STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. Building B. Wing	11/09/2017

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0221 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep each resident free from physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29128 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed, for 1 resident (Resident #13) in the survey sample of 24 residents, to ensure that Resident #13 was free of a physical restraint. The facility staff failed to ensure that Resident #13 was free of being restrained by a bed sheet tied around a Geri-chair. The Findings included: Resident #13 was a [AGE] year old who was admitted to the facility on [DATE]. Resident #13's diagnoses included Unspecified Dementia without Behavioral Disturbance, Bipolar Disorder, Insomnia, and Major Depressive Disorder. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 9/2/17, coded Resident #13 as having a Brief Interview of Mental Status Score of 3, indicating severely impaired cognition. On 11/7/17 at 2:45 P.M. an unannounced tour was conducted of the facility. Resident #13 was lying quietly in her bed. Resident #13 was on 1:1 supervision provided by a Wing-Helper (Employee A). When asked what a Wing-Helper's job functions were, she stated she sits with Resident #13, passes out ice, and makes the beds. She further stated that she was scheduled to take her Certified Nursing Assistant licensing examination that coming Saturday. On 11/8/17 at 9:00 A.M. a second observation was conducted of Resident #13. She was sitting quietly in her room with 1:1 staff supervision. On 11/8/17 a review was conducted of facility documentation, revealing a Facility Reported Incident dated 1/13/17, with a follow-up report dated 1/18/17. The facility reported that a Certified Nursing Assistant (CNA G) had been terminated for tying Resident #13 to a Geri-chair with a sheet. CNA G's Witness Statement was reviewed. She stated that she tied Resident #13 to her chair with a sheet because she wouldn't stay in bed. It read, I tied her to the Geri chair because it was stressful, this was about 0630 (6:30 A.M.) and I didn ' t know what else to do. She continued to get up - she almost fell on the floor attempting to get up. I left and forgot to untie her. I was afraid she was going to fall. (continued on next page)

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

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F 0221 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility documentation stated that Resident #13 was untied at about 8:15 A.M. on 1/13/17. She was assessed, and had no apparent injury. On 1/13/17 an Inservice Training was conducted with the nursing staff regarding the use of physical restraints. On 11/9/17 at 9:00 A.M. an interview was conducted with the Director of Nursing (DON) (Admin. B). She stated, We continue to have her on 1:1, that [NAME] the other staff to just focus on their jobs. She's going to be on 1:1 as long as she needs to be. We're documenting her behaviors. When asked about what could have been done to prevent Resident #13 from being restrained during the January, 2017 incident, the DON stated, She (CNA) should have reported to the nurse, other staff may have taken turns monitoring. Maybe she should have called the doctor and had her sent out. On 11/9/17 at 10:00 A.M. the Administrator (Admin. A) was informed of the findings. No further information was received.

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F 0281 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** 29128 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to follow the professional standards of practice for documentation of medication administration for 1 resident (Resident #8) in the survey sample of 24 residents. For Resident #8, the facility staff failed to document the administration of a dietary supplement on two occasions in August, 2017. The Findings included: Resident #8 was a [AGE] year old who was admitted to the facility on [DATE]. Resident # 8's diagnoses included Generalized Muscle Weakness, Gastroesophageal Reflux Disease, and Severe Protein Calorie Malnutrition. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 9/20/17, coded Resident #8 as having a Brief Interview of Mental Status Score of 5, indicating severely impaired cognition. On 11/8/17 a review was conducted of Resident #8's clinical record, revealing the following signed physician's order: 8/1/17. Mighty Shake by mouth three times daily with meals. Record amount consumed. Resident #8's Medication Administration Record was missing documentation of administration of Mighty Shake on 8/18/17, and 8/29/17 at 6:00 P.M. In addition, the nursing progress notes did not contain documentation of administration or of the amount consumed. There was no subsequent fluctuation is Resident #8's weights. On 11/8/17 at 10:20 A.M. an interview was conducted with the Unit Manager (Registered Nurse A). She stated, Mighty Shake is important for nutritional supplementation to prevent weight loss or further weight loss. It should be documented on the Medication Administration Record (MAR). The Unit Manager further stated that the facility utilized [NAME] as their standard of nursing practice. Guidance for professional standards of nursing for documentation of medication administration was identified. Document all medications administered in the patient's MAR or EMAR (electronic MAR). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions. [NAME] Solutions Safe Medication Administration Practices, General 10/02/2015. On 11/8/17 at 4:00 P.M. the facility Administrator (Admin. A), and Director of Nursing (Admin. B) were informed of the findings. No further information was received.

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F 0309 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide necessary care and services to maintain or improve the highest well being of each resident . **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34574 Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to provide the highest practicable well-being for Resident #7. The facility staff failed to assure that physician ordered blood glucose testing was performed and documented, and insulin given, if necessary, for Resident #7. Findings included: Resident #7, a [AGE] year-old female, was admitted to the facility on [DATE]. Resident #7's diagnoses included neurogenic bladder, atrial fibrillation, cerebral vascular accident (stroke), hemiplegia/hemiparesis, dysphagia, high cholesterol, coronary artery disease, anemia, hypertension, and diabetes. Resident #7's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/28/2017 was coded as a quarterly assessment. Resident #7 was coded a BIMS (Brief Interview of Mental Status) score of 5/15, indicating severe cognitive deficiency. Resident #7 was also coded as requiring total dependence of 2+ persons for her activities of daily living, and as being always incontinent of bowel. She required a Foley catheter for urinary elimination. A clinical record review was conducted on 11/8/2017 at 11:30 AM. It revealed a diabetic flow sheet (a facility form that documented blood glucose readings and insulin administration, if necessary) showing no blood glucose readings and subsequent insulin administration, if required, for the dates and times indicated for September 2017 and October 2017: 9/1-9:00 PM, 9/15-11:30 AM, 9/15-4:30 PM, 9/15-9:00 PM, 9/17-6:30 PM, 9/18-11:30 AM, 9/18-4:30 PM, 9/18-9:00 PM, 9/20-11:30 AM, 9/29-9:00 PM, 10/7-11:30 AM. There was no other documentation in any other part of the clinical record. A physician order was present in the clinical record stating Blood glucose checks AC/HS (before meals and bedtime). There was a further order for Novolin R insulin administration depending upon blood glucose reading. An interview was conducted with Administration B, Director of Nursing on 119/2017 at 10:00 AM. She could offer no reason for the missing documentation. Facility policy Insulin Administration stated: Documentation: 1. Resident's blood glucose result as ordered. 2. Dose and concentration of the insulin injection (continued on next page)

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F 0309 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Size and gauge of the needle used 4. Injection site 5. How well the resident tolerated the procedure. Administration was informed of findings on 11/9/2017 at 10:30 AM.

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F 0314 Level of Harm - Actual harm Residents Affected - Few	Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34574 Based on observation, staff interview, facility documentation review, and clinical record review the facility staff failed to assess and implement interventions to prevent an unstageable pressure wound resulting in harm for Resident #5. This is a past non-compliance citation (PNC). The facility staff failed to monitor and assess Resident #5 resulting in the development of an unstageable pressure wound on her sacrum. Findings included: Resident #5, a [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included CVA (Cerebral Vascular Accident-stroke), left side hemiplegia/hemiparesis, convulsions, seizure disorder, aphasia, hypertension, and diabetes. Resident #5's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/8/2017 was coded as a quarterly assessment. Resident #5 was coded as having severely impaired cognition by staff assessment. She was also coded as being totally dependent on 1-2 persons for her ADL's (activities of daily living) and as being always incontinent of bowel and bladder. A review of Resident #5's clinical record was conducted on 11/7/2017 at 2:00 PM. MDS records showed that Resident #5 had no wounds on admission to the facility. Braden scale is a clinical tool for predicting pressure wound risk. It consists of 6 categories-sensory, moisture, activity, mobility, nutrition, and friction/shear. Total scores can range from 6-23, with lower scores indicating a higher risk. Resident #5's Braden scale score on 6/7/2017 was 16/23, indicating a mild risk for pressure wound development. Progress notes revealed a note dated 6/7/2017 stating Change in condition noted related to resident noted with open areas to left buttock and sacrum. This change in condition started on 6/7/2017. A Pressure Injury Record described this new wound as originating on 6/7/2017 and being a facility acquired wound to the sacrum. This record described the wound as unstageable 3.5 cm (centimeters) x 1.8 cm x 0.1 cm containing 100% yellow necrosis. Wound Care Specialist Initial Evaluation, a report by a contracted wound care physician, dated 6/14/2017 stated that the wound was caused by pressure and described it as unstageable necrosis 3.2 cm x 1.5 cm x 0. 1 cm. The physician surgically debrided the wound and prescribed Dakins moistened gauze with dry protective dressing daily. The physician followed up with Resident #5 every 7-10 days. An additional progress note dated 6/14/2017 stated Sacral wound noted at unstageable with 100% necrotic tissue in the wound bed. (continued on next page)

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F 0314 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #5's Care Plan revealed interventions dated 11/14/2016 related to skin integrity as follows: Barrier creme to perianal area/buttocks as needed' Encourage and assist to reposition Observe skin condition with ADL (activities of daily living) care daily; report abnormalities Pressure redistributing device for bed/chair Provide preventative skincare routinely and PRN (as needed) Suspend/float heels as able On 11/8/2017 at 10:10 AM an interview was conducted with RN (Registered Nurse) C, wound care nurse. She verified that the wound on Resident #5's sacrum was initially found at an unstageable wound. Resident #5 was seen in her room on 11/8/2017 at 10:00 AM with RN C to examine the wound. The wound was seen at the bottom of the sacrum within the gluteal folds. The measurements were 1.4 cm x 1.5 cm x 0.5 cm. Muscle below the subcutaneous tissue was visible. It was a Stage 3 at this point. At the end of day meeting on 11/8/2017 at 4:00 PM Administration A, Administrator; Administration B, Director of Nursing; Administration C, Corporate RN Consultant; and Administration D, Corporate RN Consultant were informed of the possibility of a harm level citation for Resident #5's wound. On 11/9/2017 at 9:00 AM Administration B, Director of Nursing and Administration C, Corporate RN Consultant stated that the facility had identified problems identifying and preventing pressure wounds as a result of a mock survey performed in July 2017. Resident #5 was included in the mock survey. A plan of correction was developed based on these findings with an AOC (Allegation of Compliance) date of 8/3/2017. Resident #5's wound was found on 6/7/2017, prior to the AOC date. The Plan of Correction is as follows: 1. Residents with potential for wounds-Review new admissions Bradens x 4 weeks. Utilize calendar sheets to help track dates due for Bradens. Care plan updates need to be verified at change of skin condition. Foley catheter care plans need to include the size of the catheter and balloon. Update all as needed. 2. Like residents-all residents are potential like residents. 3. Education to staff on completing Bradens, fall interventions, and skin/Foley/fall care plans. 4. Audits-all new admissions for Braden scheduling, skin/catheter/fall care plans records. Three times per week. (continued on next page)

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F 0314 Level of Harm - Actual harm Residents Affected - Few	5. AOC date 8/3/2017 A total of 7 Residents with pressure wounds was included in the survey. Resident #5 had the only wound subject to a deficiency. Administration was informed of findings on 11/9/2017 at 11:00 AM.

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F 0315 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident who enters the nursing home without a catheter is not given a catheter, unless medically necessary, and that incontinent patients receive proper services to prevent urinary tract infections and restore normal bladder functions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure tubing for a urinary catheter was anchored for one of 24 residents in the survey sample. The tubing for Resident #4's urinary catheter was not anchored to minimize tension on the tubing as required in her plan of care. The findings include: Resident #4 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, sacral pressure ulcer, COPD (chronic obstructive pulmonary disease), peripheral vascular disease, stroke and anemia. The minimum data set (MDS) dated [DATE] assessed Resident #4 as cognitively intact. On 11/8/17 at 9:10 a.m., accompanied by registered nurse (RN) C and RN (D) responsible for wound care, the position of Resident #4's urinary catheter tubing was observed during a dressing change to the resident's sacral pressure ulcer. The catheter tubing was not anchored in any manner to the resident's upper leg and/or thigh area to minimize tension on the tube with movement. RN (C) was interviewed at the time of this observation about an anchor for the tubing. RN (C) stated the tubing should be anchored but she did not see an anchor in use. On 11/8/17 at 9:40 a.m. the licensed practical nurse (LPN) D caring for Resident #4 was interviewed about the catheter in use without an anchor for the tubing. LPN (D) stated the catheter tubing was supposed to be anchored. LPN (D) stated the anchor was supposed to be positioned on the resident's upper leg to hold the tubing in place. Resident #4's clinical record documented a physician's order dated 9/26/17 for a Foley urinary catheter due to management of a stage 4 sacral pressure ulcer. The resident's plan of care (revised 10/16/17) documented the resident used an indwelling urinary catheter due to a sacral pressure ulcer. Plan of care interventions to prevent catheter complications included, Secure catheter with securement device. The Lippincott Manual of Nursing Practice 10th edition on page 781 states concerning management of a patient with an indwelling catheter, Secure the indwelling catheter to patient's thigh using tape, strap, adhesive anchor, or other securement device .Properly securing the catheter prevents catheter movement and traction on the urethra . Pulling on the catheter may be painful. Backward and forward displacement of the catheter introduces contaminants into the urinary tract . (1) These findings were reviewed with the administrator and director of nursing during a meeting on 11/8/17 at 3:55 p.m. (1) Nettina, [NAME] M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/[NAME] & [NAME], 2014.

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F 0362 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hire sufficient dietary support personnel. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on observation, Family and Resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, facility staff failed to employ sufficient support staff to provide timely serving of meals and feeding assistance for 1 resident (Resident #9) in the survey sample of 24 residents. Facility staff failed to provide delivery of the Lunch meal tray and feeding assistance in a timely manner for Resident #9. The Findings included: Resident #9 was admitted to the facility on [DATE]. Resident #9's diagnoses included: Malignant neuro-endocrine tumors, hypertension, diabetes, high cholesterol, dementia, Muscle Weakness, anemia, and arthritis. The Minimum Data Set, was a full admission Assessment, with an Assessment Reference Date (ARD) of 10-27-17, coded Resident #9 as usually being understood and usually able to understand. In addition, Resident #9 was coded as requiring extensive assistance of one staff member for all activities of daily living including feeding during meals, and set-up of meals. On 11-7-17 at 2:30 P.M., after the initial tour of the facility, Resident #9's spouse approached the surveyor at the nursing station, and stated I am really angry about your meal problem here, speaking rapidly, and giving the surveyor no time to introduce herself. The Spouse of Resident #9 assumed the surveyor was a staff member. The spouse of Resident #9 rapidly went on to say I am here every day now at meal time because I can't trust the staff here to feed my wife. The spouse of Resident #9 allowed the surveyor at this point to speak and introduce self, and then he explained what the issues were. Three nursing staff members were present during the encounter (the unit manager, the nurse working with Resident #9, and a medication nurse). Resident #9's spouse stated it was well after 2:00 p.m. every day before Resident #9 received the lunch meal, and stated that the staff just replaced one tray with another, as the breakfast tray was removed when the lunch tray arrived. The surveyor observed the lunch tray being taken into Resident #9's room and the time was 2:30 p.m. she has been here three weeks, the spouse stated, and this has happened every day since we got here. An interview was conducted with LPN F at the nursing station, with the unit manager standing beside her, immediately after the encounter with Resident #9's spouse. LPN F stated there were 2 reasons why the tray was so late. She stated, number one, we have to deliver trays to all of the Residents who can feed themselves first, and then we take the trays to the feeders, who have to be fed, and number two, there are not enough of us to do both at the same time. After the staff interview was conducted, the surveyor proceeded to the room of Resident #9, where her spouse was attempting to feed her, and asked her how her meal tasted. Resident #9 stated cold, I don't want it, it is too late. During observations and interviews, the food cart was observed to be sitting in the hallway with several untouched food trays in it. (continued on next page)

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F 0362 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The cart arrival time on units form was reviewed and stated that 2 food carts would arrive on Resident #9's unit for lunch between 11:55 a.m., and 12:40 p.m. The Resident was noted to have a gastrostomy tube, and was receiving enteral feeding through the tube for extra nutrition as well as being able to eat a regular diet, for which the Resident had a current physician's order. The Nutritional Care Plan was reviewed, and read, Will tolerate regular diet through next review ., and, provide diet as ordered The care plan was dated 10-23-17. Resident #9's nursing progress notes were reviewed and documented on 11-2-17 a significant weight loss, and it was thought to be related to end of life issues. The Resident was ordered to have hospice services on 11-7-17, and was planning to be discharged home at a later undisclosed date with hospice services. On 11-8-17 a review of the facility policy on feeding assistance was conducted. The policy stated that nursing personnel will provide assistance with feeding when a resident is unable to do so independently. On 11-8-17, and 11-9-17, at the end of day debrief, the Administrator, and Director of Nursing were made aware of the findings. No further information was submitted by the facility. Complaint Deficiency

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F 0371 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Store, cook, and serve food in a safe and clean way. 21875 Based on observation, staff interview and facility document review, the facility staff failed to prepare and distribute food in a sanitary manner from the main kitchen. Ten large baking pans, identified as ready for use, were stored nested and wet. The findings include: On 11/7/17 at 12:45 p.m. accompanied by the food services director, the kitchen was inspected. Ten large baking pans, identified by the food services director as ready for use, were stored on a rack nested and wet. As the pans were separated, moisture was observed and felt on the baking surfaces of the pans. The food services director was interviewed at the time of this observation about the wet pans. The food services director stated the pans were not supposed to be stacked and stored wet. The food services director stated all pans were washed and sanitized in the three compartment sink and were supposed to dry on the designated drying rack prior to stacking/storing. The facility's dietary services policy titled Sanitization (revised December 2008) stated, The food service area shall be maintained in a clean and sanitary manner . Food preparation equipment and utensils that are manually washed will be allowed to air dry whenever practical. These findings were reviewed with the administrator and director of nursing during a meeting on 11/8/17 at 3:55 p.m.

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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 0431 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27662 Based on observation, staff interview, and facility documentation review, the facility staff failed to ensure biologicals and medications were stored appropriately on three of three units. 1. On The [NAME] Unit , one PPD (purified protein derivative) dated as opened [DATE] was available for administration to Residents. A second vial was opened with no date when opened. PPD is only good for 30 days after opened and accessed; 2. On the [NAME] Unit, a vial of flu vaccine was opened without a date. 3. On the [NAME] unit, two vials of flu vaccine was open without a date. The findings included: 1. On The [NAME] Unit , one PPD (purified protein derivative) dated as opened [DATE] was available for administration to Residents. A second vial was opened with no date when opened. PPD is only good for 30 days after opened and accessed. On [DATE] at 12:55 PM, during the initial tour, a vial of opened PPD was dated as having been opened on [DATE], over 30 days old. PPD is a solution that is utilized to test Residents and staff for exposure to tuberculosis. When interviewed,LPN (licensed practical nurse) A stated at the time of the observation, it's expired. She removed the PPD solution from the medication refrigerator. Drug Storage requirements provided by the facility were the following instructions: Remove 30 days after opening. Guidance was also provided at www.fda.gov: Vials in use for more than 30 days should be discarded. 2. On the [NAME] Unit, a vial of multidose flu vaccine was opened without a date. On [DATE] at 1:20 PM, during the initial tour, one vial of flu vaccine had been opened. There was no date when the vial was opened. RN (registered nurse) A stated, We will throw it out. We should date it. 3. On the [NAME] unit, two vials of flu vaccine was open without a date. On [DATE] at 1:25 PM, during the initial tour, two vials of multidose flu vaccine had been opened. There was no date when the vials were opened. RN (registered nurse) B stated, We are supposed to date it. On [DATE] at approximately 2:00 PM, the Director of Nursing was notified of the above findings.