STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	**831 ELLERSLIE AVE COLONIAL HEIGHTS, 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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, facility documentation, clinical record review, and in the course of an investigation, the facility staff failed to notify the Physician that the entire course of antibiotics was not administered as ordered for one Resident (Resident # 1) in a survey sample of 3 residents. The findings include: For Resident # 1, the facility staff failed to notify/consult the Physician that the entire course of antibiotics was not administered as ordered and discuss a possible need to alter or extend treatment. There were 2 missed doses. Resident #1 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident # 1's most recent MDS (Minimum Data Set) was an Admission Assessment with an ARD (Assessment Reference Date) of 1/5/2020. Resident # 1 was coded as having a Brief Interview for Mental Status of 13 out of 15 indicating no cognitive impairment. Resident # 1 was coded as requiring extensive assistance of one to two staff persons for ADLs (activities of daily living), such as bathing. Review of the closed clinical record was conducted on 3/11/2020 and 3/12/2020. Review of the Physician order [REDACTED]. Review of the January 2020 Medication Administration Record [REDACTED]. The scheduled times for administration were 9 AM., 1 PM, 5 PM and 9 PM for ten days. Review revealed blanks for 1/27/2020 at 1 PM and 1/28/2020 at 1:PM. All other scheduled doses had checkmarks and initials indicating the medication had been administered and documented as such, Review of the Medication Administration Audit report revealed the actual times of administration: On Page 5 of 6, [MEDICATION NAME] 250 milligrams by mouth four times a day for [MEDICAL CONDITION] due 1/27/2020 at 13:00 (1:00 PM) blank -not administered and no documented reason. On Page 4 of 6, [MEDICATION NAME] 250 milligrams by mouth four times a day for [MEDICAL CONDITION] due 1/28/2020 at 9 PM, administered at 11:19 PM, documented at 11:20 PM. (2 hours late). On Page 2 of 6, [MEDICATION NAME] 250 milligrams by mouth four times a day for [MEDICAL CONDITION] due 1/27/2020 at 5 PM, administered at 9:55 PM, documented at 9:55 PM (4 hours and 55 minutes late) On Page 3 of 6, [MEDICATION NAME] 250 milligrams by mouth four times a day for [MEDICAL CONDITION] due 1/28/2020 at 5 PM, administered at 11:19 PM, documented at 11:20 PM (over 6 hours late). On Page 6 of 6, [MEDICATION NAME] 250 milligrams by mouth four times a day for [MEDICAL CONDITION] due 1/28/2020 at 13: (1 PM) blank, not administered and no documented reason. According to the MAR (medication administration record) the 1/27/2020 1:00 PM and 1/28/2020 1:00 PM doses were blank. The doses were not signed off as being administered. Review of the clinical record including the Nurses Notes revealed there was no documentation that the facility staff notified the physician of the missing administration of the antibiotic, [MEDICATION NAME]. On 3/12/2020 at 11:15 AM, an interview was conducted with LPN (Licensed Practical Nurse) B who stated the nurses administer medications as ordered by the physician. LPN B stated that the nurse should document on the Medication Administration Record [REDACTED]. On 3/12/2020 at 2 PM, an interview was conducted with the Director of Nursing who stated medications should be administered as ordered by the physician. The Director of Nursing stated it was important for the full course of antibiotics to be administered as ordered to effectively treat the infection for which the antibiotic was prescribed. The DON stated the nurse should notify the physician of any missed doses and ask if the physician would like to extend the amount of time it was ordered to make up for the missing doses. During the end of day debriefing on 3/12/2020, the facility Administrator, Corporate Nurse Consultant and Director of Nursing were informed of the findings. The Director of Nursing stated the physician should be informed of incomplete courses of antibiotics. No further information was provided.
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** Based on interview, facility documentation clinical record review and in the course of an investigation, the facility staff failed to follow professional standards regarding treatments for one Resident (Resident # 1) in a survey sample of 3 residents. The findings include: For Resident # 1, treatments were not administered on 1/16/2020. Resident #1 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident # 1's most recent MDS (Minimum Data Set) was an Admission Assessment with an ARD (Assessment Reference Date) of 1/5/2020. Resident # 1 was coded as having a Brief Interview for Mental Status of 13 out of 15 indicating no cognitive impairment. Resident # 1 was coded as requiring extensive assistance of one to two staff persons for ADLs (activities of daily living), such as bathing. Review of the closed clinical record was conducted on 3/11/2020 and 3/12/2020. Review of the January 2020 Treatment Administration Record revealed missing treatments on 1/16/2020. Cleanse open area to right buttock with Normal Saline, apply skin prep and [MEDICATION NAME] dressing,. Change twice a week, every day shift every Tuesday and Thursday for Promote wound healing. Start date: 1/7/2020, D/C (Discontinue) Date: 1/21/2020. There was nothing that evidenced the treatment was perform on the Day shift on 1/16/2020. Dressing PICC (Peripherally Inserted Central Catheter)/Midline/Tunneled & Non Tunneled: 24 hours after insertion then weekly and PRN (as needed). Change needleless connector with weekly dressing change and after blood draw. If securement device is used, change at time of dressing change. every day shift every 7 days for IV protocol weekly Start Date 1/2/2020 D/C Date 1/27/2020. There was nothing that evidenced the treatment was perform on the Day shift on 1/16/2020. Valid physician's orders [REDACTED]. On 3/12/2020 at approximately 1:00 PM, the Director of Nursing (DON) was asked about the medications and treatments that were not documented as having been administered. The DON said if they are not documented they are not done. The Director of Nursing cited Lippincott as its Nursing Professional guidance used by the facility. Fundamentals of Nursing, by Lippincott, stated The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients. During the end of day debriefing on 3/12/2020, the facility Administrator, Corporate Nurse Consultant and Director of Nursing were informed of the findings. The Director of Nursing stated Nurses should follow the Professional Standards of Nursing to ensure residents receive treatments as ordered by the physician. No further information was provided.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, facility documentation clinical record review and in the course of an investigation, the facility staff failed to ensure one Resident (Resident # 1) in a survey sample of 3 residents was free from significant medication errors. There were multiple errors. The findings include: For Resident # 1, the facility staff failed to administer the antibiotic, [MEDICATION NAME], as ordered by the physician. There were missed doses and doses administered late (some doses administered over 6 hours late). Resident #1 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident # 1's most recent MDS (Minimum Data Set) was an Admission Assessment with an ARD (Assessment Reference Date) of 1/5/2020. Resident # 1 was coded as having a Brief Interview for Mental Status of 13 out of 15 indicating no cognitive impairment. Resident # 1 was coded as requiring extensive assistance of one to two staff persons for ADLs (activities of daily living), such as bathing. Review of the closed clinical record was conducted on 3/11/2020 and 3/12/2020. Review of the Physicians

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

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

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F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Orders revealed an order written [REDACTED]. Review of the January 2020 Medication Administration Record [REDACTED]. The scheduled times for administration were 9 AM., 1 PM, 5 PM and 9 PM for ten days. Review revealed blanks for 1/27/2020 at 1 PM and 1/28/2020 at 1:PM. All other scheduled doses had checkmarks and initials indicating the medication had been administered and documented as such, Review of the Medication Administration Audit report revealed the actual times of administration: On Page 5 of 6, [MEDICATION NAME] 250 milligrams by mouth four times a day for [MEDICAL CONDITION] due 1/27/2020 at 13:00 (1:00 PM) blank -not administered and no documented reason. On Page 4 of 6, [MEDICATION NAME] 250 milligrams by mouth four times a day for [MEDICAL CONDITION] due 1/28/2020 at 9 PM, administered at 11:19 PM, documented at 11:20 PM. (2 hours late). On Page 2 of 6, [MEDICATION NAME] 250 milligrams by mouth four times a day for [MEDICAL CONDITION] due 1/27/2020 at 5 PM, administered at 9:55 PM, documented at 9:55 PM (4 hours and 55 minutes late) On Page 3 of 6, [MEDICATION NAME] 250 milligrams by mouth four times a day for [MEDICAL CONDITION] due 1/28/2020 at 5 PM, administered at 11:19 PM, documented at 11:20 PM (over 6 hours late). On Page 6 of 6, [MEDICATION NAME] 250 milligrams by mouth four times a day for [MEDICAL CONDITION] due 1/28/2020 at 13: (1 PM) blank, not administered and no documented reason. On 3/12/2020 at 11:15 AM, an interview was conducted with LPN (Licensed Practical Nurse) B who stated the nurses administer medications as ordered by the physician. On 3/12/2020 at 2 PM, an interview was conducted with the Director of Nursing who stated medications should be administered as ordered by the physician. During the end of day debriefing on 3/12/2020, the facility Administrator, Corporate Nurse Consultant and Director of Nursing were informed of the findings. The Director of Nursing stated residents should be free of significant medication errors. No further information was provided.