2023, the Food and Drug Administration amended the emergency use authorization (EUA) of Novavax COVID-19 Vaccine, Adjuvanted to include the 2023-2024 formula. The Novavax COVID-19 Vaccine, Adjuvanted, a monovalent vaccine, has been updated to include the spike protein from the SARS-CoV-2 Omicron variant lineage XBB.1.5 (2023-2024 formula). The Novavax COVID-19 Vaccine, Adjuvanted (Original monovalent) is no longer authorized for use in the United States. Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) is authorized for use in individuals [AGE] years of age and older as follows: Individuals previously vaccinated with any COVID-19 vaccine: one dose of Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) is administered at least 2 months after receipt of the last previous dose of an original monovalent (Original) or bivalent (Original and Omicron BA.4/BA.5) COVID-19 vaccine. Individuals not previously vaccinated with any COVID-19 vaccine: two doses of Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) are administered three weeks apart . On 11/1/24 at 1:45 p.m., during an end of day meeting, the facility administrator, management staff and corporate staff was made aware of the above findings. No additional information was provided.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility’s Quality Assurance and Performance Improvement Program. 41449 Based on staff interviews and facility documentation review, the facility staff failed to provide as part of their Quality Assurance and Performance Improvement (QAPI) program mandatory training for five employees (certified nursing assistants- CNA #1, #4 and #5, licensed practical nurse LPN #4, and registered nurse RN #2) in a sample of five staff members reviewed for educational requirements. The findings included: On 10/31/24, a survey sample of five staff members was selected for review of their education and training. The sample included: CNA #1, CNA #4, CNA #5, LPN #4 and RN #2. The facility administration was given the names and asked to provide all evidence of education and training provided to those employees for the past two years. On 11/1/24, the general manager (GM) provided the survey team with transcript reports of education for each of the five sampled staff. The GM was asked if all the staff education is conducted as computer-based training and the GM stated that it was, and the facility used Relias for staff training. The GM also confirmed that they have a training calendar which included mandatory trainings staff had to complete each month. Review of the Annual Training Assignments/ 2024 Annual Training Calendar and Skilled Nursing Annual Training Online 2023 documents were reviewed. According to the 2023 training outline QAPI training was to be completed by all team members in January 2023. According to the 2024 training calendar, no QAPI training was listed. Review of the educational training for each of the five sampled employees was reviewed. None of the five employees had received any QAPI training in 2023 or 2024. On 11/01/24 at 11:21 a.m., an interview was conducted with the facility administrator. The administrator was asked to tell the surveyor about staff education with regards to their QAPI program and plan. The administrator said, we generally will have monthly meetings with them and go over pertinent topics such as if we have an increase in falls and ask for any input, they have with regards to possible ways to decrease them or ways to prevent them or if they have noticed anything. When asked when the monthly meetings were held, the administrator said, usually on Wednesday towards the end of the month. When the surveyor asked to see the minutes from the last six months of meetings, the facility administrator provided the surveyor with the QAPI book. It was noted that QAPI meetings were held monthly and included only management level staff and the medical director. A follow-up interview was conducted with the facility administrator who confirmed that only management level staff were in attendance at the QAPI meeting. When informed the surveyor was attempting to determine the facility's compliance with the regulation that the facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program. (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/1/24 at 1:45 p.m., the facility administrator and management staff were made aware of the above findings. No additional information was provided.