STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495305	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coliseum Nursing and Rehabilitation Center	305 Marcella Road Hampton, VA 23666

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49917 Based on observation, resident interviews and staff interviews the facility staff failed to maintain a clean, comfortable, homelike environment for 2 of 7 residents (Resident #1 and Resident #2), in the survey sample. The findings included: 1. Resident #1 was originally admitted to the facility 5/25/24 after an acute care hospital stay. The admission diagnoses included; cardiogenic shock, chronic congestive heart failure, pulmonary hypertension, muscle weakness, and chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/30/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were intact. On 5/29/24 during an observation tour for room [ROOM NUMBER], it was observed that the air conditioning unit was not functioning. On 5/29/24 at 3:05 PM an interview was conducted with Resident #1. Resident #1 stated that the air conditioning unit has not been working since his admitted [DATE]. Resident #1 also stated, I'm dying in here. I have been asking them to fix the air conditioning since I came here, and they are not doing anything to fix it. On 5/29/24 at 6:50 PM an interview was conducted with the Administrator and the Director of Nursing (DON). The Administrator stated that she is not aware of any air conditioning issues and does not know anything about air conditioning concerns for room [ROOM NUMBER], however she will report this to the Maintenance Director. On 5/30/24 at 11:00 AM an interview was conducted with the [NAME] President of Plant Operations and the Administrator. The Administrator stated that a portable air conditioning unit has been put in room [ROOM NUMBER]. Also, the [NAME] President of Plant Operations stated that the plan is for the Corporate Maintenance Team to begin installing PTAC units in all the rooms that are having air conditioning issues. He further stated that four employees from the Corporate Maintenace Team is currently on site working on the air conditioning issues. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #2 was originally admitted to the facility 3/15/24. The current diagnoses included; quadriplegia, intraspinal abscess and granuloma, cervical disc disorder with myelopathy, anxiety disorder, and essential hypertension. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/22/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were intact. On 5/29/24 at 4:10 PM during an observation tour for room # 413, it was observed that the ceiling tile was full of water and had a dirty/black stain. On 5/30/24 at 1:15 PM an interview was conducted with Resident #2. Resident #2 stated that the roof has been leaking for a couple months and the ceiling tile is full of water. Resident #2 also stated that he has been asking for the tile to be replaced and for the roof to be fixed however he is unable to get a response from the facilities management team. An interview was conducted on 5/30/24 at 5:15 PM with the Director of Maintenance and Administrator. The Director of Maintenance stated that the roof is leaking and that is why the ceiling tile is wet and dirty. The Director of Maintenance also stated that the ceiling tile was replaced around 3:00 PM this afternoon and the facility is working with a roofing company to get the roof leak issue fixed. On 5/30/24 at approximately 8:30 p.m., a final interview was conducted with the Administrator, Director of Nursing, Assistant Administrator, Regional Nursing Corporate Consultant, Resident Navigator, and Corporate Assistant Director of Nursing. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on resident interview, staff interview, and clinical record review the facility staff failed to provide toileting hygiene/toileting assistance for 2 of 7 residents (Resident #6 and 5), in the survey sample. The findings included: 1. The facility's staff failed to provide toileting hygiene to Resident #6 when requested on 5/29/24 before and during the supper meal. Resident #6 was originally admitted to the facility 4/1/2017 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included dementia, high blood pressure and diabetes. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/5/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #6's cognitive abilities for daily decision making were moderately impaired. In section GG (Functional Abilities and Goals) the resident was coded as dependent for toileting hygiene. On 5/29/24 at 5:23 PM Resident #6 stated she was wet, so she pressed the call bell. Certified Nursing Assistant (CNA) #1 answered the call bell and turned the call bell off while telling the resident that her aide would change her after dinner. At approximately 5:29 PM CNA #1 returned to Resident #6's room with the supper tray. At approximately 6:05 PM Resident #6 turned the call bell on again and it was turned off again by CNA #1 as she removed the resident's tray from the room. At 6:12 PM Resident #6 stated she had pressed her call bell to be changed and she wasn't changed and now she had to dokie too. On 5/29/24 at 6:30 PM an interview was conducted with CNA #1. CNA #1 stated she turned the resident's call light off, because she assessed her brief by viewing the color of the line on the incontinence product and the coloring indicator did not confirm the resident was wet enough to change. CNA #1 further stated the resident does not know if she is wet or not and sometimes, she requests to toilet but she doesn't get toileted because she requires transfers using a lift. CNA #1 also stated she reported to the assigned CNA of the resident's desire to be changed but she had not changed her because it was time for her to go on a break. On 5/29/24 at at 6:36 PM the resident stated that she was still waiting to receive toileting hygiene. On 5/30/24 at approximately 7:00 p.m., a final interview was conducted with the Administrative staff. The Director of Nursing stated that for every meal a CNA is designated as responsible for toileting residents who requests assistance during a meal and that was also true on 5/29/24 during the supper meal. The facility's staff had no further comments and voiced no concerns regarding the above information. 2. The facility's staff failed to provide toileting assistance to Resident #5 when requested on 5/30/24 during the breakfast meal. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6 was originally admitted to the facility 5/1/24 and she had not discharged from the facility. The current diagnoses included atrial fibrillation and renal insufficiency. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/8/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #6's cognitive abilities for daily decision making were intact. In section GG (Functional Abilities and Goals) the resident was coded as maximal assistance for toileting hygiene. On 5/30/24 at 12:32 PM an interview was conducted with Resident #5. Resident #5 stated she sat on the side of her bed that morning at approximately 6:45 AM and rung her call bell for assistance to toilet because she needed to have a bowel movement. Resident #5 further stated it took the staff over an hour before the call bell was answered and the staff stated she would have to wait until after breakfast to toilet. Resident #5 stated her breakfast was served to her while she was waiting to be toileted even after she told the nurse again that she needed to toilet. The resident stated she had to consume her breakfast while needing to have a bowel movement. Two Certified Nursing Assistant (CNA) were assigned to the unit Resident #5 resided on. An interview was conducted with CNA #2 on 5/30/24 at approximately 6:30 PM. CNA #2 stated she did not turn the resident's call bell off during breakfast and she did not tell the resident that she could not toilet during mealtime. CNA #2 stated she was assigned to the toileting task during meals but she was not informed of the resident's request by whomever provided the information to the resident. On 5/30/24 at approximately 7:00 p.m., a final interview was conducted with the Administrative staff. The Director of Nursing stated that for every meal a CNA is designated as responsible for toileting residents who requests assistance during a meal and that was also true on 5/30/24 during the breakfast meal. The facility's staff had no further comments and voiced no concerns regarding the above information.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on the resident's interview, observations, family interview, staff interviews, and clinical record review, the facility's staff failed to obtain emergency dental services for one resident (Resident 7), in the survey sample. The findings included: Resident #7 was not provided dental services who presented with a broken and severely painful left upper tooth for which the facility's staff could not provided documentation of extenuating circumstances that resulted in the delay of treatment by a dentist. Resident #7 was originally admitted to the facility 1/11/23 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included diabetes, high blood pressure and heart failure. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/4/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #7's cognitive abilities for daily decision making were moderately impaired. In section GG (Functional Abilities and Goals) the resident was coded at GG0130 (Self-Care) as requiring supervision with oral hygiene. On 5/29/24 at 4:20 PM Resident #7 stated she had a broken tooth, and the pain was so severe it was causing pain in her eyes. Resident #7 stated the tooth broke off on Thursday 5/23/24 or Friday 5/24/24 and she reported it to a nurse on Saturday 5/25/24. The resident further stated she requested Anbesol which was provided and the Anbesol helped some, but she had only received it once that she could recall. Resident #7 also stated she had received other medications the nurses told her were pain medications for the tooth pain, but the pain did not stop therefore she knew she needed to be evaluated by a dentist. After the Surveyor exited the resident's room Licensed Practical Nurse (LPN) #1, was observed in the hallway. LPN #1 stated he had administered Tylenol to the resident, and he had spoken with Social Worker (SW) #1 who had scheduled a dental appointment for Resident #1, but he did not know specifics about the appointment. Upon viewing the residents oral cavity on 5/29/24 at approximately 4:24 PM many carious teeth were observed and the resident was with very poor hygienic care. Viewing of the left upper and posterior mouth the broken tooth which was causing the pain was viewed. On 5/30/24 at 11:07 AM stated she continued to experience significant oral pain described as a 10 out of 10 from the broken tooth. The resident also stated she had not been informed when the dentist would assess the broken and painful tooth, all she knew was there was an appointment scheduled. Resident #7 stated she only consumed the eggs for breakfast because the broken tooth was so painful she could not eat the biscuit and sausage gravy. The resident stated she needed help to get to the dentist. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/30/24 at 11:21 AM and interview was conducted with SW #1. SW #1 stated the resident required stretcher transport and an escort to the dentist office and there was no local dentist to accommodate any residents who required stretcher transport. SW #1 also stated the Medical Assistant (MA) attempted to make an appointment for Resident #7 on 5/29/24 at a dental school's clinic in another city but the MA was informed that a call would need to be made to the dental school's clinic on 6/1/24, which was a Saturday, a day the MA did not work and because the niece would be required to accompany the resident therefore the MA deferred the task of scheduling the appointment to the resident's niece. On 5/30/24 at 11:51 AM - An interview was conducted with the Family Member (FM) #2 who stated the MA notified her on 5/29/24 that she would need to follow up with the dental school's clinic on Saturday 6/1/24 to schedule an appointment for Resident #7's painful, broken tooth. FM #2 stated the MA stated when she called dental school's clinic, she was informed all appointments must be made on the first day of the month. The MA provided the niece with the resident's Medicare and Medicaid numbers and the phone number to the dental school's clinic to call on 6/1/24 to schedule an appointment. FM #2 stated she did not volunteer to schedule an appointment for Resident #7, she felt she had to because the MA made it her responsibility and she did not know processes for individuals in a nursing home. FM #1 stated her preference was for the facility's staff to schedule the appointment and assist with obtaining an escort. An interview was conducted with the general practice Nurse Practitioner (NP) on 5/30/24 at approximately 6:07 PM. The NP stated oral jel and Oxycodone 5 mg for three days had been ordered on 5/25/24. The NP stated the Oxycodone order was extended and Amoxicillin 500 mg every 12 hours for seven days, was ordered to alleviate the oral pain because of the broken and painful tooth. The NP stated she also ordered labs to assess for an infectious process and felt she had done what a dentist would have done on behalf of the resident. A review of the Medication Administration Record (MAR) revealed the resident was administered Oxycodone once on 5/25/24, 5/26/24, 5/27/24, 5/29/24 and 5/30/24. On 5/30/24 at 7:00 PM a final meeting was held with the administrative staff. The Administrator stated they no longer had a contract with (name of a practice they previously had a contract with) therefore they would have to research a practice to accept the resident. At approximately 7:28 PM the facility's staff provided a scheduled dental appointment for Resident #7 for Friday 5/31/2024 at 10:00 AM. After presentation of the scheduled appointment the facility's staff had no further comments and voiced no concerns regarding the above information.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 34306 Based on resident interview and staff interviews the facility staff failed to have an agreement with a dentist to provide emergency dental services for 1 of 7 residents (Resident #7), in the survey sample. The findings included: On 5/29/24 at 4:20 PM Resident #7 stated she had a broken tooth, and the pain was so severe it was causing pain in her eyes. Resident #7 stated the tooth broke off on Thursday 5/23/24 or Friday 5/24/24 and she reported it to a nurse on Saturday 5/25/24. The resident stated she was told that a dental appointment had been scheduled but she was not provided details. On 5/30/24 at 11:21 AM and interview was conducted with SW #1. SW #1 stated the resident required stretcher transport and an escort to the dentist office and there was no local dentist to accommodate any residents who required stretcher transport. SW #1 also stated the Medical Assistant (MA) attempted to make an appointment for Resident #7 on 5/29/24 at a dental school's clinic in another city but the MA was informed that a call would need to be made to the dental school's clinic on 6/1/24, which was a Saturday, a day the MA did not work and because the niece would be required to accompany the resident therefore the MA deferred the task of scheduling the appointment to the resident's niece. On 5/30/24 at 7:00 PM a final meeting was held with the administrative staff. The Administrator stated they no longer had a contract with (name of a practice they previously had a contract with) therefore they would have to research a practice to accept the resident. The Administrator stated at approximately 7:20 PM that the Quality Corporate representative provided them with the name of a dental practice to call to schedule services for Resident #7.