STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 27660 Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to promote dignity for one of 35 residents in the survey sample, Resident #137. The findings include: For Resident #137 (R137), the facility staff instructed the resident to pee in her pants, thus not providing dignified care. On 9/15/24 at 4:53 p.m. an interview was conducted with R137. R137 stated that the staff would not get her up from the bed until therapy had screened her. When asked how she was going to the bathroom, the staff told her to pee in her pant. R137 was asked how that made her feel, she stated it made her feel like an idiot and was embarrassed. A second interview was conducted with R137 on 9/16/24 at 8:44 a.m. When asked how her night was, she stated she was told to 'pee' in her diaper through the night as she hadn't been evaluated by therapy. When asked if she was offered the use of a bedpan, R137 stated no. The Admission assessment dated , 9/14/24 at 6:46 p.m. documented in part, Resident is alert, oriented, memory is intact, had clear organized thinking. The Continence and Retraining/Scheduled Toileting and Decision/Determination form dated 9/14/24 at 7:02 p.m. documented in part, Resident's mental status and communication - no problems. Physical condition/functioning - unable to walk to bathroom. What is resident's mental awareness of toileting needs - completely aware. Based on the review above, initiate 72 - hour bowel & bladder tracking/log - no tracking indicated; continent at present. An interview was conducted with CNA (certified nursing assistant) #2 on 9/17/24 at 3:00 p.m. When asked when a new admission comes, can you get them out of bed to use the restroom, CNA #2 stated you have to first check with the nurse to see what the discharge paperwork says. When asked if she's been told not to get a resident out of bed until therapy screens them, CNA #2 stated, no. CNA #2 was asked if she has or has ever told a resident to pee in their pants, CNA #2 stated, no. When asked how she thought that would make a resident feel, CNA #2 stated, lack of dignity. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with RN (registered nurses) #6 on 9/17/24 at 3;12 p.m. When asked when a new admission comes, how is it determined if a resident could get out of bed, RN #6 stated, he would see the resident first to see if they can get up and depending on what my report from the hospital said and my assessment he would determine if the resident could get up. When asked if the resident cannot get up how do they go to the bathroom, RN #6 stated, if they are continent, then a bedpan should be offered, if incontinent then changing their brief as needed. When asked if he has ever heard a staff member tell the resident to 'pee' in your pants, RN #6 stated, he hadn't witnessed that. RN #6 was asked how it would make a resident feel if they were told that, RN #6 stated it would make them feel bed, disappointed, if they could use a bed pan, they would feel belittled. The facility policy, Resident Rights Inservice, documented in part, The Nursing Home Reform Act established the following rights for nursing home residents: The right to be treated with dignity. ASM (administrative staff member) #1, the interim administrator and ASM #2, the director of nursing, were made aware of the above findings on 9/17/24 at 5:13 p.m. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 42106 Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility failed to implement their abuse policy for reporting an allegation of abuse within two hours after the allegation was made, for one of 35 residents in the survey sample, Resident #21 (R21). The findings include: For R21, the facility staff failed to implement their abuse policy by not reporting an allegation of abuse reported to staff on 7/1/24 until 7/2/24. The facility policy Virginia Resident Abuse Policy revised 10/03/2022 documented in part, .Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy . If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the DOH (department of health) immediately, but not later than 2 hours after the allegation is made . On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/20/24, R21 scored 13 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. On 9/15/24 at 5:14 p.m., an interview was conducted with R21. R21 stated that they had recently filed a police report against another resident at the facility for threatening them. R21 stated that they had been in the hallway near the dining room and another resident [Name of Resident #64] had started arguing with them and threatened to kick her [expletive] and stab them. R21 stated that Resident #64 (R64) had threatened them and at first, they had not wanted to call the police but had changed their mind and called the police later to file a report. R21 stated that R64 was no longer allowed to come on the unit and resided on the other unit and they did not see each other anymore. R21 stated that they had reported this to the social worker who had called the police for the report. Review of R21's progress notes documented in part, - 07/01/2024 13:29 (1:29 p.m.) Resident reported being threatened over the weekend by another resident, grievance form filed and resident was asked if she wanted to press charges, resident said no, that she did not want the police involved. - 07/02/2024 15:00 (3:00 p.m.) Completed skin assessment resident's skin intact, no discolorations nor bruising noted. Able to make needs known. Shower was given this afternoon. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 07/03/2024 10:21 (10:21 a.m.) Resident was crying and clearly upset in the hallway and stated she would now like to press charges on another resident for a previous incident that occurred. See prior SS (social service) note. Non-emergency called and police report taken. A facility concern form dated 7/1/24 for R21 documented in part, .Describe concern using factual terms: resident stated that over the weekend she got into a verbal argument with another resident from unit 2. Resident stated she called APS (adult protective services) to report it and did not want to press criminal charges at this time. Individual(s) designated to take action on this concern: [Name of OSM (other staff member) #10, the director of social services/admissions coordinator] and admin. Date assigned: 7/1/24 . Review of the facility synopsis of event for R21 dated 7/2/24 documented in part, Report Date: July 2, 2024 . [Name of R21] reported another resident threatened to harm her, on an unknown day or time the past weekend. Head to toe assessment completed with no noted injuries. RP (responsible party) and MD (medical doctor) made aware. [Name of sheriff's office] contacted with report received. Final outcome to follow . The fax confirmation documented the report sent to the state agency on 7/2/24 at 3:05 p.m. On 9/17/24 at 11:32 a.m., an interview was conducted with OSM #10, the director of social services/admissions coordinator. OSM #10 stated that someone reported to him that R21 had reported R64 wandering over to the unit and threatening to stab them after they had gotten into a verbal altercation. He stated that he had completed the grievance form and reported it to the former administrator at that time. OSM #10 stated that they had spoken to R21 who did not want to file a police report at that time but then later decided to file a report after speaking with the family. He stated that he had contacted the non-emergency police number who had come out and taken the information. He stated that no one had witnessed the incident that R21 reported and R64 did not recall the incident. He stated that both residents were evaluated by psychiatric services and R64 had never had any threatening behaviors prior to that accusation and had not had any behavior issues since that incident. He stated that R21 had a history of attention seeking behaviors and other behaviors and they were unable to prove that it had happened. He stated that R64 wandered but did not exit seek and was confused but was not banned from coming on the unit but stayed away from R21. On 9/17/24 at 2:22 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that she did the investigation of the event between R21 and R64 initially reported on 7/2/24. She stated that the reporting time frame was two hours for an allegation of abuse. She stated that the allegation of abuse should have been reported on 7/1/24 when the resident reported it. On 9/18/24 at 10:43 a.m., ASM #5, the regional vice president of operations presented an action plan binder for the allegation of abuse reported by R21 on 7/1/24 and not reported until 7/2/24. She stated that they had implemented the plan after discovering that R21 had reported the allegation of abuse on 7/1/24 and it had not been reported until 7/2/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the action plan binder documented the concern form dated 7/1/24, facility synopsis of events dated 7/2/24, a resident risk tool completed 7/2/24, an investigation analysis, staff statements, a root cause analysis, staff and resident abuse audits and an ad hoc QAPI (quality assessment performance improvement) meeting regarding reporting abuse and timely reporting. The binder documented actions taken for R21 and R64, audits of five resident and five staff interviews weekly for four weeks, then monthly for two months to ensure there were no further issues with behaviors/abuse/neglect. The plan documented abuse policy education of current employees by telephone or in person dated 7/8/24. The plan documented an alleged date of compliance of 7/31/2024. Abuse education and training was reviewed and verified by multiple staff interviews. Implementation of the education was verified with additional resident interviews and observations. No current concerns were identified. On 9/18/24 at 2:59 p.m., ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator in training, and ASM #5, the regional vice president of operations were made aware of the concern recommended at past non-compliance. No further information was provided prior to exit. PAST NONCOMPLIANCE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 42106 Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility failed to report an allegation of abuse in a timely manner for one of 35 residents in the survey sample, Resident #21 (R21). The findings include: For R21, the facility staff failed to report an allegation of abuse that was reported to staff on 7/1/24 until 7/2/24. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/20/24, R21 scored 13 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. On 9/15/24 at 5:14 p.m., an interview was conducted with R21. R21 stated that they had recently filed a police report against another resident at the facility for threatening them. R21 stated that they had been in the hallway near the dining room and another resident [Name of Resident #64] had started arguing with them and threatened to kick her [expletive] and stab them. R21 stated that Resident #64 (R64) had threatened them and at first, they had not wanted to call the police but had changed their mind and called the police later to file a report. R21 stated that R64 was no longer allowed to come on the unit and resided on the other unit and they did not see each other anymore. R21 stated that they had reported this to the social worker who had called the police for the report. Review of R21's progress notes documented in part, - 07/01/2024 13:29 (1:29 p.m.) Resident reported being threatened over the weekend by another resident, grievance form filed and resident was asked if she wanted to press charges, resident said no, that she did not want the police involved. - 07/02/2024 15:00 (3:00 p.m.) Completed skin assessment resident's skin intact, no discolorations nor bruising noted. Able to make needs known. Shower was given this afternoon. - 07/03/2024 10:21 (10:21 a.m.) Resident was crying and clearly upset in the hallway and stated she would now like to press charges on another resident for a previous incident that occurred. See prior SS (social service) note. Non-emergency called and police report taken. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility concern form dated 7/1/24 for R21 documented in part, .Describe concern using factual terms: resident stated that over the weekend she got into a verbal argument with another resident from unit 2. Resident stated she called APS (adult protective services) to report it and did not want to press criminal charges at this time. Individual(s) designated to take action on this concern: [Name of OSM (other staff member) #10, the director of social services/admissions coordinator] and admin. Date assigned: 7/1/24 . Review of the facility synopsis of event for R21 dated 7/2/24 documented in part, Report Date: July 2, 2024 . [Name of R21] reported another resident threatened to harm her, on an unknown day or time the past weekend. Head to toe assessment completed with no noted injuries. RP (responsible party) and MD (medical doctor) made aware. [Name of sheriff's office] contacted with report received. Final outcome to follow . The fax confirmation documented the report sent to the state agency on 7/2/24 at 3:05 p.m. On 9/17/24 at 11:32 a.m., an interview was conducted with OSM #10, the director of social services/admissions coordinator. OSM #10 stated that someone reported to him that R21 had reported R64 wandering over to the unit and threatening to stab them after they had gotten into a verbal altercation. He stated that he had completed the grievance form and reported it to the former administrator at that time. OSM #10 stated that they had spoken to R21 who did not want to file a police report at that time but then later decided to file a report after speaking with the family. He stated that he had contacted the non-emergency police number who had come out and taken the information. He stated that no one had witnessed the incident that R21 reported and R64 did not recall the incident. He stated that both residents were evaluated by psychiatric services and R64 had never had any threatening behaviors prior to that accusation and had not had any behavior issues since that incident. He stated that R21 had a history of attention seeking behaviors and other behaviors and they were unable to prove that it had happened. He stated that R64 wandered but did not exit seek and was confused but was not banned from coming on the unit but stayed away from R21. On 9/17/24 at 2:22 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that she did the investigation of the event between R21 and R64 initially reported on 7/2/24. She stated that the reporting time frame was two hours for an allegation of abuse. She stated that the allegation of abuse should have been reported on 7/1/24 when the resident reported it. On 9/18/24 at 10:43 a.m., ASM #5, the regional vice president of operations presented an action plan binder for the allegation of abuse reported by R21 on 7/1/24 and not reported until 7/2/24. She stated that they had implemented the plan after discovering that R21 had reported the allegation of abuse on 7/1/24 and it had not been reported until 7/2/24. Review of the action plan binder documented the concern form dated 7/1/24, facility synopsis of events dated 7/2/24, a resident risk tool completed 7/2/24, an investigation analysis, staff statements, a root cause analysis, staff and resident abuse audits and an ad hoc QAPI (quality assessment performance improvement) meeting regarding reporting abuse and timely reporting. The binder documented actions taken for R21 and R64, audits of five resident and five staff interviews weekly for four weeks, then monthly for two months to ensure there were no further issues with behaviors/abuse/neglect. The plan documented abuse policy education of current employees by telephone or in person dated 7/8/24. The plan documented an alleged date of compliance of 7/31/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Abuse education and training was reviewed and verified by multiple staff interviews. Implementation of the education was verified with additional resident interviews and observations. No current concerns were identified. The facility policy Virginia Resident Abuse Policy revised 10/03/2022 documented in part, .Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy . If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the DOH (department of health) immediately, but not later than 2 hours after the allegation is made . On 9/18/24 at 2:59 p.m., ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator in training, and ASM #5, the regional vice president of operations were made aware of the concern recommended at past non-compliance. No further information was provided prior to exit. PAST NONCOMPLIANCE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 29125 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence that all hospital transfer documentation requirements were implemented for three of 35 residents in the survey sample; Residents #36, #9 and #11. The findings include: 1. For Resident #36, the facility staff failed to evidence what, if any, documents were sent to the receiving facility upon a hospital transfer and/or ensure that the physician wrote a note regarding a hospital transfer. A review of the clinical record revealed the following: A. 6/20/24 - no evidence of what, if any, documents were sent: A nurse's note dated 6/20/24 documented, Resident assessed by PA (physician's assistant) and NP (nurse practitioner) and new orders given and noted to send to (hospital) for further eval (evaluation) for possible TIA/CVA (stroke) due to symptoms. Resident noted with delayed reaction during conversation Further review revealed no evidence of what, if any, documents were sent to the hospital, including contact information of the practitioner who was responsible for the care of the resident; resident representative information, including contact information; advance directive information; all special instructions and/or precautions for ongoing care, as appropriate such as: treatments and devices (oxygen, implants, IVs, tubes/catheters); transmission-based precautions; special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions; the resident ' s comprehensive care plan goals; and all other information necessary to meet the resident ' s needs, which includes, but may not be limited to: resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs; diagnoses and allergies; medications (including when last received); and most recent relevant labs, other diagnostic tests, and recent immunizations. B. 7/6/24 - no evidence of what, if any, documents sent, a nurse's note documenting the circumstances for the hospital transfer, and a physician's note regarding the transfer: A nurse's note dated 7/6/24 at 12:14 AM documented, Resident very confused and yelling denies pain. Attempted to calm him down but after staff left from the he will start yelling. Stayed with him for awhile. Ativan 1 mg (milligram) given with positive effects. Continues on Augmentin Resident resting comfortably awake but calm and cooperative, Will continue to monitor. The very next nurse's note was dated 7/6/24 at 10:38 PM and documented, Resident returned the facility from (hospital) at about 2120 (9:20 PM) received new orders to continue Augmentin 875/123 mg po (by mouth) twice a day. Foley was replaced from the hospital All HS (bedtime) meds given taking without difficulty. Will continue to monitor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was nothing documented at the time of transfer to the hospital regarding the circumstances that necessitated the hospital transfer. In addition, there was no evidence of what, if any, documents were sent to the hospital, including contact information of the practitioner who was responsible for the care of the resident; resident representative information, including contact information; advance directive information; all special instructions and/or precautions for ongoing care, as appropriate such as: treatments and devices (oxygen, implants, IVs, tubes/catheters); transmission-based precautions; special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions; the resident ' s comprehensive care plan goals; and all other information necessary to meet the resident ' s needs, which includes, but may not be limited to: resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs; diagnoses and allergies; medications (including when last received); and most recent relevant labs, other diagnostic tests, and recent immunizations. Further review also failed to evidence any physician's note related to the hospital transfer, to include the specific resident needs the facility could not meet; the facility efforts to meet those needs; and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility. C. 7/18/24 - no evidence of a physician's note regarding the transfer: A nurse's note dated 7/18/24 documented, Resident experienced witnessed fall event as evidenced by resident was sitting in his wheelchair in the Community area and fell from w/c (wheelchair) at 2:00 p.m. Upon assessment, resident has an opened area under his right eye, two opened areas to his nose, one small, opened area to his forehead, and a laceration to his left middle finger. Resident transferred via lift and appropriate number of staff members back to wheelchair, then to bed. Areas cleansed and pressure applied. EMS (emergency medical services) called for transfer to ED (emergency department). EMS arrived at facility to transport resident and Face sheet, CCD, Transfer form, Care plan, Bed hold all sent with resident. Call placed to (hospice agency) and message left notifying them of fall with injury and transfer to ED. Further review failed to evidence any physician's note related to the hospital transfer, to include the specific resident needs the facility could not meet; the facility efforts to meet those needs; and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility. On 9/17/24 at 2:25 PM, ASM #1 (Administrative Staff Member) stated that they do not have any of the evidence requested. On 9/17/24 at 2:31 PM, an interview was conducted with LPN #10 (Licensed Practical Nurse). When asked what documents are sent to the hospital, she stated that a facesheet and a medication list. When asked about the care plan, she stated not usually. When asked about a bed hold notice, she stated, You are supposed to provide a bed hold but each facility is different. When asked how does she evidence what is sent to the hospital, she stated it would be in a nurse's note. When asked about ensuring the physician writes a note about the hospital transfer, she stated, We notify the physician and they usually try interventions and we document what we did and that the provider was notified but she did not ensure that the provider writes a note. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, Resident Discharge / Transfer Letter provided by the facility did not address hospital transfer requirements related to required nursing and physician documentation regarding the resident's change in condition necessitating a hospital transfer and what documents are to be provided to the hospital. On 9/17/24 at 4:50 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. 2. For Resident #9, the facility staff failed to evidence what, if any, documents were sent to the receiving facility upon a hospital transfer. A. 6/8/24 - no evidence of what, if any, documents were sent: A nurse's note dated 6/8/24 documented, Alerted by aid that resident had episode of vomiting, resident assessed and has a change in LOC (level of consciousness), elevated B/P (blood pressure) 188/103 Resident not responding appropriately to questions, EMS (emergency medical services) called. A second note dated 6/8/24 documented, Resident's emergency contact called and left voice mail to call back for update and status. A third nurse's note dated 6/8/24 documented, Author called (hospital) for update on resident. Resident being admitted for observations r/t (related to) stroke like symptoms. No other information present at this time. There were no further notes until 6/12/24 documenting the resident's readmission. There was no evidence of what, if any, documents were sent to the hospital, including contact information of the practitioner who was responsible for the care of the resident; resident representative information, including contact information; advance directive information; all special instructions and/or precautions for ongoing care, as appropriate such as: treatments and devices (oxygen, implants, IVs, tubes/catheters); transmission-based precautions; special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions; the resident ' s comprehensive care plan goals; and all other information necessary to meet the resident ' s needs, which includes, but may not be limited to: resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs; diagnoses and allergies; medications (including when last received); and most recent relevant labs, other diagnostic tests, and recent immunizations. B. 6/13/24 - no evidence of what, if any, documents were sent: A nurse's note dated 6/13/24 documented, Received resident in bed, alert and verbal. During AM (morning) med pass CNA (Certified Nursing Assistant) witnessed resident have two consecutive seizures approximately 90 seconds in duration 10 minutes apart. Resident was assessed and repositioned to prevent injury. Resident cold/dry to touch, Resident had drainage from both nostrils blood and mucous mixed. Resident sent to ED (emergency department) for further evaluation. On call provider and family notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There were no further notes until 7/1/24 documenting the resident's readmission. There was no evidence of what, if any, documents were sent to the hospital, including contact information of the practitioner who was responsible for the care of the resident; resident representative information, including contact information; advance directive information; all special instructions and/or precautions for ongoing care, as appropriate such as: treatments and devices (oxygen, implants, IVs, tubes/catheters); transmission-based precautions; special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions; the resident ' s comprehensive care plan goals; and all other information necessary to meet the resident ' s needs, which includes, but may not be limited to: resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs; diagnoses and allergies; medications (including when last received); and most recent relevant labs, other diagnostic tests, and recent immunizations. On 9/17/24 at 2:25 PM, ASM #1 (Administrative Staff Member) stated that they do not have any of the evidence requested. On 9/17/24 at 2:31 PM, an interview was conducted with LPN #10 (Licensed Practical Nurse). When asked what documents are sent to the hospital, she stated that a facesheet and a medication list. When asked about the care plan, she stated not usually. When asked about a bed hold notice, she stated, You are supposed to provide a bed hold but each facility is different. When asked how does she evidence what is sent to the hospital, she stated it would be in a nurse's note. The facility policy, Resident Discharge / Transfer Letter provided by the facility did not address hospital transfer requirements related to required nursing and physician documentation regarding the resident's change in condition necessitating a hospital transfer and what documents are to be provided to the hospital. On 9/17/24 at 4:50 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. 3. For Resident #11, the facility staff failed to evidence what, if any, documents were sent to the receiving facility upon a hospital transfer and/or ensure that the physician wrote a note regarding a hospital transfer. A nurse's note dated 6/2/24 documented, Resident was complaining of pain peri suprapubic site. Morphine was given at 2103 (9:03 PM). (Hospice) nurse was called to exam site. Resident continued to call 911 (emergency number) x3 (three times). Informed resident nurse was coming to exam area. Resident continued to pull on the catheter. Hospice nursed arrived at 2130 (9:30 PM). Nurse tried changing the catheter, however, catheter was stuck from resident tugging at tube. Resident sent out to ER (emergency room) by paramedics on stretcher at 2200 (10:00 PM). A nurse's note dated 6/3/24 documented, Resident arrived fromER on a stretcher with paramedics at 0205 (2:05 AM). Catheter was changed, resident is stable. There were no further notes on this hospital transfer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no evidence of what, if any, documents were sent to the hospital, including contact information of the practitioner who was responsible for the care of the resident; resident representative information, including contact information; advance directive information; all special instructions and/or precautions for ongoing care, as appropriate such as: treatments and devices (oxygen, implants, IVs, tubes/catheters); transmission-based precautions; special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions; the resident ' s comprehensive care plan goals; and all other information necessary to meet the resident ' s needs, which includes, but may not be limited to: resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs; diagnoses and allergies; medications (including when last received); and most recent relevant labs, other diagnostic tests, and recent immunizations. Further review failed to evidence any physician's note related to the hospital transfer, to include the specific resident needs the facility could not meet; the facility efforts to meet those needs; and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility. On 9/17/24 at 2:25 PM, ASM #1 (Administrative Staff Member) stated that they do not have any of the evidence requested. On 9/17/24 at 2:31 PM, an interview was conducted with LPN #10 (Licensed Practical Nurse). When asked what documents are sent to the hospital, she stated that a facesheet and a medication list. When asked about the care plan, she stated not usually. When asked about a bed hold notice, she stated, You are supposed to provide a bed hold but each facility is different. When asked how does she evidence what is sent to the hospital, she stated it would be in a nurse's note. When asked about ensuring the physician writes a note about the hospital transfer, she stated, We notify the physician and they usually try interventions and we document what we did and that the provider was notified but she did not ensure that the provider writes a note. The facility policy, Resident Discharge / Transfer Letter provided by the facility did not address hospital transfer requirements related to required nursing and physician documentation regarding the resident's change in condition necessitating a hospital transfer and what documents are to be provided to the hospital. On 9/17/24 at 4:50 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 29125 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence that written notification of a hospital transfer was provided to the resident representative and the Ombudsman for three of 35 residents in the survey sample; Residents #36, #9 and #11. The findings include: 1. For Resident #36, the facility staff failed to evidence that a written notice was provided to the resident representative and Ombudsman upon hospital transfers on 6/20/24, 7/6/24 and 7/18/24. A review of the clinical record revealed that the resident was transferred to the hospital for change in condition concerns on 6/20/24, 7/6/24 and 7/18/24. Further review failed to reveal any evidence of a written notice to the resident representative and Ombudsman for the above hospital transfers. On 9/17/24 at 2:18 PM, an interview was conducted with OSM #8 (Other Staff Member) the Director of Social Services and Admissions. He stated that for the above hospital transfers, he ran the wrong report when he was doing my hospital transfers report faxed to the Ombudsman. Regarding written notification to the resident representative, he stated that he does not send a written notice. On 9/17/24 at 2:31 PM, an interview was conducted with LPN #10 (Licensed Practical Nurse). She stated that nurses do not have a role in sending written notifications to the Ombudsman or resident representatives. The facility policy, Resident Discharge / Transfer Letter documented, .Social Service or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor, if applicable. Copies will be sent to Department of Health, Ombudsman Office and filed in the business file and/or scanned into the electronic chart with administrator/designee signature, with the certified receipt if applicable. For emergency transfers, one list can be sent to the Ombudsman at the end of month On 9/17/24 at 4:50 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. 2. For Resident #9, the facility staff failed to evidence that a written notice was provided to the resident representative and Ombudsman upon hospital transfers on 6/8/24 and 6/13/24. A review of the clinical record revealed that the resident was transferred to the hospital for change in condition concerns on 6/8/24 and 6/13/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review failed to reveal any evidence of a written notice to the resident representative and Ombudsman for the above hospital transfers. On 9/17/24 at 2:18 PM, an interview was conducted with OSM #8 (Other Staff Member) the Director of Social Services and Admissions. He stated that for the above hospital transfers, he ran the wrong report when he was doing my hospital transfers report faxed to the Ombudsman. Regarding written notification to the resident representative, he stated that he does not send a written notice. On 9/17/24 at 2:31 PM, an interview was conducted with LPN #10 (Licensed Practical Nurse). She stated that nurses do not have a role in sending written notifications to the Ombudsman or resident representatives. The facility policy, Resident Discharge / Transfer Letter documented, .Social Service or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor, if applicable. Copies will be sent to Department of Health, Ombudsman Office and filed in the business file and/or scanned into the electronic chart with administrator/designee signature, with the certified receipt if applicable. For emergency transfers, one list can be sent to the Ombudsman at the end of month On 9/17/24 at 4:50 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. 3. For Resident #11, the facility staff failed to evidence that a written notice was provided to the resident representative and Ombudsman upon hospital transfers on 6/2/24. A review of the clinical record revealed that the resident was transferred to the hospital for change in condition concerns on 6/2/24. Further review failed to reveal any evidence of a written notice to the resident representative and Ombudsman for the above hospital transfers. On 9/17/24 at 2:18 PM, an interview was conducted with OSM #8 (Other Staff Member) the Director of Social Services and Admissions. He stated that for the above hospital transfers, he ran the wrong report when he was doing my hospital transfers report faxed to the Ombudsman. Regarding written notification to the resident representative, he stated that he does not send a written notice. On 9/17/24 at 2:31 PM, an interview was conducted with LPN #10 (Licensed Practical Nurse). She stated that nurses do not have a role in sending written notifications to the Ombudsman or resident representatives. The facility policy, Resident Discharge / Transfer Letter documented, .Social Service or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor, if applicable. Copies will be sent to Department of Health, Ombudsman Office and filed in the business file and/or scanned into the electronic chart with administrator/designee signature, with the certified receipt if applicable. For emergency transfers, one list can be sent to the Ombudsman at the end of month (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/17/24 at 4:50 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29125 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence a written bed hold notice was provided to the resident and/or resident representative upon a hospital transfer for two of 35 residents in the survey sample; Residents #36 and #9. The findings include: 1. For Resident #36, the facility staff failed to evidence that a written bed hold notice was provided to the resident and/or representative upon a hospital transfer. A nurse's note dated 6/20/24 documented, Resident assessed by PA (physician's assistant) and NP (nurse practitioner) and new orders given and noted to send to (hospital) for further eval (evaluation) for possible TIA/CVA (stroke) due to symptoms. Resident noted with delayed reaction during conversation The resident was readmitted on [DATE]. Further review failed to reveal any evidence that a written bed hold notice was provided. On 9/17/24 at 2:31 PM, an interview was conducted with LPN #10 (Licensed Practical Nurse). When asked about sending a bed hold notice, she stated, You are supposed to provide a bed hold but each facility is different. When asked how does she evidence what is sent to the hospital, she stated it would be in a nurse's note. The facility policy, Resident Discharge / Transfer Letter documented, G. The resident or responsible party will receive a bed hold notice along with the discharge/transfer letter, when applicable. Bed Hold notices can be found in the electronic chart . On 9/17/24 at 4:50 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. 2. For Resident #9, the facility staff failed to evidence that a written bed hold notice was provided to the resident and/or representative upon a hospital transfer. A nurse's note dated 6/8/24 documented, Alerted by aid that resident had episode of vomiting, resident assessed and has a change in LOC (level of consciousness), elevated B/P (blood pressure) 188/103 Resident not responding appropriately to questions, EMS (emergency medical services) called. The resident was readmitted on [DATE]. Further review failed to reveal any evidence that a written bed hold notice was provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated 6/13/24 documented, Received resident in bed, alert and verbal. During AM (morning) med pass CNA (Certified Nursing Assistant) witnessed resident have two consecutive seizures approximately 90 seconds in duration 10 minutes apart. Resident was assessed and repositioned to prevent injury. Resident cold/dry to touch, Resident had drainage from both nostrils blood and mucous mixed. Resident sent to ED (emergency department) for further evaluation. On call provider and family notified. The resident was readmitted on [DATE]. Further review failed to reveal any evidence that a written bed hold notice was provided. On 9/17/24 at 2:31 PM, an interview was conducted with LPN #10 (Licensed Practical Nurse). When asked about sending a bed hold notice, she stated, You are supposed to provide a bed hold but each facility is different. When asked how does she evidence what is sent to the hospital, she stated it would be in a nurse's note. The facility policy, Resident Discharge / Transfer Letter documented, G. The resident or responsible party will receive a bed hold notice along with the discharge/transfer letter, when applicable. Bed Hold notices can be found in the electronic chart . On 9/17/24 at 4:50 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27660 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure admission orders were put in place to provide immediate care for one of 35 residents in the survey sample, Resident #139. The findings include: For Resident #139(R139), the resident was admitted on [DATE] at 5:09 p.m. The admission orders were not entered into the computer until 3/22/24, 20 hours after the resident was admitted . Review of the clinical record, failed to evidence a nursing admission assessment for 3/21/24. The Discharge documents from the hospital documented the following orders: Tylenol 650 mg (milligrams)/20 ml (milliliters) soln (solution): 20.3 ml by po/g-tube (by mouth/gastrostomy tube) every 4 hours as needed for fever - pain. - entered into the medical record on 3/22/24 at 1:45 p.m. Amlodipine 5 mg tablets: instill 1 tab (tablet) into tube once a day. Indications: high blood pressure. Entered into the medical record on 3/22/24 at 1:41 p.m. Finasteride 5 mg tab; take 1 tab by mouth once a day. Entered into the medical record on 3/22/24 at 1:51 p.m. Ipratropium-albuterol 0.5 mg-3 mg/3 ml Nebu (nebulizer): take 3 ml inhaled by mouth every 6 hours as needed. Entered into the medical record on 3/22/24. Lidocaine 4% patch; apply 1 patch as directed daily as needed for mild pain (pain score 1 - 3) moderate pain (pain score 4-6) severe pain (pain score 7-10). Entered into the medical record on 3/22/24. Magnesium oxide 400 mg; instill 2 tabs into tube once a day. Entered into the medical record on 3/22/24 at 2:04 p.m. Metoprolol 25 mg; instill 1 tab into tube twice a day. Entered into the medical record on 3/22/24 at 2:10 p.m. multivitamins - minerals- lutein tab: 1-tab po/g-tube route once a day. Entered into the medical record on 3/22/24 at 2:12 p.m. Omeprazole 2 mg/ml suspension; 10 ml by po/g-tube route once a day. Entered into the medical record on 3/22/24 at 7:22 p.m. Polyethylene glycol 17-gram packet; 1 packet by po/g-tube route once a day. Entered into the medical record on 3/22/24 at 2:30 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Potassium Chloride ER 20 mEq (milliequivalent) tablet - take 1 tab by mouth once a day, indications: low potassium in the blood. Entered into the medical record on 3/22/24 at 2:33 p.m. Sodium chloride 1000 mg Tab - instill 1 tab into tube three times daily with meals. Entered into the medical record on 3/22/24 at 2:37 p.m. tamsulosin 0.4 mg caps; 1 cap by mouth daily after supper. Entered into the medical record on 3/22/24 at 2:38 p.m. TF (tube feeding) - Jevity 1.5 KCAL/ML Dose: 300 ml. Frequency: 4 times daily. Entered into the medical record on 3/22/24 at 2:41 p.m. Trimethoprim-sulfamethoxazole 160 - 800 mg tabs: 1 tab po/g-tube route twice a day for 180 days. Can be crushed. Entered into the medical record on 3/22/24 at 1:51 p.m. Warfarin 1 mg tabs; 6 tabs by po/g-tube route once a day. Entered into the medical record on 3/22/24 at 2:44 P.M. Discharge Procedure Orders: NPO TF only - nothing by mouth tube feeding only. Further review of the clinical record failed to evidence these orders were instituted and entered into the electronic medical record until 3/22/24. A request was made for documentation of care provided to R139 from 3/21/24 until 3/22/24 at approximately 1:00 p.m. A copy of the Vital Signs, documented the resident received a dinner tray, took in 240 ml of fluid, and ate 76-100% of his meal. An interview was conducted with LPN (licensed practical nurse) #12 on 9/17/24 at 10:32 a.m. When asked the process for a new admission and their admission orders, LPN #12 stated, most of the time we have the orders before the resident gets here. We can verify them with the physician, but we can't enter them into the computer until they are physically in the building. When asked how soon the orders should be entered into the computer, LPN #12 stated, as soon as you can. LPN #12 asked if the orders can wait 20 hours before they are entered into the computer, LPN #12 stated, no, the resident would need medications by then. The facility policy, New Admission/Readmission Process Policy, documented in part, 6. Review of orders: a. Physician verification of orders noted. b. Transmitted to pharmacy. c. Transcribed to eMAR/eTAR .14. Enteral feedings orders to contain the following: a. Route and Rate of solution[s] b. Amount to be infused, per shift and/or 24hr total. c. Flushes entered on eMAR. d. Checks for residuals. e. Verification of placement. f. HOB elevated 30-450 and/or as directed by physician. ASM (administrative staff member) #1, the interim administrator and ASM #2, the director of nursing, were made aware of the above findings on 9/17/24 at 5:13 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on observations, staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide an accurate MDS (minimum data set) assessment for two out of 35 residents in the survey sample, Resident #48 and Resident #58. The findings include: 1.The facility staff failed to complete an accurate MDS (minimum data set), a quarterly assessment for Resident #48. Resident #48 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: ICH (intracranial hemorrhage), hemiplegia, hemiparesis and DM (diabetes mellitus). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 7/20/24, coded the resident as scoring a 07 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bed mobility, transfer, hygiene and set up for eating. A review of Section O-Special Treatments, Procedures and Programs: K1. Hospice care-coded 'no'. A review of the comprehensive care plan dated 12/20/23 revealed, FOCUS: The resident is on hospice services. INTERVENTIONS: Contact hospice for changes in resident condition. A review of the physician orders dated 5/8/24, revealed Admit to hospice. An interview was conducted on 9/18/24 at 11:20 AM with RN #5 and RN #7, the MDS coordinators, when asked to review Resident #48's MDS for 7/20/24, Section O-hospice. RN #5 stated he is coded as a 'no', RN #7 stated, "this will be modified now. When asked what standard is followed for MDS completion, RN #5 stated, the RAI (resident assessment instrument). On 9/18/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. According to the RAI (resident assessment instrument) MDS Section K100. Reevaluation of special treatments and procedures the resident received or performed, or programs that the resident was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments, procedures, or programs. O0100K, Hospice care: Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider. No further information was provided prior to exit. 29125 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #58, the facility staff failed to accurately code the MDS for the resident's smoking status. A review of the clinical record revealed a smoking assessment dated [DATE] that documented the resident intends to smoke, does not wish to quit, and was assessed as a safe smoker. Further review of the clinical record revealed a care plan dated 7/18/22 that documented, (Resident #58) is a smoker. At risk for health issues. This care plan included interventions dated 7/18/22 for Orient/review with resident smoking policy, times and places to smoke and Staff to complete smoking assessment to ensure safety. On 9/16/24 at approximately 8:00 AM, Resident #58 was observed outside smoking with others. A review of the annual MDS (Minimum Data Set) dated 2/24/24, revealed in section J1300 Current Tobacco Use that No was marked. On 9/17/24 at 2:49 PM, an interview was conducted with RN #7 (Registered Nurse) the MDS nurse. She stated that the MDS should have been coded as a smoker / tobacco user since they did the assessment and he smokes. She stated the MDS was not coded accurately. A review of the RAI Manual (Resident Assessment Instrument) dated October 2023, page 388, documented, The negative effects of smoking can shorten life expectancy and create health problems that interfere with daily activities and adversely affect quality of life This item opens the door to negotiation of a plan of care with the resident that includes support for smoking cessation. If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed On 9/17/24 at 4:50 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42106 Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement the comprehensive care plan for four of 35 residents in the survey sample, Residents #42, #21, #138 and #11. The findings include: 1. For Resident #42 (R42), the facility staff failed to implement the comprehensive care plan to A) get the resident out of bed and B) provide tube feeding as ordered. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/13/24, the resident was assessed as being severely impaired for making daily decisions, not rejecting care, being dependent on staff for transfers and having a feeding tube. A) On 9/15/24 at 5:24 p.m., an observation was conducted of R42 in their room. R42 was observed in bed watching television with tube feeding observed hanging beside them on a feeding tube pump. At that time, an interview was conducted with R42 who was able to verbalize some words and use a communication board. R42 stated that they had the feeding tube for about six months and had problems with it recently. R42 stated that they liked to get up in their wheelchair every day and had not been up in five days. When asked if they had asked the staff to get them up, R42 nodded and stated, They won't get me up. On 9/16/24 at 8:22 a.m., R42 was observed in their room in bed. R42 stated again that they wanted to get out of bed in the wheelchair and had not been up in five days. A CNA (certified nursing assistant) in the hallway outside of R42's room was made aware of R42's request who stated that the CNA assigned to R42 was in the dining room at that time and they would be sure that R42 got out of bed as soon as she got back. Additional observations of R42 on 9/16/24 at 11:08 a.m., 12:36 p.m., and 3:15 p.m. revealed R42 remained in bed. At 12:36 p.m., R42 pointed at the clock and stated, See what time it is? They won't get me up. The comprehensive care plan for R42 documented in part, [Name of R42] has an ADL Self Care Performance Deficit r/t (related to) Activity Intolerance, Fatigue, Hemiplegia with right sided weakness, Musculoskeletal impairment - DJD (degenerative joint disease), right arm pain, neuropathy, respiratory failure . Date Initiated: 09/28/2021. Under Interventions it documented in part, .Resident's preference is to get out of bed before lunch. Encourage him to get up daily. Date Initiated: 09/29/2021 . Up daily by 11am if refuses place note in chart. Date Initiated: 09/26/2022 . Review of the ADL (activities of daily living) documentation for R42 for 9/16/24 under How did the resident transfer? documented Activity did not occur. Review of the ADL documentation for R42 documented R42 transferring last on 9/14/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The progress notes for R42 failed to evidence documentation of refusal to get out of bed on 9/16/24. On 9/17/24 at 11:08 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the purpose of the care plan was to provide them with the plan of care for the resident. She stated that the care plan should be implemented. She stated that all residents should be getting out of bed unless they did not want to. She stated that R42 got up at least four times a week and required a mechanical lift to get them up. She stated that R42 was alert and oriented and she was able to communicate with them and understand them. She stated that R42 also had a communication board to use if needed. She stated that R42 wanted to get up every day and she knew that he was up on Saturday because she had come to the facility for something. She stated that she was not aware that R42 had requested to get out of bed and not gotten up on 9/16/24. She stated that they had a lot of agency staff at the facility, and it was very hard to manipulate the staffing. On 9/17/24 at 11:25 a.m., an interview was conducted with CNA #5. CNA #5 stated that residents should be offered to get out of bed each day and if they refused, they reported it to the nurse. She stated that they encouraged the residents to get out of bed to help prevent bed sores and to socialize with other residents. B) The comprehensive care plan for R42 documented in part, Problem Start Date: 06/05/2024. Category: Nutritional Status. [Name of R42] is at increased nutrition/hydration risk r/t (related to) dx/pmhx (diagnoses/primary medical history) of hemiplegia & hemiparesis on R side . Enteral nutrition support via G (gastrostomy) Tube. Hx (history) of sig (significant) wt (weight) chnages [sic]. Under Interventions it documented in part, .Provide tube feed per order . The progress notes for R42 documented in part, 05/04/2024 16:09 (4:09 p.m.) This nurse notified by off going nurse peg tube is clogged. This nurse exhausted all efforts to unclog patients peg tube patient complains of 5/10 pain. Patient was apparently not connected to his tube feeding throughout the day. Patient is complaining of hunger pain. Called [Name of physician group] on-call and was given instructions to send patient out. Patient and emergency contact [Name of emergency contact] notified. Provider to be notified via on-call nurse. EMS (emergency medical services) notified. The eMAR (electronic medication administration record) dated 5/1/24-5/31/24 for R42 documented the resident receiving no tube feeding on day shift 5/3/24 or night shift 5/3/24. The eMAR documented R42 being out due to a clogged g tube on 5/4/24 at 6:00 p.m. Review of the clinical record for R42 failed to evidence documentation of why the resident did not receive feeding on 5/3/24, the physician being notified or an order to hold the tube feeding on 5/3/24. It further failed to evidence documentation of the feeding tube being clogged on day shift on 5/4/24 or notification of the physician of the feeding tube concerns until evening shift on 5/4/24. On 9/17/24 at 11:08 a.m., an interview was conducted with LPN #1. LPN #1 stated that the purpose of the care plan was to provide them with the plan of care for the resident. She stated that the care plan should be implemented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/18/24 at 9:45 a.m., a follow-up interview was conducted with LPN #1. LPN #1 stated that if a residents feeding tube became clogged, they attempted to unclog the tube and if they were not successful, they called the doctor to see what they wanted them to do. She stated that they called the doctor right then because there could be an obstruction and the resident needed their medications and the feedings. On 9/18/24 at 12:06 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that they would expect nursing staff to have another staff member assist them if the feeding tube was clogged and if they were unsuccessful in opening the tube, they should call the physician right away to get further guidance. She stated that she would not expect the resident to go a day without feeding or until the next shift to have the tube unclogged. The facility policy Comprehensive Care Planning Policy revised 3/2/2021 documented in part, .All staff must be familiar with each resident's Care Plan and all approaches must be implemented . All direct care staff must always know, understand, and follow their Resident's Care Plan. If unable to implement any part of the plan, notify your Charge Nurse or MDS Coordinator, so that this can be documented, or the Care Plan changed if necessary. On 9/17/24 at 5:11 p.m., ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator in training, and ASM #5, the regional vice president of operations were made aware of the concern regarding not implementing the care plan to get R42 out of bed. On 9/18/24 at 2:59 p.m., ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator in training, and ASM #5, the regional vice president of operations were made aware of the concern regarding not implementing the care plan to provide tube feeding. No further information was provided prior to exit. 2. For Resident #21 (R21), the facility staff failed to implement the comprehensive care plan to obtain labs as ordered. The comprehensive care plan for R21 documented in part, Resident has potential for fluid deficit r/t (related to) diuretic use. Created Date: 6/26/2023. Under Interventions it documented in part, .Medications/labs per physician order. Created Date: 6/26/2023 . Review of the pharmacy consultation report for R21 dated 5/6/24 documented a recommendation to monitor labs (TSH- thyroid stimulating hormone) due to the use of the medication amiodarone on the next convenient lab day and every six months thereafter. The consultation report documented the physician review completed on 5/14/24 with the recommendations accepted and physician's order to check BMP, CBC, TSH (basic metabolic panel, complete blood count, TSH) next lab day. Review of the clinical record failed to evidence the laboratory tests completed or results of the BMP, CBC, or TSH. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/17/24 at 11:08 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the purpose of the care plan was to provide them with the plan of care for the resident. She stated that the care plan should be implemented. On 9/18/24 at approximately 10:00 a.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of the BMP, CBC and TSH ordered by the physician on the 5/14/24 pharmacy consultation. On 9/18/24 at 2:02 p.m., ASM #2 stated that R21 had not had any labs since February of 2024, and they had received an order to have them drawn today. She stated that the process in May of 2024 was for the pharmacy to email the recommendations to her and she would print them out to put them in the folder for the physician who would review and then the former assistant director of nursing would enter orders and act on the recommendations based on the physician response. She stated that there was a new team now. On 9/18/24 at 2:59 p.m., ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator in training, and ASM #5, the regional vice president of operations were made aware of the concern. No further information was provided prior to exit. 27660 3. For Resident #138, the facility staff failed to implement the comprehensive care plan for treating a resident's pain and anxiety. The baseline care plan dated, 9/10/24 documented in part, Approach: Behaviors: behavioral needs will be evaluated for impact on quality of life, safety and safety of others. Behavioral management plan will be addressed in needed with physician/NP (nurse practitioner) IDT (interdisciplinary team) and resident/resident representative .Approach: Pain: evaluation of pain will be performed routinely to address pain management needs. I will receive medication per physician/NP orders. Pain medication effectiveness will be documented and reported as needed. An interview was conducted with R138 on 9/15/24 at 5:06 p.m. R138 stated he got to the facility on [DATE] at 6:00 p.m. He didn't get any medications for over 12 hours. The physician orders dated 9/10/24, documented the following: Gabapentin capsule 300 mg (milligrams) (used to treat pain) (1); Administer 1 cap (capsule) by mouth three times a day. Dx (diagnosis) neuralgia and neuritis. Buspirone tablet 5 mg (used to treat anxiety) (2); administer 1 tab (tablet) by mouth three times a day, Dx - anxiety. Baclofen tablet 10 mg (used to treat anxiety) (3); administer 1 tab by mouth three times a day, DX - no listed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the September 2024 MAR (medication administration record) documented the above orders. For the Gabapentin the first dose received was on 9/11/24 at 9:00 a.m. There was a blank for the dose on 9/10/24 at 9:00 p.m. For the Buspirone the first dose received was on 9/11/24 at 9:00 a.m. There was a blank for the dose on 9/10/24 at 9:00 p.m. For the Baclofen the first dose administered was on 9/11/24 at 9:00 a.m. There were blanks for the 9:00 p.m. dose on 9/10/24, 9/11/24 and 9/12/24. Review of the contents of the Omnicell (emergency backup medication system) revealed Gabapentin, Buspirone, and Baclofen were in the system and available for administration. An interview was conducted with RN (registered nurse) #6 on 9/17/24 at 3:12 p.m. When asked what the purpose of the care plan and should it be followed, RN #6 stated the care plan is to give you a good idea of what the patient is here for, the plan of care in relations to physical therapy, occupational therapy and speech therapy, and the plan for discharge. RN #6 stated the care plan should be followed. ASM (administrative staff member) #1, the interim administrator, and ASM #2, the director of nursing, were made aware of the above findings on 9/18/24 at 3:00 p.m. No further information was obtained prior to exit. 29125 4. For Resident #11, the facility staff failed to implement the comprehensive care plan for the administration of oxygen. On 9/15/24 at 4:59 PM, 9/16/24 at 11:20 AM, and 9/17/24 at 2:39 PM, Resident #11 was observed in bed, wearing a nasal cannula for oxygen and the oxygen concentrator was set at 2 liters per minute. A review of the clinical record revealed a physician's order dated 5/8/24 for oxygen at 4 liters per minute. A review of the comprehensive care plan revealed one dated 5/8/24 and revised 8/8/24, that documented, (Resident #11) requires oxygen therapy R/T (related to) COPD and emphysema. An intervention dated 8/28/24 documented, Administer oxygen at 4L (4 liters) via nasal cannula. Observed oxygen precautions. On 9/17/24 at 2:57 PM an interview was conducted with LPN #3 (Licensed Practical Nurse) who was the assigned to Resident #11. When asked about the oxygen rate vs the ordered rate, she stated that the order was not being followed. When asked if the care plan documented to administer oxygen at 4 liters and the resident was receiving 2 liters, was the care plan being followed, she stated that it was not. The facility policy, Comprehensive Care Planning documented, All staff must be familiar with each resident's Care Plan and all approaches must be implemented On 9/17/24 at 4:50 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of practice for one of 35 residents in the survey sample, Resident #5. The findings include: For Resident #5 (R5), the facility staff failed to obtain a physician's order prior to administering insulin (used to treat diabetes) to the resident on 5/12/24. R5 was readmitted to the facility on [DATE]. A review of R5's clinical record failed to reveal any physician's medication orders when the resident was readmitted on [DATE]. A review of R5's MAR (medication administration record) for 5/11/24 and 5/12/24 failed to reveal any medication orders. A nurse's note dated 5/12/24 at 10:58 p.m. (recorded as a late entry on 5/13/24), documented, Received care of resident at 22:40 (10:40 p.m.) Resident had been released from the hospital a day before after falling face first on concrete. Resident states she is in a severe pain. This nurse looked at resident's MAR which was inadequately updated since resident has been back. It was noted that the last time resident received insulin or glucose checks was on 05/08/2024 .Blood glucose 579. Lispro (insulin) and Levemir (insulin) administered. 911 was called per brother's request. Resident was transferred to (name of hospital) at 0115 (1:15 a.m.) via stretcher. Resident has been admitted to the hospital unit. The nurse who documented the above note was not available for interview during the survey. On 9/18/24 at 8:28 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated nurses should have a physician's order to administer insulin because they would be practicing out of their scope if they did otherwise. On 9/18/24 at 3:25 p.m., ASM (administrative staff member) #1 (the interim administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility document titled, Skills Checklist 1: Oral Medication Administration documented, 3 Check Medication Record for order. No further information was presented prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27660 Based on resident interview, staff interview, facility document review, and clinical record review it was determined the facility staff failed to provide ADL (activities of daily living) care for three of 35 residents in the survey sample, Residents #33, 46, and #42. The findings include: 1. For Resident #33 (R33), the facility staff failed to provide oral care. An interview was conducted with R33 on 9/15/24 at 5:29 p.m. The resident was in bed. R33 stated she has to ask for help in brushing her teeth. She stated she had asked someone to assist her this afternoon but no one has responded. A second interview was conducted with R33 on 9/16/24 at 8:47 a.m. She stated she was never offered to brush her teeth after this writer left on 9/15/24. On the most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 8/30/24, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section GG - Functional Abilities and Goals, the resident was coded as requiring set up or clean up assistance for oral hygiene, the resident completes the activity. Review of the ADL documentation from 9/9/24 through 9/16/24, the column for Personal Hygiene was blank. There was no documented evidence the resident received personal hygiene care. The comprehensive care plan dated, 1/30/23 documented in part, Focus: (R33) has ADL/self-care deficit related to hand assisted feeding with all meals. The Interventions documented in part, Assist with activities of daily living, dressing, grooming, toileting, oral care. An interview was conducted with CNA (certified nursing assistant) #2 on 9/17/24 at 3:00 p.m. When asked when a resident is offered to brush their teeth, CNA #2 stated, it should be daily. She stated if a resident wants it then you assist them. When asked if R33 asks for oral care, CNA #2 stated when she is assigned to the resident, she many times is in the bathroom, and I assist her in setting up and she brushes her teeth at the sink. CNA #2 was asked if the resident is in bed and wishes to brush her teeth, CNA #2 stated, she would set her up with the supplies on the over bed table and assist if needed. CNA #2 stated, she can do it herself, she just needs to be set up to do it. When asked where it is documented that oral care was provided, CNA #2 stated, in (name of electronic medical records system). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Morning Care/AM Care. documented in part, Morning care will be offered each day to promote resident comfort, cleanliness, grooming, and general wellbeing. Residents who are capable of performing their own personal care are encouraged to do so but will be provided with setup assistance if needed . 4. Assist with/provide oral hygiene. Assist with dentures; clean and replace. The facility policy, Evening Care/PM Care, documented in part, Nursing staff will offer evening/PM care to residents to promote personal hygiene, comfort, relaxation and safety. Residents who are capable of performing their own care are encouraged to do so, with assistance as needed. PM care may be performed at the bedside or in the bathroom, according to resident preference .7. Assist resident with oral care. ASM (administrative staff member) #1, the interim administrator, and ASM #2, the director of nursing, were made aware of the above findings on 9/18/24 at 3:00 p.m. No further information was obtained prior to exit. 42183 2.The facility staff failed to provide evidence of incontinence care for dependent Resident #46. Resident #46 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: dementia, hypertension and CKD (chronic kidney disease). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 7/24/24, coded the resident as scoring a 09 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as being dependent for toileting, bathing and hygiene. A review of the comprehensive care plan with a revision date of 2/16/24, revealed, FOCUS: The resident has a self-care deficit related to age related mobility. INTERVENTIONS: Resident requires 1 person assist for ADLs: toileting, hygiene, dressing and bathing. A review of the June-September 2024 ADL (activities of daily living) record revealed missing documentation for incontinence care/toileting on the following dates: 6/30, 7/7, 7/9, 7/13, 7/19, 7/26, 7/27, 8/2, 8/6, 8/7, 8/11, /8/15, 8/17, 8/20, 8/21, 8/22, 8/24, 8/29, 8/31, 9/2, 9/3, 9/4, 9/7 and 9/13. An interview was conducted on 9/16/24 at 6:50 AM with CNA (certified nursing assistant) #1. When asked the process for incontinence care, CNA #1 stated, we round every two to three hours and provide the incontinence care. When asked where the incontinence care would be evidenced, CNA #1 stated, we document it in the ADL record in Matrix. An interview was conducted on 9/17/24 at 11:15 AM with Resident #46. Resident #46 stated she had not been changed since night shift. I requested Resident #46 put on call light. LPN (licensed practical nurse) #1 entered the room. Resident #46 informed LPN #1 that she had not seen a CNA (certified nursing assistant) on day shift and she had not been changed. LPN #1 was interviewed by surveyor regarding expectations for incontinence care, LPN #1 stated, it should be done every two hours. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:35 AM, CNA #4 provided incontinence care for Resident #46. Adult depends was saturated but had not leaked onto sheets. CNA #4 stated, she is not my patient, but I am happy to take care of her. When asked the frequency of incontinence rounds, CNA #4 stated, it should be every 2-3 hours. On 9/18/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. According to the facility, no specific policy related to incontinence care is found. No further information was provided prior to exit. 42106 3. For Resident #42 (R42), the facility staff failed to get the resident out of bed per the resident's request. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/13/24, the resident was assessed as being severely impaired for making daily decisions, not rejecting care, being dependent on staff for transfers and having a feeding tube. On 9/15/24 at 5:24 p.m., an observation was conducted of R42 in their room. R42 was observed in bed watching television with tube feeding observed hanging beside them on a feeding tube pump. At that time, an interview was conducted with R42 who was able to verbalize some words and use a communication board. R42 stated that they had the feeding tube for about six months and had problems with it recently. R42 stated that they liked to get up in their wheelchair every day and had not been up in five days. When asked if they had asked the staff to get them up, R42 nodded and stated, They won't get me up. On 9/16/24 at 8:22 a.m., R42 was observed in their room in bed. R42 stated again that they wanted to get out of bed in the wheelchair and had not been up in five days. A CNA (certified nursing assistant) in the hallway outside of R42's room was made aware of R42's request who stated that the CNA assigned to R42 was in the dining room at that time and they would be sure that R42 got out of bed as soon as she got back. Additional observations of R42 on 9/16/24 at 11:08 a.m., 12:36 p.m., and 3:15 p.m. revealed R42 remained in bed. At 12:36 p.m., R42 pointed at the clock and stated, See what time it is? They won't get me up. Review of the ADL (activities of daily living) documentation for R42 for 9/16/24 under How did the resident transfer? documented Activity did not occur. Review of the ADL documentation for R42 documented R42 transferring last on 9/14/24. The progress notes for R42 failed to evidence documentation of refusal to get out of bed on 9/16/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan for R42 documented in part, [Name of R42] has an ADL Self Care Performance Deficit r/t (related to) Activity Intolerance, Fatigue, Hemiplegia with right sided weakness, Musculoskeletal impairment - DJD (degenerative joint disease), right arm pain, neuropathy, respiratory failure . Date Initiated: 09/28/2021. Under Interventions it documented in part, .Resident's preference is to get out of bed before lunch. Encourage him to get up daily. Date Initiated: 09/29/2021 . Up daily by 11am if refuses place note in chart. Date Initiated: 09/26/2022 . On 9/17/24 at 11:08 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that all residents should be getting out of bed unless they did not want to. She stated that R42 got up at least four times a week and required a mechanical lift to get them up. She stated that R42 was alert and oriented and she was able to communicate with them and understand them. She stated that R42 also had a communication board to use if needed. She stated that R42 wanted to get up every day and she knew that he was up on Saturday because she had come to the facility for something. She stated that she was not aware that R42 had requested to get out of bed and not gotten up on 9/16/24. She stated that they had a lot of agency staff at the facility, and it was very hard to manipulate the staffing. On 9/17/24 at 11:25 a.m., an interview was conducted with CNA #5. CNA #5 stated that residents should be offered to get out of bed each day and if they refused, they reported it to the nurse. She stated that they encouraged the residents to get out of bed to help prevent bed sores and to socialize with other residents. The facility provided document Resident Rights Inservice documented in part, .All residents in long term care facilities have rights guaranteed to them under Federal and State law. The facility must promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights .Right to make independent choices. Make personal decisions, such as what to wear and how to spend free time. Reasonable accommodation of one's needs and preferences . On 9/17/24 at 5:11 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator in training, and ASM #5, the regional vice president of operations were made aware of the concern. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to maintain residents' highest level of well-being for eight of 35 residents in the survey sample, Residents #5, #138, #139, #63, #32, #48, #16, and #88. The findings include: 1. For Resident #5 (R5), the facility staff failed to obtain and verify physician orders for blood sugar checks and insulin (used to treat diabetes) when the resident was readmitted to the facility on [DATE] at 2:00 p.m. This resulted in harm: on [DATE] at approximately 1:15 a.m., R5's blood sugar was documented as 579 (1). The resident was transferred to the hospital, diagnosed with diabetic ketoacidosis (2) and required an insulin drip (insulin that is intravenously infused). R5 was admitted to the facility on [DATE] with a diagnosis of diabetes. A review of R5's clinical record revealed a nurse's note dated [DATE] that documented the resident sustained a fall and was transferred to the hospital. R5 was discharged from the hospital back to the facility on [DATE]. The hospital discharge medication list dated [DATE] documented, CONTINUE taking these medications: -Insulin Lispro 100 unit/mL (milliliter) insulin pen- two units beneath the skin Three Times Daily with Meals. If eats at least 50% of meal or drinks a supplement shake. -Insulin Lispro 100 unit/mL insulin pen- Inject ,d+[DATE] Units beneath the skin 4 Times a Day Before Meals & at Bedtime. Per sliding scale (based on the resident's blood sugars): ,d+[DATE]=1 unit ,d+[DATE]=2 units ,d+[DATE]=3 units Call & notify MD (Medical Doctor) if BG (Blood Glucose) > (greater than) 400. -LEVEMIR 100 unit/mL (3 mL) insulin pen- Inject 9 Units beneath the skin Every Night at Bedtime. Further review of R5's clinical record failed to reveal any physician's medication orders when the resident was readmitted on [DATE]. A review of R5's MAR (medication administration record) for [DATE] and [DATE] failed to reveal any medication orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	A nurse's note dated [DATE] at 4:13 p.m. documented, Pt (Patient) returned from (name of hospital) at 1400 (2:00 p.m.) via stretcher. Received report from hospital. Pt is alert and oriented. Generalized bruising visible on face, scalp and both legs. Dried blood on face and scalp. Left side of hair line has 2 sutures. Bridge of nose with 3 sutures intact. Rt (Right) knee with honeycomb dressing bilaterally. Abrasion lower rt leg front. Left hip with Honeycomb dressing dry and intact. Petal pulse present bilaterally. Left side weaker than right, chronic issue. Lungs clear, abd (abdomen) soft with bowel sounds all 4 quads (quadrants). Pt has script for Neurontin q (every) 8 hours prn (as needed) for pain. BS (Blood sugar) 132. Vitals ,d+[DATE] (blood pressure), 92 (pulse), 16 (respirations), 98 (temperature), 96% (oxygen level). A nurse's note dated [DATE] at midnight ([DATE] into [DATE]) documented, During hand off report, previous nurse reports to this nurse that patient arrived to facility at 1400 but she did not confirm orders with MD (Medical Doctor)/enter orders in MAR (medication administration record). Writer contacted (name of physician group) on call to confirm orders. Writer spoke with (name of a nurse practitioner). (Name of the nurse practitioner) refuses to confirm orders with nurse because patient came to facility at 1400. Writer attempted to explain to On call (name of nurse practitioner) that this nurse shift started at 1900 (7:00 p.m.) and this nurse just finished passing medication on unit and just needed to confirm the orders because previous nurse did not. (Name of nurse practitioner) states, 'I am not doing that. I am not approving medications after 8pm.' Due to (name of physician group) (name of nurse practitioner) refusing to confirm orders for patient, writer cannot enter patients [sic] orders/treatments into MAR at this time. Will endorse oncoming nurse. Will make management aware of clinical situation. There were no nurses' notes documented in R5's clinical record during the 7:00 a.m. to 7:00 p.m. shift on [DATE]. A nurse's note dated [DATE] at 10:58 p.m. (recorded as a late entry on [DATE]), documented, Received care of resident at 22:40 (10:40 p.m.) Resident had been released from the hospital a day before after falling face first on concrete. Resident states she is in a severe pain. This nurse looked at resident's MAR which was inadequately updated since resident has been back. It was noted that the last time resident received insulin or glucose checks was on [DATE]. This nurse noted that the only pain medicine ordered is Tylenol 1000mg (milligrams). This nurse called nurse on 3West in (name of hospital) to get more information about resident's stay in the hospital. The only discharge papers were a list of medications. No Dx (diagnoses), tests, test results were noted. Nurse at (name of hospital) was not able to give any information since the resident had already been released. On call doctor was noted; on call doctor advised nurse to either administer Tylenol or send resident to the hospital if pain gets too intense. Resident's brother was noted and he drove to be at his sister's bedside at 0030 (12:30 a.m.). Tylenol was not effective. Resident was repositioned; ineffective. Blood glucose 579. Lispro and Levemir administered. 911 was called per brother's request. Resident was transferred to (name of hospital) at 0115 (1:15 a.m.) via stretcher. Resident has been admitted to the hospital unit. A hospital discharge summary dated [DATE] documented, Per patient, since discharge (from the hospital on [DATE]) was not able to get her insulin and noted increased pain on bilateral lower ext (extremities) .EMS reported BS (Blood Sugar) 600. The discharge summary further documented a diagnosis of diabetic ketoacidosis, and the resident was administered an insulin drip at the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	A facility synopsis of events dated [DATE] documented, (R5's) brother, (name), called the DON (Director of Nursing) to inquire about prescribed medications and administration. Based upon this concern, the facility immediately started an internal investigation. The facility interviewed all nurses responsible for (R5's) care, the physician on-call upon the resident's return to the community and reviewed the resident's medical record. (R5) returned to the facility on [DATE] after an unrelated hospitalization . A review of the physician orders revealed medication errors regarding transcription of new orders upon return to the facility. Interviews of the nursing team members responsible for (R5's) care revealed unsuccessful attempts to verify the medications with the resident provider group via telephone upon return. Upon the orders being unsuccessfully verified (R5) to return to the ER (emergency room) for evaluation. The resident returned to the facility on [DATE] . Based on the schedule, the nurses that would have completed her admission and or delivered medications. The nurses who assumed care for the resident were placed on a do not return list and are not allowed to work in the facility . The synopsis contained multiple statements by facility staff as documented below. A statement signed on [DATE] by RN (registered nurse) #3 (the nurse who worked the 7:00 a.m. to 7:00 p.m. shift on [DATE] on another unit) documented, On Sunday [DATE] on Day shift provider for (R5) called unit one inquiring about resident if she had returned from hospital. Updated provider that resident returned but did not have any pain medication. Provider reporting that they would escribe (electronically prescribe) pain medication to (name of pharmacy), did not specify what medication, dose, or frequency. RN #3 was available for interview during the survey. A statement signed by LPN (licensed practical nurse) #7 (the nurse who worked the 7:00 p.m. to 7:00 a.m. shift on another unit [DATE] into [DATE]) (no signature date) documented, To Whom it may concern: I, (name of LPN #7) was approached by (LPN #6), regarding patient, (R5) on Unit 1 nurses station. (LPN #6) stated, '(R5) is having uncontrolled pain and she has no pain medications.' (LPN #6) continued, 'Oh! and her blood sugar is around 600.' This nurse then replied, 'Send her out.' (LPN #6) then replied, 'Well I gave her Levemir for her sugar.' I again stated, 'Send her out.' (LPN #6) walked to her computer to print off (R5's) paperwork for transfer. (R5's) brother was in her room. When (LPN #6) stated, 'She has only 1 or 2 medications, so I didn't print it off.' This nurse then went to computer and there were no medications under (R5's) orders. This nurse stated to EMTs (Emergency Medical Technicians) that patient 'does not have any medications on her orders.' This nurse stated, 'I don't know of any medications being administered, other than Levemir (LPN #6) gave her.' This nurse then left the room and the unit. Another statement signed by LPN #7 (no signature date) documented, To Whom it may concern: I, (name of LPN #7), had no interaction with nurse on unit 2, until 1020 PM on [DATE]th 2024. Said nurse on unit 2 (RN #2) approached the nurses station on unit 1 @ 1020 PM regarding her relief. On call nurse (LPN #8) was notified and there was no other interaction after 1030 PM.- Regarding (RN #2) (the nurse who cared for R5 during the 7:00 a.m. to 7:00 p.m. shift on [DATE]). LPN #7 was not available for interview during the survey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	A statement signed by LPN #8 (R5's unit manager) on [DATE] documented, On Monday [DATE], I came in to relieve the nurse (LPN #6) because she needed to leave by 630 am. (LPN #6) gave me report on the unit, she told me that she sent (R5) out because of the pain she was having. I asked her did she let anyone know. She stated no it was late it was 1 am. I then stated two residents went to the hospital on your watch, on call should have been called. I explained that and proceeded to take report. A statement signed by LPN #8 on [DATE] documented, On [DATE] at 12:32 am, nurse (LPN #5) text my phone to state the nurse during the day did not get the meds approved at 2 pm when the resident was admitted on 5.11.24. (LPN #5) stated she called (name of physician group) on call to get the meds verified but the on call (name of nurse practitioner) refused to verify the meds because she stated she doesn't verify meds after 8pm. Once I woke up to the text at 0738 (7:38 a.m.) I contacted (LPN #5) and she explained what she wrote in her text. I then called (name of medical director) explaining what happened, he stated this was not the first time on call has done this that he would be reaching out. Resident meds still needed to be verified, (name of medical director) stated to call on call and have them verify the meds. (Name of medical director) was contacted by me on [DATE] at 0838 (8:38 a.m.). This writer then called the building x (times) 4, no one answered. I then called the housekeeper supervisor to check all phones in the building because no one was picking up, she took phone to nurse. I told (RN #2- the nurse who cared for R5 during the 7:00 a.m. to 7:00 p.m. shift on [DATE]) to place the orders in (name of computer system) because she stated to me that (RN #3), the nurse on unit one already verified the meds. (RN #2) stated she had one more resident to give meds to and she was going to put the orders in. LPN #8 was not available for interview during the survey. On [DATE] at 2:10 p.m., a telephone interview was conducted with LPN #5. LPN #5 stated she could not recall details and to refer to her note. RN #2 was not available for interview during the survey. A printed text message from LPN #6 (the nurse who sent R5 to the hospital on the night of [DATE]) to ASM (administrative staff member) #2 (the Director of Nursing) (no date) documented, Hello (ASM #2), I need to talk to you about last night. So much happened and I just came in trying to help. Seems like there are so many miscommunications about the events that took place. This morning I left the building feeling like the unit manager (LPN #8), and I were on the same page about how things went. Please call me at your earliest convenience. Thank you, (LPN #6). Another printed text message from LPN #6 to ASM #2 (no date) documented, Hello (ASM #2), I need to talk to you about last night. So much happened and I just came in trying to help. Seems like there are so many miscommunications about the events that took place. This morning I left the building feeling like the unit manager (LPN #8) and I were on the same page about how things went. Please call me at your earliest convenience. Thank you, (LPN #6). ASM #2, I have been waiting for a phone call from you. Since I haven't, I am going to write an incident report to my agency and I will report you to the VA (Virginia) board of nursing. The patient I sent to the hospital hadn't got her insulin for a day and a half because the dr (doctor) on call refused to verify the meds since (R5) didn't return to the facility while she was on call . LPN #6 was not available for interview during the survey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	A statement signed by ASM #2 (the Director of Nursing) (no date) documented, On [DATE], 11 a.m. I called (name of nursing staff agency) to request (RN #1's) telephone number and reported Nurse's failure to initiate an admission nor verify medications to treat resident. Resident arrived at 2pm. Staffing agency, stated that they would contact Nurse and have her return my call. Upon return call, I inquired of the reason (RN #1- the nurse who cared for R5 when the resident was readmitted on [DATE]) did not initiate the admission process for the readmission. Nurse verbalized, she was extremely busy. 'I had to discharge a resident and was not sure of the process, and that the Unit Manager (who was on call and in the building) assisted her with printing discharge paperwork. 'I am not familiar with your version of (name of computer software), I use (name of computer software) at another facility, and however I am more familiar with (name of another computer software). I did ask (LPN #7) on the other unit, what I needed to do for the admission, and she told me the resident was a regular resident and all the medications for her were on the cart.' I went on to ask the Nurse had she received a discharge packet from the Medical transportation personnel, her response was, 'yes.' I continued by referencing her admission note and resident's script upon her return and inquired about the failure to call MD (medical doctor) for verification of orders. Nurse (RN #1) stated, she was unaware of the need to call since, she was told her medications were on the cart. I followed up by asking, Did you see a MAR (medication administration record) for the resident? 'No.' Did you ask the Unit Manager for assistance? 'No.' When you completed your assessment [sic] the resident and noted the script for Gabapentin (used to treat seizures and pain), why did you not input the new script? 'I continued to pass the other medications to the other residents.' Have you ever performed an admission? 'Yes, your system is different, and in (name of another computer system) after putting the resident in the system the admission assessments automatically populates [sic].' 'I informed the oncoming nurse that I had an admission but did not finish it and she said she would finish it, I offered to stay if she would walk me through the process, but she told me she would complete it.' (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Interviewed (LPN #5- the nurse who cared for R5 during the 7:00 p.m. to 7:00 a.m. shift [DATE] into [DATE]), via telephone. She verbalized she did inform the nurse that she would complete the admission, but initially was not aware of that the medications were not transcribed nor verified. (LPN #5), during her medication pass noted (R5) did not have a MAR, immediately after her medication pass, she made an attempt to call to verify orders, and after speaking with the On call Physician, who would not verify the orders. She texted the On Call Nurse. (LPN #5) was asked, why she did not call (name of the medical director) and she verbalized that she was not aware that she could since there was an On Call system in place. I educated (LPN #5), to call instead of text the On Call Nurse management team member or myself, and in cases of this importance (name of the medical director) can be called. (LPN #5) added that she did inform the oncoming Nurse to call to have the orders verified. However, the oncoming Nurse stated, 'I will not be doing that because it [sic] Mother's Day.' Called (name of nurse staffing agency), informed that of (RN #2- the nurse who cared for R5 during the 7:00 a.m. to 7:00 p.m. shift on [DATE]), failure to complete Medication Administration Record documentation, failure to follow up on a readmission, and failure to complete skilled documentation. Interviewed via telephone, (RN #2), stated she 'thought' she signed off her medications, 'I was constantly on the cart, tending to residents, answering questions for family members, and made attempts to control (R5's) pain since the resident only came back with gabapentin. They called in Tramadol (used to treat pain) to the pharmacy and it did not come in, then I got an order for Tylenol 1000 mg (milligrams) and gave it to resident.' I inquired of why the orders were not transcribed on the MAR nor documented in the system and was she aware that (R5's) medication were not verified? 'There was a lot going on and I planned to do it.' Why did you did [sic] not call the On call Nurse for assistance? 'I do not have anyone's number and like I said it was a lot going on.' (RN #2) was informed that there is a calendar at the desk with all On Call Nurses numbers attached. (RN #2) said she did not have time to look for anyone's numbers, but she did ask (LPN #7) for assistance. On [DATE] at 9:33 a.m., an interview was conducted with LPN #4 (the current unit manager). LPN #4 stated that when a resident is readmitted from the hospital, he or she returns with a package that contains a medication list and discharge instructions, and the admitting nurse should call the doctor to verify the medication list. LPN #4 stated sometimes the doctor changes medication orders and after medications have been verified, the nurse should put all orders into the computer system. LPN #4 stated that after orders are put into the computer system, they are transmitted to the pharmacy and transcribed onto a MAR. LPN #4 stated she would not stop in the middle of a medication pass to complete this process, but it should be done as soon as the resident arrives. LPN #4 stated, That's the first thing they should do because we need the meds. LPN #4 stated if the physician or nurse practitioner will not verify medications upon re-admission, the admitting nurse should call the medical director and inform the Director of Nursing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:46 a.m., an interview was conducted with ASM #2 (the Director of Nursing). ASM #2 stated that when a resident is readmitted , the nurse should greet the resident, make sure the resident is comfortable, then go to the desk and open the packet of information and orders from the hospital. ASM #2 stated the nurse should enter/transcribe the orders into the queue in the computer system then verify the orders with the physician because the physician may want to change the orders. ASM #2 stated that after the orders are verified with the physician, the nurse should make the orders active in the computer system so the orders are activated onto the MAR and sent to the pharmacy. ASM #2 stated she was not made aware of the above incident regarding R5 until the resident was being sent back to the hospital on ([DATE] into [DATE]). ASM #2 stated it was the middle of the night and she received a phone call from R5's brother regarding the resident's pain. ASM #2 stated she could not recall if she was made aware of R5's blood sugar. ASM #5 stated that when R5 was readmitted to the facility on [DATE], the first nurse should have queued the medications in the computer system, called the physician to verify the medications, sent the medication orders to the pharmacy, and if the resident was in pain or required insulin, the nurse should have contacted the pharmacy and obtained medications from the box in the facility. ASM #2 stated that if the nurse didn't know what to do, she should have called the on-call nurse or ASM #2. ASM #2 stated that if the nurse practitioner refused to verify the medications, then the nurse should have notified her so she could have notified the medical director. On [DATE] at 11:23 a.m., an interview was conducted with ASM #6 (the medical director). ASM #6 stated the responsibilities of the on-call physician or nurse practitioner are to take care of the patient, verify orders, and send the pharmacy an e-script (electronic prescription) if needed. In regard to the above incident involving R5, ASM #6 stated that if he recalled, there were errors on multiple sides. ASM #6 stated the orders should have been called in to the on-call nurse practitioner as soon as R5 arrived to the facility but it was the responsibility of the on-call nurse practitioner to verify orders and send e-scripts whenever called, regardless of the time. ASM #6 stated, It is our responsibility to make sure it happens with as little delay as possible. ASM #6 stated he should have been notified when the on-call nurse practitioner refused to verify R5's orders but he was not notified until the next day. ASM #6 stated the on-call nurse practitioner does not round at the facility and is only on-call for the group, but he escalated the incident to the chief medical officer because the patient actually came to some harm and had to go the emergency room for a lack of order verification and pain management. On [DATE] at 1:11 p.m. another interview was conducted with ASM #6. ASM #6 was made aware of the statement signed by LPN #8 on [DATE] that documented he (ASM #6) was notified on [DATE] at 8:38 a.m. ASM #6 stated he went back through his phone records. ASM #6 stated that during the morning on [DATE], LPN #8 made him aware that R5 was admitted at 2:00 p.m. on the previous day and the medications were not called to the on-call nurse practitioner until midnight and the nurse practitioner declined to verify the medications because she thought they should have been called to her earlier in the day. ASM #6 stated he told LPN #8 to call the on-call nurse practitioner back since it was not after 8:00 p.m., and if the nurse practitioner did not verify the medications, call him back. ASM #6 stated he was not notified again until R5 was sent to the hospital. On [DATE] at 1:25 p.m., ASM (administrative staff member) #1 (the interim administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, New Admission/Readmission Process Policy documented, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	6. Review of orders: a. Physician verification of orders noted b. Transmitted to pharmacy c. Transcribed to eMAR/eTAR (electronic medication administration record/electronic treatment administration record). References: (1) A blood sugar test measures the amount of a sugar called glucose in a sample of your blood. If you had a fasting blood glucose test, a level of 70 to 99 mg (milligrams)/dL (deciliter) is considered normal. If you had a random blood glucose test, a normal result depends on when you last ate. Most of the time, the blood glucose level will be 125 mg/dL or lower . (2) Diabetic ketoacidosis (DKA) is a life-threatening problem that affects people with diabetes. It occurs when the body starts breaking down fat at a rate that is much too fast. The liver processes the fat into a fuel called ketones, which causes the blood to become acidic. This information was obtained from the website: https://medlineplus.gov/ency/article/000320.htm 27660 2. For Resident #138, the facility staff failed to administer medications per the physician orders. Resident #138 (R138) was admitted to the facility on [DATE] at 6:21 p.m. The physician orders were entered into the computer system on [DATE]. An interview was conducted with R138 on [DATE] at 5:06 p.m. R138 stated he got to the facility on [DATE] at 6:00 p.m. He didn't get any medications for over 12 hours. The physician orders dated [DATE], documented the following: Gabapentin capsule 300 mg (milligrams) (used to treat pain) (1); Administer 1 cap (capsule) by mouth three times a day. Dx (diagnosis) neuralgia and neuritis. Buspirone tablet 5 mg (used to treat anxiety) (2); administer 1 tab (tablet) by mouth three times a day, Dx - anxiety. Baclofen tablet 10 mg (used to treat anxiety) (3); administer 1 tab by mouth three times a day, DX - no listed. Review of the [DATE] MAR (medication administration record) documented the above orders. For the Gabapentin the first dose received was on [DATE] at 9:00 a.m. There was a blank for the dose on [DATE] at 9:00 p.m. For the Buspirone the first dose received was on [DATE] at 9:00 a.m. There was a blank for the dose on [DATE] at 9:00 p.m. For the Baclofen the first dose administered was on [DATE] at 9:00 a.m. There were blanks for the 9:00 p.m. dose on [DATE], [DATE] and [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the contents of the Omnicell (emergency backup medication system) revealed Gabapentin, Buspirone, and Baclofen were in the system and available for administration. The baseline care plan dated, [DATE] documented in part, Approach: Behaviors: behavioral needs will be evaluated for impact on quality of life, safety and safety of others. Behavioral management plan will be addressed in needed with physician/NP (nurse practitioner) IDT (interdisciplinary team) and resident/resident representative .Approach: Pain: evaluation of pain will be performed routinely to address pain management needs. I will receive medication per physician/NP orders. Pain medication effectiveness will be documented and reported as needed. An interview was conducted with LPN (licensed practical nurse) #12 on [DATE] at 10:32 a.m. When asked how you obtain medications for a new admission or when medications are not on the medication cart, LPN #12 stated for the new admissions, you have to send them to the pharmacy and ask for the medications early, then it takes a bit for the medication to come. LPN #12 was asked if the nurses can cover any of the medications before they come from the pharmacy, LPN #12 stated you can get them from the Omnicell, including some narcotics. If it's a narcotic the pharmacy sends a code, and you need two nurses to pull it out. LPN #12 stated she was an agency nurse before coming as a permanent employee and had a code for the Omnicell, but it expired in two weeks and had to be renewed. She stated she currently did not have a code for the Omnicell. An interview was conducted with LPN #1 on [DATE] at 9:42 a.m. When asked how does a nurse evidence that they have administered a medication, LPN #1 stated, by signing it off on the MAR, if it's not documented it wasn't done. ASM (administrative staff member) #1, the interim administrator, and ASM #2, the director of nursing, were made aware of the above findings on [DATE] at 5:13 p.m. No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a694007.html. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a688005.html. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a688005.html. 3. For Resident #139 (R139), the facility staff failed to administer medications per the physician order. R139 was admitted to the facility on [DATE] at 5:09 p.m. The admission physician orders were dated [DATE] at the following times: 1:41 p.m. Amlodipine tablet 5 mg (used to treat high blood pressure and heart disease) (1); administer 1 tab by mouth once a day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	1:41 p.m. Bactrim DS (used to treat infections) (2) tablet ,d+[DATE] mg; administer 1 tab via gastric tube twice a day. 1:51 p.m. Finasteride (used to treat enlargement of the prostate) (3) once a day. 2:04 p.m. Magnesium Oxide tablet (supplement) 400 mg; administer 1 tab by mouth once a day. 2:33 p.m. Potassium Chloride tablet extended release 20 mEq (milliequivalent) (supplement); administer 1 tablet via gastric tube once a day. 2:10 p.m. Metoprolol tartrate (used to treat high blood pressure and heart disease) (4) tablet 25 mg; administer 1 tab by mouth twice a day. 2:37 p.m. Sodium Chloride 1,000 mg (supplement); administer 1000 mg via gastric tube three times a day. 2:38 p.m. Tamsulosin capsule 0.4 mg (used to treat enlarged prostate) (5); administer 1 capsule via gastric tube once a day. 2:44 p.m. Warfarin tablet (blood thinner) (6)1 mg, administer 6 tabs via gastric tube once a day. The [DATE] MAR documented the above orders. For the Amlodipine the first dose was administered on [DATE], two days after admission, missing one dose since admission. For the Bactrim DS, the first dose was administered on [DATE] at 6:00 p.m., missing two doses since admission. For the Finasteride, the first dose was administered on [DATE], two days after admission, missing one dose since admission. For the Magnesium Oxide, the first dose was administered on [DATE], two days after admission, missing one dose since admission. For the Potassium Chloride, the first dose was administered on [DATE], two days after admission, missing one dose since admission. For the Metoprolol tartrate. the first dose was administered on [DATE] at 9:00 p.m., missing two doses since admission. For the Sodium Chloride, the first dose was administered on [DATE] at 8:00 p.m., missing three doses since admission. For the Tamsulosin capsule, the first dose was administered on [DATE] at 9:00 a.m., missing one dose since admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	For the Warfarin tablets, the first dose was administered on [DATE] at 6:00 p.m. missing two doses since admission, the nurse documented for [DATE], waiting for RX (pharmacy) delivery. Review of the Omnicell system inventory, documented the above medications were all available in the emergency backup medication system and available for administration. An interview was conducted with LPN (licensed practical nurse) #12 on [DATE] at 10:32 a.m. When asked how you obtain medications for a new admission or when medications are not on the medication cart, LPN #12 stated for the new admissions, you have to send them to the pharmacy and ask for the medications early, then it takes a bit for the medication to come. LPN #12 was asked if the nurses can cover any of the medications before they come from the pharmacy, LPN #12 stated you can get them from the Omnicell, including some narcotics. If it's a narcotic the pharmacy sends a code, and you need two nurses to pull it out. LPN #12 stated she was an agency nurse before coming as a permanent employee and had a code for the Omnicell but it expired in two weeks and had to be renewed. She stated she currently did not have a code for the Omnicell. ASM (administrative staff member) #1, the interim administrator, and ASM #2, the director of nursing, were made aware of the above findings on [DATE] at 5:13 p.m. No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a692044.html/. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a684026.html. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a698016.html. (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682864.html. (5) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a698012.html. (6) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682277.html. 42106 4 [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27660 Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services for a feeding tube for two of 35 residents in the survey sample, Residents #139 and #42. The findings include: 1. For Resident #139, the facility staff failed to administer tube feedings per the physician orders and as documented, let the resident eat a meal tray upon admission to the facility, the resident was to be NPO (nothing by mouth). Resident #139 (R139), the resident was admitted on [DATE] at 5:09 p.m. The hospital discharge orders documented in part, TF (tube feeding) - Jevity 1.5 KCAL/ML (calories per milliliter) Dose: 300 ml. Frequency: 4 times daily. Discharge Procedure Orders: NPO TF only (nothing by mouth tube feeding only). Entered into the medical record on 3/22/24 at 2:41 p.m. The MAR (medication administration record) for March 2024, documented the above order. The resident did not receive any tube feedings on 3/21/24 at 8:00 p.m., 3/22/24 at 8:00 a.m. and 12:00 p.m. The ADL (activities of daily living) documentation, dated 3/21/24 at 7:55 p.m. documented, Fluids - 240 ml (milliliters); Dinner - 76-100%. This indicated the resident received a meal tray for dinner. There was no documentation for ADL care on 3/22/24 so it is unknown if the resident got a breakfast or lunch tray of food on 3/22/24. There was no nursing documentation related to care and condition of the resident on 3/21/24. An interview was conducted with LPN (licensed practical nurse) #12 on 9/17/24 at 10:32 a.m. When asked the process for a new admission and their admission orders, LPN #12 stated, most of the time we have the orders before the resident gets here. We can verify them with the physician, but we can't enter them into the computer until they are physically in the building. When asked how soon the orders should be entered into the computer, LPN #12 stated, as soon as you can. LPN #12 asked if the orders can wait 20 hours before they are entered into the computer, LPN #12 stated, no, the resident would need medications by then. When asked should the nurse and/or CNA (certified nursing assistant) verify the resident's diet before giving them a meal tray, LPN #12 stated, yes. The facility policy, New Admission/Readmission Process Policy, documented in part, 6. Review of orders: a. Physician verification of orders noted. b. Transmitted to pharmacy. c. Transcribed to eMAR/eTAR .14. Enteral feedings orders to contain the following: a. Route and Rate of solution[s] b Amount to be infused, per shift and/or 24hr total. c. Flushes entered on eMAR. d. Checks for residuals. e. Verification of placement. f. HOB elevated 30-450 and/or as directed by physician. ASM (administrative staff member) #1, the interim administrator and ASM #2, the director of nursing, were made aware of the above findings on 9/17/24 at 5:13 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit. 42106 2. For Resident #42 (R42), the facility staff failed to address and notify the physician of feeding tube complications in a timely manner. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/13/24, the resident was assessed as being severely impaired for making daily decisions and having a feeding tube. On 9/15/24 at 5:24 p.m., an observation was conducted of R42 in their room. R42 was observed in bed watching television with tube feeding observed hanging beside them on a feeding tube pump. At that time, an interview was conducted with R42 who was able to verbalize some words and use a communication board. R42 stated that they had the feeding tube for about six months and had problems with it recently. The progress notes for R42 documented in part, 05/04/2024 16:09 (4:09 p.m.) This nurse notified by off going nurse peg (percutaneous endoscopic gastrostomy) tube is clogged. This nurse exhausted all efforts to unclog patients peg tube patient complains of 5/10 pain. Patient was apparently not connected to his tube feeding throughout the day. Patient is complaining of hunger pain. Called [Name of physician group] on-call and was given instructions to send patient out. Patient and emergency contact [Name of emergency contact] notified. Provider to be notified via on-call nurse. EMS (emergency medical services) notified. The eMAR (electronic medication administration record) dated 5/1/24-5/31/24 for R42 documented the resident receiving no tube feeding on day shift 5/3/24 or night shift 5/3/24. The eMAR documented R42 being out due to a clogged g-tube on 5/4/24 at 6:00 p.m. Review of the clinical record for R42 failed to evidence documentation of why the resident did not receive feeding on 5/3/24, the physician being notified or an order to hold the tube feeding on 5/3/24. It further failed to evidence documentation of the feeding tube being clogged on day shift on 5/4/24 or notification of the physician of the feeding tube concerns until evening shift on 5/4/24. The comprehensive care plan for R42 documented in part, Problem Start Date: 06/05/2024. Category: Nutritional Status. [Name of R42] is at increased nutrition/hydration risk r/t (related to) dx/pmhx (diagnoses/primary medical history) of hemiplegia & hemiparesis on R side . Enteral nutrition support via G (gastrostomy) Tube. Hx (history) of sig (significant) wt (weight) chnages [sic]. Under Interventions it documented in part, .Provide tube feed per order . Telephone interviews were attempted with the LPN's (licensed practical nurses) who worked with R42 on day and evening shift of 5/4/24 however the calls were not returned. The nurses who worked with R42 on 5/3/24 day and night shift no longer worked at the facility and could not be interviewed, this was verified by ASM (administrative staff member) #2, the director of nursing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 9:45 a.m., an interview was conducted with LPN #1. LPN #1 stated that if a residents feeding tube became clogged, they attempted to unclog the tube and if they were not successful, they called the doctor to see what they wanted them to do. She stated that they called the doctor right then because there could be an obstruction and the resident needed their medications and the feedings. On 9/18/24 at 12:06 p.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that they would expect nursing staff to have another staff member assist them if the feeding tube was clogged and if they were unsuccessful in opening the tube, they should call the physician right away to get further guidance. She stated that she would not expect the resident to go a day without feeding or until the next shift to have the tube unclogged. The facility policy Enteral Feeding Tube[s] Policy revised 12/22/2023 documented in part, Nurses should monitor the condition of the tube with each use and inform the physician if the tube becomes unusable, leaks, or may need replacement . On 9/18/24 at 2:59 p.m., ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator in training, and ASM #5, the regional vice president of operations were made aware of the concern. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services for a midline for one of 35 residents, Residents #88. The findings include: Resident #88 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: respiratory failure, hypertension, diverticulitis and coronary artery disease. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 10/30/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as max assist for bed mobility, transfer, hygiene and set up for eating. Section O-Special Procedures: coded the resident for antibiotic, midline and isolation. A review of the comprehensive care plan dated 10/27/23 revealed, FOCUS: The resident has infection related to diverticulitis. Resident is on antibiotics for Pneumonia. INTERVENTIONS: Administer antibiotics/antiviral as ordered by the physician. A review of the physician orders dated 10/25/23 revealed Change IV dressing every 7 days as well as needed for soiling and/or dislodgement for midline left arm. Monitor for signs/symptoms of infiltrations or infection. Document abnormal findings in progress note and notify provider every shift and report any changes to physician. A review of the October 2023 MAR (medication administration record) revealed, IV dressing changed 10/25 and midline discontinued 11/1/23. Monitoring for signs/symptoms of infiltrations or infection, was not evidenced on 10/27, 10/28, 10/29 or 10/30 day shift, midline discontinued 11/1/23. An interview was conducted on 9/16/24 at 3:15 PM with LPN (licensed practical nurse) #3. When asked the care of a midline catheter, LPN #3 stated, we monitor it for signs/symptoms of infection and if any infiltration occurs. We notify the physician if any of that happens. When asked where this care would be evidenced, LPN #3 stated, it is documented on the MAR. An interview was conducted on 9/17/24 at 10:40 AM with LPN #12. When asked where evidence of midline care would be found, LPN #12 stated, we document it on the MAR. On 9/18/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. According to the facility, there is no midline care policy. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 29125 Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide oxygen related care and services for three of 35 residents in the survey sample; Residents #60, #11, and #42. The findings include: 1. For Resident #60, the facility staff failed to ensure an order was in place for the administration of oxygen. On 9/15/24 at 5:01 PM, Resident #60 was observed in bed, wearing a nasal cannula for oxygen and the oxygen concentrator was set at 3 liters per minute. On 9/16/24 at 11:19 AM, Resident #60 was observed in bed, wearing a nasal cannula for oxygen and the oxygen concentrator was set at 3.5 liters per minute. On 9/17/24 at 2:42 PM, Resident #60 was observed in bed, wearing a nasal cannula for oxygen and the oxygen concentrator was set at 3.5 liters per minute. A review of the clinical record failed to reveal any evidence of a physician's order for the use of oxygen. On 9/17/24 at 2:57 PM an interview was conducted with LPN #3 (Licensed Practical Nurse) who was the assigned to Resident #60. When asked about his order for oxygen, she reviewed the record and stated that she did not see any orders for it. She stated that there has to be a physician's order in place for oxygen. The facility policy, Oxygen Administration documented, Policy: Licensed clinicians with demonstrated competence will administer oxygen via the specified route as ordered by a provider Procedure: 1. Verify provider order . On 9/17/24 at 4:50 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. 2. For Resident #11, the facility staff failed to administer oxygen at the physician ordered rate. On 9/15/24 at 4:59 PM, 9/16/24 at 11:20 AM, and 9/17/24 at 2:39 PM, Resident #11 was observed in bed, wearing a nasal cannula for oxygen and the oxygen concentrator was set at 2 liters per minute. A review of the clinical record revealed a physician's order dated 5/8/24 for oxygen at 4 liters per minute. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/17/24 at 2:57 PM an interview was conducted with LPN #3 (Licensed Practical Nurse) who was the assigned to Resident #11. When asked about the oxygen rate vs the ordered rate, she stated that the order was not being followed. A review of the comprehensive care plan revealed one dated 5/8/24 and revised 8/8/24, that documented, (Resident #11) requires oxygen therapy R/T (related to) COPD and emphysema. An intervention dated 8/28/24 documented, Administer oxygen at 4L (4 liters) via nasal cannula. Observed oxygen precautions. The facility policy, Oxygen Administration documented, Policy: Licensed clinicians with demonstrated competence will administer oxygen via the specified route as ordered by a provider Procedure: 1. Verify provider order . On 9/17/24 at 4:50 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. 42106 3. For Resident #42 (R42), the facility staff failed to store a nebulizer in a sanitary manner when not in use. On 9/15/24 at 5:24 p.m., an observation was conducted of R42 in their room. R42 was observed in bed watching television. A metal cart was observed beside R42 to the left side of the bed with a nebulizer machine on the top. A nebulizer mask was observed uncovered sitting on top of the cart on the metal surface. Additional observation of the nebulizer mask uncovered on the metal cart was made on 9/15/24 at 5:57 p.m. The physician orders for R42 documented in part, Start Date: 09/10/2024. Ipratropium-albuterol solution for nebulization 0.5mg-3mg (2.5mg base)/3ml three times a day . The order documented the medications to be given at 8:00 a.m., 2:00 p.m. and 8:00 p.m. The eMAR (electronic medication administration record) dated 9/1/24-9/30/24 for R42 documented the resident last receiving the ipratropium-albuterol nebulizer treatment on 9/15/24 at 2:00 p.m. and scheduled for the next dosage at 8:00 p.m. The comprehensive care plan for R42 documented in part, Problem Start Date: 07/26/2024. Category: Respiratory. [Name of R42] requires oxygen therapy R/T (related to) COPD (chronic obstructive pulmonary disease) and respiratory failure. Created: 07/31/2024. On 9/17/24 at 11:08 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that nebulizer masks were supposed to be stored in a bag when they were not in use. She stated that the nebulizer masks and bags were supposed to be changed every Sunday and this was done for infection control purposes to keep them clean. She stated that they had a lot of agency staff at the facility, and it was very hard. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Nebulizer Administration Policy revised 8/10/23 documented in part, . Empty nebulizer cup, rinse with sterile water/sterile saline and air dry. Wipe mask with alcohol wipe and store the neb set in a plastic bag labeled with the patient's name when dried . On 9/17/24 at 5:11 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator in training, and ASM #5, the regional vice president of operations were made aware of the concern. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to implement an effective pain management program for two of 35 residents in the survey sample, Residents #5 and #138. The findings include: 1. For Resident #5 (R5), the facility staff failed to obtain and verify physician orders for pain medications when the resident was readmitted to the facility at 2:00 p.m. on 5/11/24 with two broken femurs (thigh bones). This resulted in harm: on 5/13/24 at approximately 1:15 a.m., R5 was transferred to the hospital for inadequate pain control. A review of R5's clinical record revealed a nurse's note dated 6/5/24 that documented the resident sustained a fall and was transferred to the hospital. R5 was discharged from the hospital back to the facility on [DATE]. The hospital discharge summary dated 5/11/24 documented a primary discharge diagnosis of bilateral distal femur fractures secondary to osteoporosis and a mechanical fall. The hospital discharge medication list documented, CONTINUE taking these medications: gabapentin (used to treat seizures and pain) 400 mg (milligrams)- one capsule every eight hours for five days. Further review of R5's clinical record failed to reveal any physician's medication orders when the resident was readmitted on [DATE]. A review of R5's MAR (medication administration record) for 5/11/24 and 5/12/24 failed to reveal any medication orders. A nurse's note dated 5/11/24 at 4:13 p.m. documented, Pt (Patient) returned from (name of hospital) at 1400 (2:00 p.m.) via stretcher. Received report from hospital. Pt is alert and oriented. Generalized bruising visible on face, scalp and both legs. Dried blood on face and scalp. Left side of hair line has 2 sutures. Bridge of nose with 3 sutures intact. Rt (Right) knee with honeycomb dressing bilaterally. Abrasion lower rt leg front. Left hip with Honeycomb dressing dry and intact. Petal pulse present bilaterally. Left side weaker than right, chronic issue. Lungs clear, abd (abdomen) soft with bowel sounds all 4 quads (quadrants). Pt has script for Neurontin (gabapentin) q (every) 8 hours prn (as needed) for pain. BS (Blood sugar) 132. Vitals 139/63 (blood pressure), 92 (pulse), 16 (respirations), 98 (temperature), 96% (oxygen level). A nurse's note dated 5/12/24 at midnight (5/11/24 into 5/12/24) documented, During hand off report, previous nurse reports to this nurse that patient arrived to facility at 1400 but she did not confirm orders with MD (Medical Doctor)/enter orders in MAR (medication administration record). Writer contacted (name of physician group) on call to confirm orders. Writer spoke with (name of a nurse practitioner). (Name of the nurse practitioner) refuses to confirm orders with nurse because patient came to facility at 1400. Writer attempted to explain to On call (name of nurse practitioner) that this nurse shift started at 1900 (7:00 p.m.) and this nurse just finished passing medication on unit and just needed to confirm the orders because previous nurse did not. (Name of nurse practitioner) states, 'I am not doing that. I am not approving medications after 8pm.' Due to (name of physician group) (name of nurse practitioner) refusing to confirm orders for patient, writer cannot enter patients [sic] orders/treatments into MAR at this time. Will endorse oncoming nurse. Will make management aware of clinical situation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	An admission/readmission observation dated 5/12/24 at 2:59 a.m. documented R5 reported pain or hurting almost constantly over the last five days, the pain almost constantly made it hard to sleep, the pain almost constantly limited day-to-day activities, the pain was rated as an eight on a scale from zero to ten, and the intensity of the pain was severe. There were no nurses' notes documented in R5's clinical record during the 7:00 a.m. to 7:00 p.m. shift on 5/12/24. R5's May 2024 MAR documented the resident's pain as a ten (on a scale from zero to ten) during the day shift on 5/12/24 and the resident's pain as an eight during the night shift on 5/12/24. A nurse's note dated 5/12/24 at 10:58 p.m. (recorded as a late entry on 5/13/24), documented, Received care of resident at 22:40 (10:40 p.m.) Resident had been released from the hospital a day before after falling face first on concrete. Resident states she is in a severe pain. This nurse looked at resident's MAR which was inadequately updated since resident has been back .This nurse noted that the only pain medicine ordered is Tylenol 1000mg (milligrams). This nurse called nurse on 3West in (name of hospital) to get more information about resident's stay in the hospital. The only discharge papers were a list of medications. No Dx (diagnoses), tests, test results were noted. Nurse at (name of hospital) was not able to give any information since the resident had already been released. On call doctor was noted; on call doctor advised nurse to either administer Tylenol or send resident to the hospital if pain gets too intense. Resident's brother was noted and he drove to be at his sister's bedside at 0030 (12:30 a.m.). Tylenol was not effective. Resident was repositioned; ineffective .911 was called per brother's request. Resident was transferred to (name of hospital) at 0115 (1:15 a.m.) via stretcher. Resident has been admitted to the hospital unit. A hospital discharge summary dated 5/17/24 documented, Per patient, since discharge (from the hospital on 5/11/24) was not able to get her insulin and noted increased pain on bilateral lower ext (extremities) .Started insulin drip per DKA (diabetic ketoacidosis) protocol and pain meds and admitted . A facility synopsis of events dated 5/22/24 documented, (R5's) brother, (name), called the DON (Director of Nursing) to inquire about prescribed medications and administration. Based upon this concern, the facility immediately started an internal investigation. The facility interviewed all nurses responsible for (R5's) care, the physician on-call upon the resident's return to the community and reviewed the resident's medical record. (R5) returned to the facility on [DATE] after an unrelated hospitalization . A review of the physician orders revealed medication errors regarding transcription of new orders upon return to the facility. Interviews of the nursing team members responsible for (R5's) care revealed unsuccessful attempts to verify the medications with the resident provider group via telephone upon return. Upon the orders being unsuccessfully verified (R5) to return to the ER (emergency room) for evaluation. The resident returned to the facility on [DATE] . Based on the schedule, the nurses that would have completed her admission and or delivered medications. The nurses who assumed care for the resident were placed on a do not return list and are not allowed to work in the facility . The synopsis contained multiple statements by facility staff as documented below. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	A statement signed on 5/15/24 by RN (registered nurse) #3 (the nurse who worked the 7:00 a.m. to 7:00 p. m. shift on 5/12/24 on another unit) documented, On Sunday 5/12/24 on Day shift provider for (R5) called unit one inquiring about resident if she had returned from hospital. Updated provider that resident returned but did not have any pain medication. Provider reporting that they would escribe (electronically prescribe) pain medication to (name of pharmacy), did not specify what medication, dose, or frequency. RN #3 was available for interview during the survey. A statement signed by LPN (licensed practical nurse) #7 (the nurse who worked the 7:00 p.m. to 7:00 a.m. shift on another unit 5/12/24 into 5/13/24) (no signature date) documented, To Whom it may concern: I, (name of LPN #7) was approached by (LPN #6), regarding patient, (R5) on Unit 1 nurses station. (LPN #6) stated, '(R5) is having uncontrolled pain and she has no pain medications.' (LPN #6) continued, 'Oh! and her blood sugar is around 600.' This nurse then replied, 'Send her out.' (LPN #6) then replied, 'Well I gave her Levemir for her sugar.' I again stated, 'Send her out.' (LPN #6) walked to her computer to print off (R5's) paperwork for transfer. (R5's) brother was in her room. When (LPN #6) stated, 'She has only 1 or 2 medications, so I didn't print it off.' This nurse then went to computer and there were no medications under (R5's) orders. This nurse stated to EMTs (Emergency Medical Technicians) that patient 'does not have any medications on her orders.' This nurse stated, 'I don't know of any medications being administered, other than Levemir (LPN #6) gave her.' This nurse then left the room and the unit. Another statement signed by LPN #7 (no signature date) documented, To Whom it may concern: I, (name of LPN #7), had no interaction with nurse on unit 2, until 1020 PM on May 12th 2024. Said nurse on unit 2 (RN #2) approached the nurses station on unit 1 @ 1020 PM regarding her relief. On call nurse (LPN #8) was notified and there was no other interaction after 1030 PM.- Regarding (RN #2) (the nurse who cared for R5 during the 7:00 a.m. to 7:00 p.m. shift on 5/12/24). LPN #7 was not available for interview during the survey. A statement signed by LPN #8 (R5's unit manager) on 5/13/24 documented, On Monday 5/13/24, I came in to relieve the nurse (LPN #6) because she needed to leave by 630 am. (LPN #6) gave me report on the unit, she told me that she sent (R5) out because of the pain she was having. I asked her did she let anyone know. She stated no it was late it was 1 am. I then stated two residents went to the hospital on your watch, on call should have been called. I explained that and proceeded to take report. A statement signed by LPN #8 on 5/15/24 documented, On 5/12/24 at 12:32 am, nurse (LPN #5) text my phone to state the nurse during the day did not get the meds approved at 2 pm when the resident was admitted on 5.11.24. (LPN #5) stated she called (name of physician group) on call to get the meds verified but the on call (name of nurse practitioner) refused to verify the meds because she stated she doesn't verify meds after 8pm. Once I woke up to the text at 0738 (7:38 a.m.) I contacted (LPN #5) and she explained what she wrote in her text. I then called (name of medical director) explaining what happened, he stated this was not the first time on call has done this that he would be reaching out. Resident meds still needed to be verified, (name of medical director) stated to call on call and have them verify the meds. (Name of medical director) was contacted by me on 5/12/24 at 0838 (8:38 a.m.). This writer then called the building x (times) 4, no one answered. I then called the housekeeper supervisor to check all phones in the building because no one was picking up, she took phone to nurse. I told (RN #2- the nurse who cared for R5 during the 7:00 a.m. to 7:00 p.m. shift on 5/12/24) to place the orders in (name of computer system) because she stated to me that (RN #3), the nurse on unit one already verified the meds. (RN #2) stated she had one more resident to give meds to and she was going to put the orders in. LPN #8 was not available for interview during the survey. On 9/17/24 at 2:10 p.m., a telephone interview was conducted with LPN #5. LPN #5 stated she could not recall details and to refer to her note. RN #2 was not available for interview during the survey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	A printed text message from LPN #6 (the nurse who sent R5 to the hospital on the night of 5/12/24) to ASM (administrative staff member) #2 (the Director of Nursing) (no date) documented, Hello (ASM #2), I need to talk to you about last night. So much happened and I just came in trying to help. Seems like there are so many miscommunications about the events that took place. This morning I left the building feeling like the unit manager (LPN #8) and I were on the same page about how things went. Please call me at your earliest convenience. Thank you, (LPN #6). Another printed text message from LPN #6 to ASM #2 (no date) documented, Hello (ASM #2), I need to talk to you about last night. So much happened and I just came in trying to help. Seems like there are so many miscommunications about the events that took place. This morning I left the building feeling like the unit manager (LPN #8) and I were on the same page about how things went. Please call me at your earliest convenience. Thank you, (LPN #6). ASM #2, I have been waiting for a phone call from you. Since I haven't, I am going to write an incident report to my agency and I will report you to the VA (Virginia) board of nursing. The patient I sent to the hospital hadn't got her insulin for a day and a half because the dr (doctor) on call refused to verify the meds since (R5) didn't return to the facility while she was on call . LPN #6 was not available for interview during the survey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	A statement signed by ASM #2 (the Director of Nursing) (no date) documented, On 5/13/2024, 11 a.m. I called (name of nursing staff agency) to request (RN #1's) telephone number and reported Nurse's failure to initiate an admission nor verify medications to treat resident. Resident arrived at 2pm. Staffing agency, stated that they would contact Nurse and have her return my call. Upon return call, I inquired of the reason (RN #1- the nurse who cared for R5 when the resident was readmitted on [DATE]) did not initiate the admission process for the readmission. Nurse verbalized, she was extremely busy. 'I had to discharge a resident and was not sure of the process, and that the Unit Manager (who was on call and in the building) assisted her with printing discharge paperwork. 'I am not familiar with your version of (name of computer software), I use (name of computer software) at another facility, and however I am more familiar with (name of another computer software). I did ask (LPN #7) on the other unit, what I needed to do for the admission, and she told me the resident was a regular resident and all the medications for her were on the cart.' I went on to ask the Nurse had she received a discharge packet from the Medical transportation personnel, her response was, 'yes.' I continued by referencing her admission note and resident's script upon her return and inquired about the failure to call MD (medical doctor) for verification of orders. Nurse (RN #1) stated, she was unaware of the need to call since, she was told her medications were on the cart. I followed up by asking, Did you see a MAR (medication administration record) for the resident? 'No.' Did you ask the Unit Manager for assistance? 'No.' When you completed your assessment [sic] the resident and noted the script for Gabapentin (used to treat seizures and pain), why did you not input the new script? 'I continued to pass the other medications to the other residents.' Have you ever performed an admission? 'Yes, your system is different, and in (name of another computer system) after putting the resident in the system the admission assessments automatically populates [sic].' 'I informed the oncoming nurse that I had an admission but did not finish it and she said she would finish it, I offered to stay if she would walk me through the process, but she told me she would complete it.' Interviewed (LPN #5- the nurse who cared for R5 during the 7:00 p.m. to 7:00 a.m. shift 5/11/24 into 5/12/24), via telephone. She verbalized she did inform the nurse that she would complete the admission, but initially was not aware of that the medications were not transcribed nor verified. (LPN #5), during her medication pass noted (R5) did not have a MAR, immediately after her medication pass, she made an attempt to call to verify orders, and after speaking with the On call Physician, who would not verify the orders. She texted the On Call Nurse. (LPN #5) was asked, why she did not call (name of the medical director) and she verbalized that she was not aware that she could since there was an On Call system in place. I educated (LPN #5), to call instead of text the On Call Nurse management team member or myself, and in cases of this importance (name of the medical director) can be called. (LPN #5) added that she did inform the oncoming Nurse to call to have the orders verified. However, the oncoming Nurse stated, 'I will not be doing that because it [sic] Mother's Day.' Called (name of nurse staffing agency), informed that of (RN #2- the nurse who cared for R5 during the 7:00 a.m. to 7:00 p.m. shift on 5/12/24), failure to complete Medication Administration Record documentation, failure to follow up on a readmission, and failure to complete skilled documentation. Interviewed via telephone, (RN #2), stated she 'thought' she signed off her medications, 'I was constantly on the cart, tending to residents, answering questions for family members, and made attempts to control (R5's) pain since the resident only came back with gabapentin. They called in Tramadol (used to treat pain) to the pharmacy and it did not come in, then I got an order for Tylenol 1000 mg (milligrams) and gave it to resident.' I inquired of why the orders were not transcribed on the MAR nor documented in the system and was she aware that (R5's) medication were not verified? 'There was a lot going on and I planned to do it.' Why did you did [sic] not call the On call Nurse for assistance? 'I do not have anyone's number and like I said it was a lot going on.' (RN #2) was informed that there is a calendar at the desk with all On Call Nurses numbers attached. (RN #2) said she did not have time to look for anyone's numbers, but she did ask (LPN #7) for assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	On 9/17/24 at 9:33 a.m., an interview was conducted with LPN #4 (the current unit manager). LPN #4 stated that when a resident is readmitted from the hospital, he or she returns with a package that contains a medication list and discharge instructions, and the admitting nurse should call the doctor to verify the medication list. LPN #4 stated sometimes the doctor changes medication orders and after medications have been verified, the nurse should put all orders into the computer system. LPN #4 stated that after orders are put into the computer system, they are transmitted to the pharmacy and transcribed onto a MAR. LPN #4 stated she would not stop in the middle of a medication pass to complete this process, but it should be done as soon as the resident arrives. LPN #4 stated, That's the first thing they should do because we need the meds. LPN #4 stated if the physician or nurse practitioner will not verify medications upon re-admission, the admitting nurse should call the medical director and inform the Director of Nursing. On 9/17/24 at 10:46 a.m., an interview was conducted with ASM #2 (the Director of Nursing). ASM #2 stated that when a resident is readmitted , the nurse should greet the resident, make sure the resident is comfortable, then go to the desk and open the packet of information and orders from the hospital. ASM #2 stated the nurse should enter/transcribe the orders into the queue in the computer system then verify the orders with the physician because the physician may want to change the orders. ASM #2 stated that after the orders are verified with the physician, the nurse should make the orders active in the computer system so the orders are activated onto the MAR and sent to the pharmacy. ASM #2 stated she was not made aware of the above incident regarding R5 until the resident was being sent back to the hospital on (5/12/24 into 5/13/24). ASM #2 stated it was the middle of the night and she received a phone call from R5's brother. ASM #2 stated the facility staff could not manage R5's pain. ASM #2 stated R5's brother said R5 was in significant pain and had not received any pain medications in over 24 hours. ASM #2 stated that at that point, all she could do was agree that pain medications should have been obtained for R5 then she called the facility staff to make sure they sent R5 to the hospital and documented a note. ASM #5 stated that when R5 was readmitted to the facility on [DATE], the first nurse should have queued the medications in the computer system, called the physician to verify the medications, sent the medication orders to the pharmacy, and if the resident was in pain, the nurse should have contacted the pharmacy and obtained medications from the box in the facility. ASM #2 stated that if the nurse didn't know what to do, she should have called the on-call nurse or ASM #2. ASM #2 stated that if the nurse practitioner refused to verify the medications, then the nurse should have notified her so she could have notified the medical director. On 9/17/24 at 11:23 a.m., an interview was conducted with ASM #6 (the medical director). ASM #6 stated the responsibilities of the on-call physician or nurse practitioner are to take care of the patient, verify orders, and send the pharmacy an e-script (electronic prescription) if needed. In regard to the above incident involving R5, ASM #6 stated that if he recalled, there were errors on multiple sides. ASM #6 stated the orders should have been called in to the on-call nurse practitioner as soon as R5 arrived to the facility but it was the responsibility of the on-call nurse practitioner to verify orders and send e-scripts whenever called, regardless of the time. ASM #6 stated, It is our responsibility to make sure it happens with as little delay as possible. ASM #6 stated he should have been notified when the on-call nurse practitioner refused to verify R5's orders but he was not notified until the next day. ASM #6 stated the on-call nurse practitioner does not round at the facility and is only on-call for the group, but he escalated the incident to the chief medical officer because the patient actually came to some harm and had to go the emergency room for a lack of order verification and pain management. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	On 9/18/24 at 1:11 p.m. another interview was conducted with ASM #6. ASM #6 was made aware of the statement signed by LPN #8 on 5/13/24 that documented he (ASM #6) was notified on 5/12/24 at 8:38 a.m. ASM #6 stated he went back through his phone records. ASM #6 stated that during the morning on 5/12/24, LPN #8 made him aware that R5 was admitted at 2:00 p.m. on the previous day and the medications were not called to the on-call nurse practitioner until midnight and the nurse practitioner declined to verify the medications because she thought they should have been called to her earlier in the day. ASM #6 stated he told LPN #8 to call the on-call nurse practitioner back since it was not after 8:00 p.m., and if the nurse practitioner did not verify the medications, call him back. ASM #6 stated he was not notified again until R5 was sent to the hospital. On 9/17/24 at 1:25 p.m., ASM (administrative staff member) #1 (the interim administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Pain Management Protocol documented, It is the policy of this community to ensure any resident that is admitted to the facility is assessed for pain and/or the potential for pain in order for the resident to reach and maintain his/her highest practicable level of physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. 27660 2. For Resident #138 (R138), the facility staff failed to administer physician prescribed pain medications. The Brief Interview for Mental Status (BIMS) form dated, 9/12/24, the resident scored a 12 out of 15 on the BIMS score, indicating the resident was not cognitively impaired for making daily decisions. R138 was admitted to the facility on [DATE] at 6:21 p.m. An interview was conducted with R138 on 9/15/24 at 5:06 p.m. R138 stated he had pain upon admission, and they didn't give him his pain medications. It took a while to get his pain under control because he stated he got behind the curve with it. The physician orders dated 9/10/24, documented, Morphine tablet extended release; 15 mg (milligrams); 3 tabs (tablets) every 12 hours for malignant neoplasm of prostate. The September 2024 MAR (medication administration record) documented the above order. There were blanks on the MAR for 9/10/24 at 9:00 p.m., 9/11/24 at 9:00 p.m. and 9/12/24 at 9:00 p.m. The Controlled Medication Utilization Record documented the medication was received at the facility on 9/12/24. Review of the Omnicell (on site emergency medication system) inventory list failed to evidence the Morphine extended release was stocked in it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	The Baseline Care plan dated 9/10/24, documented in part, Approach: Pain - evaluation of pain will be performed routinely to address pain management needs. I will receive pain medication per physician/NP (nurse practitioner) orders. Paim medication effectiveness will be documented and recorded as needed. An interview was conducted with LPN (licensed practical nurse) #12 on 9/17/24 at 10:32 a.m. When asked how you get narcotics for a new admission, LPN #12 stated if they don't have the medications here, there's the Omnicell. You need two nurses to get out narcotics and the pharmacy must give you a code to get into it. LPN #12 stated, when she gets report from the hospital, she asks them to medicate the resident for pain, if indicated, as transfers can be rough on the resident. LPN #12 further stated if you don't tell the pharmacy, you want them on the first run, then you don't get them until the night run. When asked about R138, LPN #12 stated she had done his admission, the narcotics should have come that night, unless there was an insurance delay. She stated someone had added (R138) to the system but can't transmit the orders to the pharmacy until the resident is actually in the building. ASM (administrative staff member) #1, the interim administrator and ASM #2, the director of nursing, were made aware of the above findings on 9/17/24 at 5:13 p.m. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 27660 Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to complete an accurate bed rail assessment for two of 35 residents in the survey sample, Residents #137 and #138. The findings include: 1. For Resident #137(R137), the facility staff failed to accurately document the side rails on the assessment tool. R137 was observed on 9/15/24 at 4:53 p.m. in bed, with grab bars on both sides of the bed. The Enabler/Physical Restraint/Side Rail Review dated, 9/14/24 at 7:36 p.m. documented in part, Does resident currently use a device that could be considered a restraint (side rail, seat belt, lap buddy, trunk restraint, etc.)? A mark was made next to, no. An interview was conducted with LPN (licensed practical nurse) #1, on 9/18/24 at 9:42 a.m. When asked why a side rail assessment is completed, LPN #1 stated that they could be considered a restraint, so a side rail assessment is done to determine if they need them or want them for mobility. LPN #1 was asked if a grab bar or halo bar are considered side rails, LPN #1 stated, no, that's what she always thought. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 9/18/24 at 12:07 p.m. The above Assessment was reviewed with ASM #2. ASM #2 stated she was not familiar with the resident, but the beds have rails unless they are removed. The facility policy, Bed Identification and Safety Inspection Policy, documented in part, The use of bed rails will be limited to circumstances where they are used to treat a medical condition and enhance the resident's functional abilities. Whenever a bed/side rail or grab/enabler bar or anything else is attached to the bedframe or added to the bed environment/system, evaluation of the entrapment zones as laid out below will occur. ASM #1, the interim administrator, and ASM #2, the director of nursing, were made aware of the above findings on 9/18/24 at 3:00 p.m. No further information was obtained prior to exit. 2. For Resident #138 (R138), the facility staff failed to accurately document the side rails on the assessment tool. Observation was made of R138 on 9/15/24 at 5:06 p.m. The resident was in his bed with halo bars attached to both sides of the bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Enabler/Physical Restraint/Side Rail Review dated, 9/10/24 at 6:32 p.m. documented in part, Does resident currently use a device that could be considered a restraint (side rail, seat belt, lap buddy, trunk restraint, etc.)? A mark was made next to, no. An interview was conducted with LPN (licensed practical nurse) #1, on 9/18/24 at 9:42 a.m. When asked why a side rail assessment is completed, LPN #1 stated that they could be considered a restraint, so a side rail assessment is done to determine if they need them or want them for mobility. LPN #1 was asked if a grab bar or halo bar are considered side rails, LPN #1 stated, no, that's what she always thought. An interview was conducted with ASM #2 on 9/18/24 at 12:04 p.m. The above assessment was reviewed with ASM #2. ASM #2 stated the assessment was not correct as the resident did have halo bars on the bed that were removed today. ASM #1, the interim administrator, and ASM #2, the director of nursing, were made aware of the above findings on 9/18/24 at 3:00 p.m. No further information was obtained prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0710 Level of Harm - Actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide physician services for one of 35 residents in the survey sample, Resident #5. The findings include: For Resident #5 (R5), the on-call nurse practitioner failed to verify medication orders when the resident was readmitted on [DATE]. This resulted in harm: on 5/13/24 at approximately 1:15 a.m., R5 was transferred to the hospital for inadequate pain control. Also, the R5's blood sugar was documented as 579 (1), the resident was diagnosed with diabetic ketoacidosis (2), and the resident required an insulin drip (insulin that is intravenously infused). A review of R5's clinical record revealed a nurse's note dated 6/5/24 that documented the resident sustained a fall and was transferred to the hospital. R5 was discharged from the hospital back to the facility on [DATE]. The hospital discharge summary dated 5/11/24 documented a primary discharge diagnosis of bilateral distal femur fractures secondary to osteoporosis and a mechanical fall. The hospital discharge medication list documented, CONTINUE taking these medications: -gabapentin (used to treat seizures and pain) 400 mg (milligrams)- one capsule every eight hours for five days. -Insulin Lispro 100 unit/mL (milliliter) insulin pen- two units beneath the skin Three Times Daily with Meals. If eats at least 50% of meal or drinks a supplement shake. -Insulin Lispro 100 unit/mL insulin pen- Inject 0-3 Units beneath the skin 4 Times a Day Before Meals & at Bedtime. Per sliding scale (based on the resident's blood sugars): 250-350=1 unit 351-400=2 units 401-800=3 units Call & notify MD (Medical Doctor) if BG (Blood Glucose) > (greater than) 400. -LEVEMIR 100 unit/mL (3 mL) insulin pen- Inject 9 Units beneath the skin Every Night at Bedtime. Further review of R5's clinical record failed to reveal any physician's medication orders when the resident was readmitted on [DATE]. A review of R5's MAR (medication administration record) for 5/11/24 and 5/12/24 failed to reveal any medication orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0710 Level of Harm - Actual harm Residents Affected - Few	A nurse's note dated 5/11/24 at 4:13 p.m. documented, Pt (Patient) returned from (name of hospital) at 1400 (2:00 p.m.) via stretcher. Received report from hospital. Pt is alert and oriented. Generalized bruising visible on face, scalp and both legs. Dried blood on face and scalp. Left side of hair line has 2 sutures. Bridge of nose with 3 sutures intact. Rt (Right) knee with honeycomb dressing bilaterally. Abrasion lower rt leg front. Left hip with Honeycomb dressing dry and intact. Petal pulse present bilaterally. Left side weaker than right, chronic issue. Lungs clear, abd (abdomen) soft with bowel sounds all 4 quads (quadrants). Pt has script for Neurontin q (every) 8 hours prn (as needed) for pain. BS (Blood sugar) 132. Vitals 139/63 (blood pressure), 92 (pulse), 16 (respirations), 98 (temperature), 96% (oxygen level). A nurse's note dated 5/12/24 at midnight (5/11/24 into 5/12/24) documented, During hand off report, previous nurse reports to this nurse that patient arrived to facility at 1400 but she did not confirm orders with MD (Medical Doctor)/enter orders in MAR (medication administration record). Writer contacted (name of physician group) on call to confirm orders. Writer spoke with (name of a nurse practitioner). (Name of the nurse practitioner) refuses to confirm orders with nurse because patient came to facility at 1400. Writer attempted to explain to On call (name of nurse practitioner) that this nurse shift started at 1900 (7:00 p.m.) and this nurse just finished passing medication on unit and just needed to confirm the orders because previous nurse did not. (Name of nurse practitioner) states, 'I am not doing that. I am not approving medications after 8pm.' Due to (name of physician group) (name of nurse practitioner) refusing to confirm orders for patient, writer cannot enter patients [sic] orders/treatments into MAR at this time. Will endorse oncoming nurse. Will make management aware of clinical situation. There were no nurses' notes documented in R5's clinical record during the 7:00 a.m. to 7:00 p.m. shift on 5/12/24. A nurse's note dated 5/12/24 at 10:58 p.m. (recorded as a late entry on 5/13/24), documented, Received care of resident at 22:40 (10:40 p.m.) Resident had been released from the hospital a day before after falling face first on concrete. Resident states she is in a severe pain. This nurse looked at resident's MAR which was inadequately updated since resident has been back. It was noted that the last time resident received insulin or glucose checks was on 05/08/2024. This nurse noted that the only pain medicine ordered is Tylenol 1000mg (milligrams). This nurse called nurse on 3West in (name of hospital) to get more information about resident's stay in the hospital. The only discharge papers were a list of medications. No Dx (diagnoses), tests, test results were noted. Nurse at (name of hospital) was not able to give any information since the resident had already been released. On call doctor was noted; on call doctor advised nurse to either administer Tylenol or send resident to the hospital if pain gets too intense. Resident's brother was noted and he drove to be at his sister's bedside at 0030 (12:30 a.m.). Tylenol was not effective. Resident was repositioned; ineffective. Blood glucose 579. Lispro and Levemir administered. 911 was called per brother's request. Resident was transferred to (name of hospital) at 0115 (1:15 a.m.) via stretcher. Resident has been admitted to the hospital unit. A hospital discharge summary dated 5/17/24 documented, Per patient, since discharge (from the hospital on 5/11/24) was not able to get her insulin and noted increased pain on bilateral lower ext (extremities) .EMS reported BS (Blood Sugar) 600. Started insulin drip per DKA (diabetic ketoacidosis) protocol and pain meds and admitted . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0710 Level of Harm - Actual harm Residents Affected - Few	A facility synopsis of events dated 5/22/24 documented, (R5's) brother, (name), called the DON (Director of Nursing) to inquire about prescribed medications and administration. Based upon this concern, the facility immediately started an internal investigation. The facility interviewed all nurses responsible for (R5's) care, the physician on-call upon the resident's return to the community and reviewed the resident's medical record. (R5) returned to the facility on [DATE] after an unrelated hospitalization . A review of the physician orders revealed medication errors regarding transcription of new orders upon return to the facility. Interviews of the nursing team members responsible for (R5's) care revealed unsuccessful attempts to verify the medications with the resident provider group via telephone upon return. Upon the orders being unsuccessfully verified (R5) to return to the ER (emergency room) for evaluation. The resident returned to the facility on [DATE] . Based on the schedule, the nurses that would have completed her admission and or delivered medications. The nurses who assumed care for the resident were placed on a do not return list and are not allowed to work in the facility . The synopsis contained multiple statements by facility staff as documented below. A statement signed on 5/15/24 by RN (registered nurse) #3 (the nurse who worked the 7:00 a.m. to 7:00 p. m. shift on 5/12/24 on another unit) documented, On Sunday 5/12/24 on Day shift provider for (R5) called unit one inquiring about resident if she had returned from hospital. Updated provider that resident returned but did not have any pain medication. Provider reporting that they would escribe (electronically prescribe) pain medication to (name of pharmacy), did not specify what medication, dose, or frequency. RN #3 was available for interview during the survey. A statement signed by LPN (licensed practical nurse) #7 (the nurse who worked the 7:00 p.m. to 7:00 a.m. shift on another unit 5/12/24 into 5/13/24) (no signature date) documented, To Whom it may concern: I, (name of LPN #7) was approached by (LPN #6), regarding patient, (R5) on Unit 1 nurses station. (LPN #6) stated, '(R5) is having uncontrolled pain and she has no pain medications.' (LPN #6) continued, 'Oh! and her blood sugar is around 600.' This nurse then replied, 'Send her out.' (LPN #6) then replied, 'Well I gave her Levemir for her sugar.' I again stated, 'Send her out.' (LPN #6) walked to her computer to print off (R5's) paperwork for transfer. (R5's) brother was in her room. When (LPN #6) stated, 'She has only 1 or 2 medications, so I didn't print it off.' This nurse then went to computer and there were no medications under (R5's) orders. This nurse stated to EMTs (Emergency Medical Technicians) that patient 'does not have any medications on her orders.' This nurse stated, 'I don't know of any medications being administered, other than Levemir (LPN #6) gave her.' This nurse then left the room and the unit. Another statement signed by LPN #7 (no signature date) documented, To Whom it may concern: I, (name of LPN #7), had no interaction with nurse on unit 2, until 1020 PM on May 12th 2024. Said nurse on unit 2 (RN #2) approached the nurses station on unit 1 @ 1020 PM regarding her relief. On call nurse (LPN #8) was notified and there was no other interaction after 1030 PM.- Regarding (RN #2) (the nurse who cared for R5 during the 7:00 a.m. to 7:00 p.m. shift on 5/12/24). LPN #7 was not available for interview during the survey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0710 Level of Harm - Actual harm Residents Affected - Few	A statement signed by LPN #8 (R5's unit manager) on 5/13/24 documented, On Monday 5/13/24, I came in to relieve the nurse (LPN #6) because she needed to leave by 630 am. (LPN #6) gave me report on the unit, she told me that she sent (R5) out because of the pain she was having. I asked her did she let anyone know. She stated no it was late it was 1 am. I then stated two residents went to the hospital on your watch, on call should have been called. I explained that and proceeded to take report. A statement signed by LPN #8 on 5/15/24 documented, On 5/12/24 at 12:32 am, nurse (LPN #5) text my phone to state the nurse during the day did not get the meds approved at 2 pm when the resident was admitted on 5.11.24. (LPN #5) stated she called (name of physician group) on call to get the meds verified but the on call (name of nurse practitioner) refused to verify the meds because she stated she doesn't verify meds after 8pm. Once I woke up to the text at 0738 (7:38 a.m.) I contacted (LPN #5) and she explained what she wrote in her text. I then called (name of medical director) explaining what happened, he stated this was not the first time on call has done this that he would be reaching out. Resident meds still needed to be verified, (name of medical director) stated to call on call and have them verify the meds. (Name of medical director) was contacted by me on 5/12/24 at 0838 (8:38 a.m.). This writer then called the building x (times) 4, no one answered. I then called the housekeeper supervisor to check all phones in the building because no one was picking up, she took phone to nurse. I told (RN #2- the nurse who cared for R5 during the 7:00 a.m. to 7:00 p.m. shift on 5/12/24) to place the orders in (name of computer system) because she stated to me that (RN #3), the nurse on unit one already verified the meds. (RN #2) stated she had one more resident to give meds to and she was going to put the orders in. LPN #8 was not available for interview during the survey. On 9/17/24 at 2:10 p.m., a telephone interview was conducted with LPN #5. LPN #5 stated she could not recall details and to refer to her note. RN #2 was not available for interview during the survey. A printed text message from LPN #6 (the nurse who sent R5 to the hospital on the night of 5/12/24) to ASM (administrative staff member) #2 (the Director of Nursing) (no date) documented, Hello (ASM #2), I need to talk to you about last night. So much happened and I just came in trying to help. Seems like there are so many miscommunications about the events that took place. This morning I left the building feeling like the unit manager (LPN #8) and I were on the same page about how things went. Please call me at your earliest convenience. Thank you, (LPN #6). Another printed text message from LPN #6 to ASM #2 (no date) documented, Hello (ASM #2), I need to talk to you about last night. So much happened and I just came in trying to help. Seems like there are so many miscommunications about the events that took place. This morning I left the building feeling like the unit manager (LPN #8) and I were on the same page about how things went. Please call me at your earliest convenience. Thank you, (LPN #6). ASM #2, I have been waiting for a phone call from you. Since I haven't, I am going to write an incident report to my agency and I will report you to the VA (Virginia) board of nursing. The patient I sent to the hospital hadn't got her insulin for a day and a half because the dr (doctor) on call refused to verify the meds since (R5) didn't return to the facility while she was on call . LPN #6 was not available for interview during the survey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0710 Level of Harm - Actual harm Residents Affected - Few	A statement signed by ASM #2 (the Director of Nursing) (no date) documented, On 5/13/2024, 11 a.m. I called (name of nursing staff agency) to request (RN #1's) telephone number and reported Nurse's failure to initiate an admission nor verify medications to treat resident. Resident arrived at 2pm. Staffing agency, stated that they would contact Nurse and have her return my call. Upon return call, I inquired of the reason (RN #1- the nurse who cared for R5 when the resident was readmitted on [DATE]) did not initiate the admission process for the readmission. Nurse verbalized, she was extremely busy. 'I had to discharge a resident and was not sure of the process, and that the Unit Manager (who was on call and in the building) assisted her with printing discharge paperwork. 'I am not familiar with your version of (name of computer software), I use (name of computer software) at another facility, and however I am more familiar with (name of another computer software). I did ask (LPN #7) on the other unit, what I needed to do for the admission, and she told me the resident was a regular resident and all the medications for her were on the cart.' I went on to ask the Nurse had she received a discharge packet from the Medical transportation personnel, her response was, 'yes.' I continued by referencing her admission note and resident's script upon her return and inquired about the failure to call MD (medical doctor) for verification of orders. Nurse (RN #1) stated, she was unaware of the need to call since, she was told her medications were on the cart. I followed up by asking, Did you see a MAR (medication administration record) for the resident? 'No.' Did you ask the Unit Manager for assistance? 'No.' When you completed your assessment [sic] the resident and noted the script for Gabapentin (used to treat seizures and pain), why did you not input the new script? 'I continued to pass the other medications to the other residents.' Have you ever performed an admission? 'Yes, your system is different, and in (name of another computer system) after putting the resident in the system the admission assessments automatically populates [sic].' 'I informed the oncoming nurse that I had an admission but did not finish it and she said she would finish it, I offered to stay if she would walk me through the process, but she told me she would complete it.' Interviewed (LPN #5- the nurse who cared for R5 during the 7:00 p.m. to 7:00 a.m. shift 5/11/24 into 5/12/24), via telephone. She verbalized she did inform the nurse that she would complete the admission, but initially was not aware of that the medications were not transcribed nor verified. (LPN #5), during her medication pass noted (R5) did not have a MAR, immediately after her medication pass, she made an attempt to call to verify orders, and after speaking with the On call Physician, who would not verify the orders. She texted the On Call Nurse. (LPN #5) was asked, why she did not call (name of the medical director) and she verbalized that she was not aware that she could since there was an On Call system in place. I educated (LPN #5), to call instead of text the On Call Nurse management team member or myself, and in cases of this importance (name of the medical director) can be called. (LPN #5) added that she did inform the oncoming Nurse to call to have the orders verified. However, the oncoming Nurse stated, 'I will not be doing that because it [sic] Mother's Day.' Called (name of nurse staffing agency), informed that of (RN #2- the nurse who cared for R5 during the 7:00 a.m. to 7:00 p.m. shift on 5/12/24), failure to complete Medication Administration Record documentation, failure to follow up on a readmission, and failure to complete skilled documentation. Interviewed via telephone, (RN #2), stated she 'thought' she signed off her medications, 'I was constantly on the cart, tending to residents, answering questions for family members, and made attempts to control (R5's) pain since the resident only came back with gabapentin. They called in Tramadol (used to treat pain) to the pharmacy and it did not come in, then I got an order for Tylenol 1000 mg (milligrams) and gave it to resident.' I inquired of why the orders were not transcribed on the MAR nor documented in the system and was she aware that (R5's) medication were not verified? 'There was a lot going on and I planned to do it.' Why did you did [sic] not call the On call Nurse for assistance? 'I do not have anyone's number and like I said it was a lot going on.' (RN #2) was informed that there is a calendar at the desk with all On Call Nurses numbers attached. (RN #2) said she did not have time to look for anyone's numbers, but she did ask (LPN #7) for assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0710 Level of Harm - Actual harm Residents Affected - Few	On 9/17/24 at 9:33 a.m., an interview was conducted with LPN #4 (the current unit manager). LPN #4 stated that when a resident is readmitted from the hospital, he or she returns with a package that contains a medication list and discharge instructions, and the admitting nurse should call the doctor to verify the medication list. LPN #4 stated sometimes the doctor changes medication orders and after medications have been verified, the nurse should put all orders into the computer system. LPN #4 stated that after orders are put into the computer system, they are transmitted to the pharmacy and transcribed onto a MAR. LPN #4 stated she would not stop in the middle of a medication pass to complete this process, but it should be done as soon as the resident arrives. LPN #4 stated, That's the first thing they should do because we need the meds. LPN #4 stated if the physician or nurse practitioner will not verify medications upon re-admission, the admitting nurse should call the medical director and inform the Director of Nursing. On 9/17/24 at 10:46 a.m., an interview was conducted with ASM #2 (the Director of Nursing). ASM #2 stated that when a resident is readmitted , the nurse should greet the resident, make sure the resident is comfortable, then go to the desk and open the packet of information and orders from the hospital. ASM #2 stated the nurse should enter/transcribe the orders into the queue in the computer system then verify the orders with the physician because the physician may want to change the orders. ASM #2 stated that after the orders are verified with the physician, the nurse should make the orders active in the computer system so the orders are activated onto the MAR and sent to the pharmacy. ASM #2 stated she was not made aware of the above incident regarding R5 until the resident was being sent back to the hospital on (5/12/24 into 5/13/24). ASM #2 stated it was the middle of the night and she received a phone call from R5's brother. ASM #2 stated the facility staff could not manage R5's pain. ASM #2 stated R5's brother said R5 was in significant pain and had not received any pain medications in over 24 hours. ASM #2 stated that at that point, all she could do was agree that pain medications should have been obtained for R5 then she called the facility staff to make sure they sent R5 to the hospital and documented a note. ASM #2 stated she could not recall what facility staff she talked to or if she was made aware of R5's blood sugar. ASM #5 stated that when R5 was readmitted to the facility on [DATE], the first nurse should have queued the medications in the computer system, called the physician to verify the medications, sent the medication orders to the pharmacy, and if the resident was in pain or required insulin, the nurse should have contacted the pharmacy and obtained medications from the box in the facility. ASM #2 stated that if the nurse didn't know what to do, she should have called the on-call nurse or ASM #2. ASM #2 stated that if the nurse practitioner refused to verify the medications, then the nurse should have notified her so she could have notified the medical director. On 9/17/24 at 11:23 a.m., an interview was conducted with ASM #6 (the medical director). ASM #6 stated the responsibilities of the on-call physician or nurse practitioner are to take care of the patient, verify orders, and send the pharmacy an e-script (electronic prescription) if needed. In regard to the above incident involving R5, ASM #6 stated that if he recalled, there were errors on multiple sides. ASM #6 stated the orders should have been called in to the on-call nurse practitioner as soon as R5 arrived to the facility but it was the responsibility of the on-call nurse practitioner to verify orders and send e-scripts whenever called, regardless of the time. ASM #6 stated, It is our responsibility to make sure it happens with as little delay as possible. ASM #6 stated he should have been notified when the on-call nurse practitioner refused to verify R5's orders but he was not notified until the next day. ASM #6 stated the on-call nurse practitioner does not round at the facility and is only on-call for the group, but he escalated the incident to the chief medical officer because the patient actually came to some harm and had to go the emergency room for a lack of order verification and pain management. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0710 Level of Harm - Actual harm Residents Affected - Few	On 9/18/24 at 1:11 p.m. another interview was conducted with ASM #6. ASM #6 was made aware of the statement signed by LPN #8 on 5/13/24 that documented he (ASM #6) was notified on 5/12/24 at 8:38 a.m. ASM #6 stated he went back through his phone records. ASM #6 stated that during the morning on 5/12/24, LPN #8 made him aware that R5 was admitted at 2:00 p.m. on the previous day and the medications were not called to the on-call nurse practitioner until midnight and the nurse practitioner declined to verify the medications because she thought they should have been called to her earlier in the day. ASM #6 stated he told LPN #8 to call the on-call nurse practitioner back since it was not after 8:00 p.m., and if the nurse practitioner did not verify the medications, call him back. ASM #6 stated he was not notified again until R5 was sent to the hospital. On 9/17/24 at 1:25 p.m., ASM (administrative staff member) #1 (the interim administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Physician/Provider Orders documented, ADMISSION ORDERS: All information received from the referring facility or agency shall be reviewed. 1. Transcribe all orders from the transfer form to the facility admission physician order form. 2. The attending physician shall review and confirm the orders. References: (1) A blood sugar test measures the amount of a sugar called glucose in a sample of your blood. If you had a fasting blood glucose test, a level of 70 to 99 mg (milligrams)/dL (deciliter) is considered normal. If you had a random blood glucose test, a normal result depends on when you last ate. Most of the time, the blood glucose level will be 125 mg/dL or lower . (2) Diabetic ketoacidosis (DKA) is a life-threatening problem that affects people with diabetes. It occurs when the body starts breaking down fat at a rate that is much too fast. The liver processes the fat into a fuel called ketones, which causes the blood to become acidic. This information was obtained from the website: https://medlineplus.gov/ency/article/000320.htm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 42183 Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to post daily staffing for one of four days reviewed. The findings include: During the Sufficient and Competent Staffing facility task review started on 9/15/24 and ending on 9/18/24, a review of the daily staffing evidenced the following: On 9/15/24 at 3:00 PM entered the facility for the survey. On the receptionist area in the main lobby the staff posting with a date of 9/13/24 on form. The daily staffing was posted correctly on 9/15/24 by 6:00 PM. On 9/18/24 at 8:50 AM, an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked to describe the staff posting process, ASM #2 stated, we just hired a staffing coordinator last week, it will be her responsibility. When asked the process for the weekends, ASM #2 stated, it is the manager on call's responsibility to post the staffing. The manager on call came in both days this weekend, but to deal with emergency situations, so the posted staffing was not changed. On 9/18/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. According to the facility there is no policy. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27660 Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide pharmacy services for five of 35 residents in the survey sample and on one of two units, Residents #138, #63, #48, #16, #88 and Unit 2. The findings include: 1. For Resident #138, the facility staff failed to provide physician prescribed medications, Morphine Sulfate, in a timely manner. An interview was conducted with R138 on [DATE] at 5:06 p.m. R138 stated he got to the facility on [DATE] at 6:00 p.m. He didn't get any medications for over 12 hours. The physician order dated, [DATE] at 3:59 p.m. documented, Morphine tablet extended release; 15 mg (milligrams); administer 3 tabs (tablets) every 12 hours for malignant neoplasm of prostate. The [DATE] MAR (medication administration record) documented the above order. There were blanks on the MAR for the administration of the Morphine on [DATE], [DATE] and [DATE] at 9:00 p.m. The Controlled Medication Utilization Record documented the above physician order. The date the facility received the medication was documented as [DATE]. An interview was conducted with LPN (licensed practical nurse) #12 on [DATE] at 10:32 a.m. When asked how you obtain medications for a new admission or when medications are not on the medication cart, LPN #12 stated, for the new admissions, you have to send them to the pharmacy and ask for the medications early, then it takes a bit for the medication to come. LPN #12 was asked if the nurses can cover any of the medications before they come from the pharmacy, LPN #12 stated, you can get them from the Omnicell, including some narcotics. If it's a narcotic the pharmacy sends a code, and you need two nurses to pull it out. LPN #12 stated she was an agency nurse before coming as a permanent employee and had a code for the Omnicell, but it expired in two weeks and had to be renewed. She stated she currently did not have a code for the Omnicell. ASM (administrative staff member) #1, the interim administrator, and ASM #2, the director of nursing, were made aware of the above on [DATE] at 5:13 p.m. No further information was provided prior to exit. 42106 2. For Resident #63 (R63), the facility staff failed to ensure medications were available for administration as ordered by the physician on multiple dates in August and September of 2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of [DATE], the resident scored 10 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. The assessment documented R63 receiving insulin injections. On [DATE] at 6:05 p.m., an interview was conducted with R63 in their room. R63 stated that they had concerns regarding the facility staff running out of their medications and they were missing doses of medications. R63 stated that they had missed medications because the nurses told them they were out. A review of R63's clinical record revealed the following physician's orders: - Humalog Mix ,d+[DATE](U-100) Insulin (insulin lispro protamin-lispro) suspension; 100 unit/ml (,d+[DATE]); amt: 20 units: subcutaneous once a morning. 0900. Order Date: [DATE]. A review of R63's [DATE] eMAR (electronic medication administration record) failed to evidence the humalog mix ,d+[DATE] insulin administered as ordered on [DATE], [DATE], [DATE], [DATE], and [DATE] for the 9:00 a.m. doses. The eMAR notes documented the reason for the medication not being administered on [DATE] being BLE (bilateral lower extremities) wrapped and [DATE] being Not administered: other comment: waiting for insulin syringe. The eMAR dates for [DATE] and [DATE] were observed to be blank. A review of R63's [DATE] eMAR failed to evidence the humalog mix ,d+[DATE] insulin administered as ordered on [DATE] and [DATE] for the 9:00 a.m. doses. The eMAR notes documented the reason for the medication not being administered on [DATE] being Not administered: other comment: was not given due to not having a log in. The [DATE] eMAR date was observed to be blank. Review of the clinical record failed to evidence documentation of notification of the pharmacy or the physician for the dates listed above. On [DATE] at 11:08 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that medications were evidenced as given by the nurse signing off on the eMAR and if they were not given it was documented in the progress note why and that the physician was notified. She stated that if the medication was not available from the pharmacy the staff should contact the pharmacy and see if it could be sent over and notify the physician to see if an alternate was appropriate or held. She stated that there was an in-house medication stock that all staff should have access to. She stated that the director of nursing gave access to the agency staff to the in-house medication stock, and some had it and some did not. She stated that they had been working to get everyone access. She stated that if a standing order ran out the pharmacy was called, and they would either send the medication over stat or the staff would pull it from the in-house medication supply. She stated that the humalog ,d+[DATE] insulin for R63 was an insulin pen and was resident specific. She stated that this was not kept in the in-house medication supply and the nurse should call the pharmacy to have it sent over stat if they were out. LPN #1 stated that she could not say why the insulin was not administered due to the lower extremities being wrapped and thought that it may be a charting error. She stated that it was not a reason to hold the medication because there were multiple sites to administer insulin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 3:19 p.m., an interview was conducted with RN (registered nurse) #6. RN #6 reviewed R63's eMAR notes and stated that they would not administer insulin in the lower extremities so them being wrapped would not be an excuse to not give the medication. He stated that if a medication was not available on the cart the staff were supposed to call the physician and the pharmacy to see if they could get an alternate. On [DATE] at 2:59 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator in training, and ASM #5, the regional vice president of operations were made aware of the concern. No further information was provided prior to exit. 42183 3. The facility staff failed to provide pharmacy services by administering medications as ordered, specifically Insulin Lispro 100 units/milliliter and Insulin Lispro 100 units/milliliter, for Resident #48. Resident #48 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: ICH (intracranial hemorrhage), hemiplegia, hemiparesis and DM (diabetes mellitus). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of [DATE], coded the resident as scoring a 07 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bed mobility, transfer, hygiene and set up for eating. A review of Section O-Special Treatments, Procedures and Programs: K1. Hospice care-coded 'no'. A review of the comprehensive care plan dated [DATE] revealed, FOCUS: The resident is at risk for unstable blood glucose related to diabetes. INTERVENTIONS: Administer insulin as directed by the physician. A review of the physician orders dated [DATE] revealed Insulin Lispro 100 units/milliliter SQ, administer 3 units with meals, hold if blood sugar less than 120. A review of the physician orders dated [DATE] revealed, Amoxicillin-,d+[DATE] tablet, give 1 tablet twice a day x 10 days for UTI. A review of the August MAR (medication administration record) revealed, Insulin Lispro 100 units/milliliter not given on ,d+[DATE] at 5:00 PM-no insulin syringe. Amoxicillin-,d+[DATE] tablet not given on ,d+[DATE] at 8:00 AM-drug unavailable, ,d+[DATE] at 8:00 AM-drug unavailable and ,d+[DATE] 8:00 PM-drug unavailable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on [DATE] at 10:40 AM with LPN (licensed practical nurse) #12. When asked how medications are delivered, LPN #12 stated, there are two runs a day I believe. When asked when medications are delivered, LPN #12 stated, it should be either delivered on the next run or the next day at the latest. I am not sure of the cut off time to get medication orders in for the next run. When asked if there is an emergency drug supply, LPN #12 stated, yes, the Omnicell, we should get the medications from there if they are on the list. An interview was conducted on [DATE] at 8:50 AM with ASM (administrative staff member) #2, the director of nursing. When asked the process for medication delivery, ASM #2 stated, they deliver twice a day. If they are not delivered, the nurse should check the Omnicell and if it is there, give it. The OTC (over the counter) drugs are located in the top drawer of the medication cart. On [DATE] at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. According to the facility, there is no policy regarding pharmacy delivery. No further information was provided prior to exit. 4. The facility staff failed to provide pharmacy services by administering medications as ordered, specifically Revlimid capsule 5 mg po (milligram), for Resident #16. Resident #16 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: myelodispastic syndrome, seizures and paroxysmal atrial fibrillation. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of [DATE], coded the resident as scoring a 09 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bed mobility, transfer, hygiene and set up for eating. A review of the comprehensive care plan dated [DATE] revealed, FOCUS: The resident has potential for pain. INTERVENTIONS: Administer pharmacological interventions as ordered by physician and monitor the effectiveness. A review of the physician orders dated [DATE] revealed Revlimid capsule 5 mg po, give 1 capsule daily for 21 days. Hold 7 days, repeat. A review of the September MAR (medication administration record) revealed, Revlimid capsule 5 mg po not given on ,d+[DATE] AM med pass, ,d+[DATE] AM med pass, ,d+[DATE] AM med pass, ,d+[DATE] AM med pass and ,d+[DATE] AM med pass. An interview was conducted on [DATE] at 10:40 AM with LPN (licensed practical nurse) #12. When asked how medications are delivered, LPN #12 stated, there are two runs a day I believe. When asked when medications are delivered, LPN #12 stated, it should be either delivered on the next run or the next day at the latest. I am not sure of the cut off time to get medication orders in for the next run. When asked if there is an emergency drug supply, LPN #12 stated, yes, the Omnicell, we should get the medications from there if they are on the list. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on [DATE] at 8:50 AM with ASM (administrative staff member) #2, the director of nursing. When asked the process for medication delivery, ASM #2 stated, they deliver twice a day. If they are not delivered, the nurse should check the Omnicell and if it is there, give it. The OTC (over the counter) drugs are located in the top drawer of the medication cart. On [DATE] at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. According to the facility, there is no policy regarding pharmacy delivery. No further information was provided prior to exit. 5. The facility staff failed to provide pharmacy services by administering medications as ordered for Resident #88. Resident #88 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: respiratory failure, hypertension, diverticulitis and coronary artery disease. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of [DATE], coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as max assist for bed mobility, transfer, hygiene and set up for eating. Section O-Special Procedures: coded the resident for antibiotic, midline and isolation. A review of the comprehensive care plan dated [DATE] revealed, FOCUS: The resident has infection related to diverticulitis. Resident is on antibiotics for Pneumonia. INTERVENTIONS: Administer antibiotics/antiviral as ordered by the physician. A review of the physician orders dated [DATE] revealed Meropenem 1 gram intravenously every 8 hours for diverticulitis for 6 days. A review of the [DATE] MAR (medication administration record) revealed, Meropenem 1 gram IV not administered on ,d+[DATE] 6:00 AM, 2:00 PM and 10:00 PM; ,d+[DATE] 6:00 AM, 2:00 PM. An interview was conducted on [DATE] at 10:40 AM with LPN (licensed practical nurse) #12. When asked how medications are delivered, LPN #12 stated, there are two runs a day I believe. When asked when medications are delivered, LPN #12 stated, it should be either delivered on the next run or the next day at the latest. I am not sure of the cut off time to get medication orders in for the next run. When asked if there is an emergency drug supply, LPN #12 stated, yes, the Omnicell, we should get the medications from there if they are on the list. An interview was conducted on [DATE] at 8:50 AM with ASM (administrative staff member) #2, the director of nursing. When asked the process for medication delivery, ASM #2 stated, they deliver twice a day. If they are not delivered, the nurse should check the Omnicell and if it is there, give it. The OTC (over the counter) drugs are located in the top drawer of the medication cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. According to the facility, there is no policy regarding pharmacy delivery. No further information was provided prior to exit. 31753 6. For unit two, the facility staff failed to evidence reconciliation of controlled substances during shift change on [DATE]. A review of the unit two, med cart two shift change controlled substance inventory count sheet failed to reveal a reconciliation of controlled substances on [DATE]. The nurses responsible for reconciliation of controlled substances on unit two on [DATE] were not available for interview during the survey. On [DATE] at 3:25 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated that during shift change, the on-coming and off-going nurses are supposed to count the controlled substances then sign the shift change controlled substance sheet to evidence the count was done. On [DATE] at 9:30 p.m., ASM (administrative staff member) #1 (the interim administrator) and ASM #2 (the director of nursing) were made aware of the above concern. A facility PowerPoint presentation titled, Detection of Drug Diversion in a Long Term Care Facility documented, Keys to Prevention: Chain of custody procedures; Inventory & record keeping; Custody of keys from one authorized nurse to another, Chain of key custody recoded at each shift .CS (Controlled Substances) are counted by the on-coming with the Off-going nurse; both sign. No further information was presented prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 42106 Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to act upon pharmacy recommendations in a timely manner for two of 35 residents in the survey sample, Residents #21 and #63. The findings include: 1. For Resident #21 (R21), the facility staff failed to act upon the pharmacy recommendations dated 5/6/24 that the physician approved and ordered lab studies to be completed on the next lab day. Review of the pharmacy consultation report for R21 dated 5/6/24 documented a recommendation to monitor labs (TSH- thyroid stimulating hormone) due to the use of the medication amiodarone on the next convenient lab day and every six months thereafter. The consultation report documented the physician review completed on 5/14/24 with the recommendations accepted and physician's order to check BMP, CBC, TSH (basic metabolic panel, complete blood count, TSH) next lab day. Review of the clinical record failed to evidence the laboratory tests completed or results of the BMP, CBC, or TSH. On 9/18/24 at approximately 10:00 a.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of the BMP, CBC and TSH ordered by the physician on the 5/6/24 pharmacy consultation. On 9/18/24 at 12:47 p.m., an interview was conducted with RN (registered nurse) #6. RN #6 stated that someone from the lab came in each day. He stated that if an order stated on the next lab day it would be drawn the day after the lab was ordered. He stated that the process was for a lab slip to be completed based on the physician's order and the slip was placed in the lab book at the nurse's station behind the corresponding date tab for the date it needed to be drawn. He stated that when the phlebotomist came in each day, they checked the book and pulled the lab slips behind the date and drew the labs as ordered. He stated that if the labs were not able to be drawn that day the lab notified them before they left, and the nurse documented it in the progress notes and notified the physician. On 9/18/24 at 2:02 p.m., ASM #2 stated that R21 had not had any labs since February of 2024, and they had received an order to have them drawn today. She stated that the process in May of 2024 was for the pharmacy to email the recommendations to her and she would print them out to put them in the folder for the physician who would review and then the former assistant director of nursing would enter orders and act on the recommendations based on the physician response. She stated that there was a new team now. The facility policy Medication Regimen Review revised 6/1/24, documented in part, .Facility should encourage physician/prescriber or other responsible parties receiving the MRR (medication regimen review) and the director of nursing to act upon the recommendations contained in the MRR . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 2:59 p.m., ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator in training, and ASM #5, the regional vice president of operations were made aware of the concern. No further information was provided prior to exit. 2. For Resident #63 (R63), the facility staff failed to act upon the pharmacy recommendations dated 5/6/24 for a HbA1c (hemoglobin A1c) lab study that the physician approved and ordered to be completed on the next lab day. Review of the pharmacy consultation report for R63 dated 5/6/24 documented a recommendation to monitor the HbA1c due to the diagnosis of diabetes on the next convenient lab day and every six months if meeting treatment goals, or every three months if therapy has changed or goals are not being met. The consultation report documented the physician review completed on 5/14/24 with the recommendations accepted and physician's response I accept the recommendation(s) above, please implement the following order(s): Order(s): BMP, CBC, Hgb A1c next lab day. Review of the clinical record failed to evidence a Hb A1c lab test completed for R63. On 9/18/24 at approximately 10:00 a.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of the lab results as ordered by the physician on the 5/6/24 pharmacy consultation. On 9/18/24 at approximately 2:00 p.m., ASM #2, the director of nursing provided a BMP and CBC completed on 6/28/24 for R63. The lab report failed to evidence results of a Hb A1c test. The progress notes for R63 documented in part, 06/28/2024 12:39 (12:39 p.m.) [Name of lab service] STAT team arrived and collected CBC and BMP for generalized weakness. On 9/18/24 at 12:47 p.m., an interview was conducted with RN (registered nurse) #6. RN #6 stated that someone from the lab came in each day. He stated that if an order stated on the next lab day it would be drawn the day after the lab was ordered. He stated that the process was for a lab slip to be completed based on the physician's order and the slip was placed in the lab book at the nurse's station behind the corresponding date tab for the date it needed to be drawn. He stated that when the phlebotomist came in each day, they checked the book and pulled the lab slips behind the date and drew the labs as ordered. He stated that if the labs were not able to be drawn that day the lab notified them before they left, and the nurse documented it in the progress notes and notified the physician. On 9/18/24 at 2:02 p.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that R63 had only had the BMP and CBC done on 6/28/24 and had not had a Hb A1c done. She stated that they had received an order to have one drawn today. She stated that the process in May of 2024 was for the pharmacy to email the recommendations to her and she would print them out to put them in the folder for the physician who would review and then the former assistant director of nursing would enter orders and act on the recommendations based on the physician response. She stated that there was a new team now. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 2:59 p.m., ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator in training, and ASM #5, the regional vice president of operations were made aware of the concern. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. 31753 Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to ensure residents were free of unnecessary medications for one of 35 residents in the survey sample, Resident #39. The findings include: For Resident #39 (R39), the physician ordered furosemide (used to treat swelling) 20mg (milligrams)- one tablet two times a day and to administer an additional tablet if the resident presented with a weight gain greater than two pounds in one day. The facility staff failed to weigh the resident daily to determine if an additional tablet was needed. A review of R39's clinical record revealed a physician's order dated 7/20/24 for furosemide 20 mg- one tablet twice a day for congestive heart failure. The physician ordered special instructions documented to administer an additional one tablet for a weight gain greater than two pounds in one day. Further review of R39's clinical record failed to reveal any weights for 9/1/24 through 9/14/24. A facility document titled, Sept Monthly weights documented multiple residents' names and documented R39 refused a monthly weight but failed to reveal staff attempted to obtain daily weights. On 9/17/24 at 3:25 p.m., an interview was conducted with RN (registered nurse) #6. The above physician's order was reviewed with RN #6. RN #6 stated that R39 should receive an additional tablet of furosemide if the resident gains more than two pounds in one day. RN #6 stated that if a resident has that type of order, staff should obtain that person's weight during the morning every day to differentiate if there is an increase in weight. RN #6 stated the daily weights should be documented and a resident's refusal of a daily weight should be documented. On 9/17/24 at 9:30 p.m., ASM (administrative staff member) #1 (the interim administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42106 Based on observation, resident interview, staff interview, and facility document review, it was determined the facility staff failed to serve food at a palatable temperature for five of 35 residents in the survey sample, Residents #21, #63, #46, #39 and #59. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/20/24, Resident #21 (R21) scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 9/15/24 at 5:14 p.m., an interview was conducted with R21. The resident stated the facility food was nasty and cold when it arrived. On the most recent MDS, a quarterly assessment with an ARD of 8/16/24, Resident #63 (R63) scored 10 out of 15 on the BIMS, indicating the resident was moderately impaired for making daily decisions. On 9/15/24 at 6:05 p.m., an interview was conducted with R63. The resident stated the facility food was often cold. On the most recent MDS, a quarterly assessment with an ARD of 7/24/24, Resident #46 (R46) scored 9 out of 15 on the BIMS, indicating the resident was moderately impaired for making daily decisions. On 9/15/24 at 5:33 p.m., an interview was conducted with R46 and their family member at the bedside. The resident stated that some of the facility food was cold when it was served, and the family member stated that R46 had lost weight due to the food being overcooked and inedible. On the most recent MDS, a quarterly assessment with an ARD of 7/9/24, Resident #39 (R39) scored 15 out of 15 on the BIMS, indicating the resident was cognitively intact for making daily decisions. On 9/15/24 at 5:02 p.m., an interview was conducted with R39. The resident stated the facility food was cold. On the most recent MDS, a quarterly assessment with an ARD of 8/14/24, Resident #59 (R59) scored 15 out of 15 on the BIMS, indicating the resident was cognitively intact for making daily decisions. On 9/15/24 at 5:12 p.m., an interview was conducted with R59. The resident stated the facility food was cold. On 9/16/24 during lunch service test trays were conducted. The test trays left the kitchen on 9/16/24 at 12:20 p.m. with the final food cart. The last resident tray was served at 12:35 p.m. The test tray was then tested . The temperatures of the food were as follows: - mechanical soft roasted red potatoes: 108.2. - regular roasted red potatoes: 102.3. - pureed seasoned greens: 104.8. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The test tray was tasted by OSM (other staff member) #10 and the surveyors. When asked how the roasted potatoes and seasoned greens tasted regarding the temperature, OSM #10 stated that they were warm but could be warmer. OSM #10 stated that she would prefer the potatoes to be warmer. On 9/17/24 at 2:15 p.m., an interview was conducted with OSM #1, the regional dietician. OSM #1 stated that the kitchen staff utilized domes and bases, hot plates and steam tables to serve food at a palatable temperature. She stated that food temperatures had been a concern brought up recently in resident council and had been a focus for them. She stated that they had been doing test trays randomly and they were addressing resident concerns and were working to resolve temperature concerns. The facility policy, Food Temperatures Policy revised 8/28/2019, documented in part, . Hot food should be palatable at point of delivery . 5. Food should be transported as quickly as possible to maintain temperatures for delivery and service . On 9/17/24 at 5:11 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator in training, and ASM #5, the regional vice president of operations were made aware of the concern. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to prepare food in a form to meet the resident's needs for one of 35 residents, Resident #46. The findings include: Resident #46 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: dementia, hypertension, CKD (chronic kidney disease). The most recent MDS (minimum data set) assessment, a quarterly Medicare assessment, with an ARD (assessment reference date) of 7/24/24, coded the resident as scoring a 09 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring supervision for eating. MDS Section L-Dental codes the resident as missing/broken or loose teeth-yes. A review of the comprehensive care plan dated 3/14/24, which revealed, FOCUS: The resident has oral/dental health needs due to edentulous. Resident is at risk for malnutrition. INTERVENTIONS: Dietician to assess per protocol. Respect/honor resident's dietary choices. A review of the physician's orders dated 2/26/24 revealed, Regular Diet. A review of the progress note dated 9/17/24 at 12:34 PM revealed. Varied intake recorded at meals ranging from 25-100%. Met with resident and her son to update food preference and discuss chewing issues. Resident reports chewing issues due to poor dentition. Discussed the idea of a trial mechanical soft tray. Resident and son agreeable. Discussed options that were naturally soft that resident already enjoys. Food Services Director spoke with daughter who requested no lettuce with meals. Facility registered dietician made aware and will follow. A review of the progress note dated 9/17/24 at 6:30 PM revealed, Resident provided mechanical soft trial tray at lunch, however, was too full from eating her soup to try the mechanical soft meat. Observed resident eating mechanical soft tray at dinner and resident reports that she liked it and would like to continue with mechanical soft. Daughter agreeable to downgrade. An interview was conducted on 9/15/24 at approximately 4:00 PM with Resident #46 and grandson. When asked about food, Resident #46 stated, it is too hard for me. I do not have teeth and they serve me pizza and hard chicken tenders. I cannot eat a lot of the food. When asked if the dietician had addressed her concerns, Resident #46 stated, no, the food has not changed. Grandson stated, the food she is eating now is food I brought, rice noodles, soup and soft food. Resident #46 stated, yes, it is good. An interview was conducted on 9/16/24 at 10:05 AM with OSM (other staff member) #1, the regional dietician. When asked about Resident #46's diet and her concerns, OSM #1 stated, I will go and talk with her about it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #46's 9/16/24 lunch tray included turkey, mashed potatoes no gravy and greens. On 9/16/24 at 3:00 PM, Resident #46 was asked how her lunch was, Resident #46 stated, the turkey was not able to be eaten, I ate the mashed potatoes and a little of the greens. When asked if the dietician had talked with her, Resident #46 stated, no, she has not. On 9/18/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. A review of the facility's Meal Identification and Preference policy reveals, The permanent meal ID card/ticket should include the name of the individual, diet order, beverage preferences, food dislikes and any other applicable diet information. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 27660 Based on observation, staff interview and facility document review, it was determined the facility staff failed to be in compliance with state laws and regulations in regard to maintaining emergency medical equipment on one of two units. The findings include: Observation was made of the Emergency Carts on both units on 9/16/24 at 3:18 p.m. Both carts had a locking device in place, the carts could not be opened without breaking the lock. The Emergency Cart Daily Checklist was reviewed on both carts. The Unit 2 March 2024 Emergency Cart Daily Checklist was reviewed. The cart was signed off as being checked on 3/1/24. From 3/2/24 through 3/31/24, the form was checked off by the same person with their signature on 3/2/24 and a line drawn down for the entire month, ending on 3/31/24. The nurse, the unit manager, that signed the Checklist was no longer employed at the facility and unavailable for interview. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 9/17/24 at 9:58 a.m. The above checklist was reviewed with ASM #2. When asked why the nurse would have signed off the checklists for the entire month at a time, ASM #2 stated she could not give an honest answer as to why the nurse documented it that way. ASM #2 stated the nurse did not work every day in March. ASM #2 was asked whose responsibility it is to check the emergency carts, ASM #2 stated, it is the night shift that is to do it and if it isn't done, then the unit manager is responsible. ASM #2 stated, however, the facility have a lot of agency nurses working here and the nurse who signed it off was responsible for checking it. When asked when the locking system was put in place, ASM #2 stated, the facility just started that in June 2024. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 27660 Based on staff interview, facility policy review and clinical record review, it was determined the facility staff failed to have a contract with a dialysis center where one of 35 residents in the survey sample was getting treatment from, Resident #33. The findings include: Resident #33 attended the dialysis center three times a week. There was no contract between the dialysis center and the facility. The physician orders dated, 8/15/24, documented, Resident to have dialysis on days: M-W-F (Mondays - Wednesdays - Fridays) Dialysis Center name: (name of dialysis center with address), Chair time: 2 p.m. Catheter Site: RUC (right upper chest), Dialysis Transport: (name of transport company with phone number) Bag meal/snack to go with resident to Dialysis. Once a day on Mon, Wed, Fri. A request was made for the contract with the dialysis center documented in the resident's clinical record, on 9/17/24 at 5:13 p.m. and then again on 9/18/24 at 3:00 p.m. No contract was provided prior to exit. The facility policy, Contract Administration and Management Policy, documented in part, A. A Contract must be approved by a Contract Responsible Party before a Vendor provides goods and/or services. B. Upon approval by a Contract Responsible Party, a Contract must be in writing and signed by the Vendor and Facility Administrator. C. A Contract must be amended and restated if a Vendor requests changes in an already existing Contract (instead of creating a new Contract with the same Vendor). ASM (administrative staff member) #1, the interim administrator, and ASM #2, the director of nursing, were made aware of the above findings on 9/18/24 at 3:00 p.m. No further information was obtained prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 27660 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain an accurate clinical record for one of 35 residents in the survey sample, Resident #18. The findings include: For Resident #18 (R18), the facility staff failed to accurate document the administration of a medication. The physician order dated, 3/19/24, documented, Micafungin recon (reconcentrated) soln (solution) (used to treat fungal infections) (1); Amount to Administer: 2 vials of 100 mg (milligram) intravenous. The March 2024 MAR (medication administration record) documented the above order. For the 9:00 a.m. dose on 3/21/24, the initials documented were those of ASM (administrative staff member) #2, the director of nursing. An interview was conducted with ASM #2 on 9/17/24 8:56 a.m. The above MAR was reviewed with ASM #2. When asked if she administered the medication above on 3/21/24, ASM #2 stated she did not. ASM #2 stated she had started to pass medications on the hallway as there was not a nurse to do so. She had logged into the computer and when the ADON (assistant director of nursing) came in, he must not have signed me off when he took over the cart. When asked if the resident received the above medication, ASM #2 stated, R18 did get the dose on 3/21/24 - the ADON had restarted the IV and then it infiltrated later and was pulled out. The facility did not provide a policy on an accurate medical record. ASM #1, the interim administrator, and ASM #2 were made aware of the above findings on 9/18/24 at 3:00 p. m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a623021. html

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on staff interview, clinical record review, and review of facility documents, the facility's staff failed to provide a Hospice Care Plan for 1 of 25 residents (Resident #106), in the survey sample. The findings included: Resident #106 was originally admitted to the facility 02/06/23 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Hemiplegia, Type 1 diabetes mellitus with diabetic neuropathy and Cerebral Vascular disease. The significant change, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/18/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #106 cognitive abilities for daily decision making were severely impaired. In Section O Special Treatments and Programs. K1= Coded resident as receiving Hospice Care. The Physician's Order Summary (POS) for October 2024 read: Hospice Evaluation and Treat, 10/03/24. The person-centered care plan dated 10/05/24 read that resident requires hospice related to Cerebral Vascular Disease (CVD). The Goal for Resident #106 is Resident will experience death with dignity and physical comfort. Advanced directive wishes will be honored. The Interventions for Resident #106-Communicate with hospice when any changes are indicated to the plan of care and Coordinate plan of care with hospice agency reflecting the hospice philosophy (10/07/24). A review of a nurses note dated 11/07/24 at 1:46 PM., read that resident continues under hospice care. On 11/14/24 a review of the medical records revealed no Hospice care plan was available for review. On 11/14/24 at approximately 2:30 PM., a hospice care plan was requested from Corporate Staff #1 (Vice President of Operations). On 11/14/24 at approximately 3:20 PM., Corporate Staff #1, presented with a hospice care plan. Corporate Staff #1 was asked where she received the Hospice care plan the Hospice Care Plan was located. On 11/14/24 at approximately 3:30 PM., an interview was conducted with the DON concerning the Hospice Care Plan received earlier. The DON said that the Resident's Hospice Care Plan was faxed by the Hospice agency earlier. The DON also mentioned that the Hospice Care Plan should have been uploaded to the Resident's Medical Record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at approximately 4:35 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Staff (Vice President of Operations). An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center, LLC	1604 Old Donation Pkwy Virginia Beach, VA 23454

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 27660 Based on staff interview and facility document review, it was determined the facility staff failed to maintain a complete infection control program. The findings include: The facility staff failed to maintain infection control surveillance for December 2023 and February 2024 and incomplete tracking for March, April and May 2024. The infection control surveillance tracking was reviewed. There was nothing documented for December 2023 and February 2024, it was blank. The tracking logs for March, April and May 2024 had attached the Antibiotic Medications Reports only. There was no documentation of date symptoms started, culture results, or radiology reports. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 9/18/24 at 2:18 p.m. The above documents were reviewed with ASM #2. When asked about the December 2023 tracking, ASM #2 stated the book was given to the previous ADON (assistant director of nursing) to take care of. The documentation for March, April and May 2024 were reviewed. When asked if this was accurate documentation of surveillance of infections in the facility, ASM #2 stated, no. The facility policy, Infection Prevention and Control Program Policy, documented in part, POLICY: It is our policy to maintain an organized, effective facility-wide program designed to systematically prevent, identify, control and reduce the risk of acquiring and transmitting infections among employees, volunteers, visitors, and contract healthcare workers; to conduct surveillance of communicable disease and infectious outbreaks; and to monitor employee health. This program involves the intersection of many programs, policies and services within the facility and is designed to meet the intent of regulatory guidance .Particular focus of the program will be on conducting risk assessment, surveillance, reducing healthcare associated infections, limiting transmission of disease, immunization, promoting antibiotic stewardship, and reporting as necessary . The Infection Preventionist's responsibilities for infection prevention and control include, but may not be limited to: Conducts surveillance of staff and residents for facility-associated or community associated infections and/or communicable diseases. ASM #1, the interim administrator, and ASM #2 were made aware of the above findings on 9/18/24 at 3:00 p. m. No further information was provided prior to exit.