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Colonial Manor
8679 Pocahontas Trail
Williamsburg, VA 23185
(757) 476-6721

Current Inspector: Darunda Flint (757) 807-9731

Inspection Date: Jan. 31, 2021

Complaint Related: No

Areas Reviewed:

Part II- Administration and Administrative Services
Part III- Personnel
Part IV- Staffing and Supervision
Part V- Admission, Retention and Discharge of Residents
Part VI- Resident Care and Related Services
Part VII-Resident Accommodations and Related Provisions
Part VIII- Buildings and Grounds
Part IX- Emergency Preparedness
22VAC 40-90

Comments:

This inspection was conducted by licensing staff using an alternate remote protocol necessary due to a state of emergency health pandemic declared by the Governor of Virginia.

A renewal inspection was initiated on 1-14-21 and concluded on 1-26-21. The assistant to the administrator was contacted by telephone to initiate the inspection. The assistant to the administrator reported that the current census was 45. The inspector emailed the assistant to the administrator a list of items to complete the inspection. The inspector reviewed three resident records, three staff records, staff schedules, sworn disclosure and background checks of new staff since last inspection, fire drills and emergency preparedness documents, fire and health inspections, healthcare oversight/nutrition/ and pharmacy report for sample residents.

Information gathered during the inspection determined non-compliances with applicable standards or law, and violations were documented on the violation notice issued to the facility.

Violations:

Standard #:	22VAC40-73-320-A
Description:	Based on a review of resident records and staff interview, the facility failed to ensure the physical examination form included all required information for one of three records. Evidence: 1. Resident #2?s physical examination document dated 6-2-20 did not include the address and telephone number, height, weight and blood pressure. 2. Staff #1 acknowledged the information was not documented on the physical examination form.
Plan of Correction:	Facilities History & Physical Form will be updated to state ?All information is required for admission. Paperwork will be returned and admission delayed if information is missing? Please write N/A if not applicable A disclaimer will be added to the facilities history and physical form for resident/family/POA to sign/date stating they are aware that the entire form must be completed and signed by a licensed physician. In the event information is missing, the paperwork may be returned for completion and admission will be delayed.
Standard #:	22VAC40-73-450-C
Description:	Based on a review of resident records and staff interview, the facility failed to ensure the individualized service plan (ISP) include all assessed and documented need for two of three residents. Evidence: 1. Resident #1?s uniform assessment instrument (UAI) dated 3-17-20 documented bowel and bladder need as greater than weekly and a notation of the use of briefs. Resident?s individualized service plan (ISP) dated 3-17-20 did not include

	these assessed needs. Resident?s medication administration record (MAR) for December 2020 documented resident is administered a nutritional supplement twice a day and ?family supply? supplement is not documented on the ISP. In addition, the MAR documented resident?s Risamine Ointment is kept at bedside, this is not documented on the resident?s ISP. 2. Resident #2?s physical examination dated 6-2-20 documented physical and occupational therapy recommended. A physician?s order dated 7-14-20 documented ?d/c pt/ot as per resident + family request?. These services were not documented on the ISP dated 6-3-20 and updated 7-7-20. 3. Staff #1 acknowledged the services assessed and documented were not on the residents ISP.
Plan of Correction:	Nursing staff will be in-serviced by RN (Nurse Overseer) on the importance of relaying information required to be included on resident?s ISP?s to Administrator, Assistant Administrator and RN to ensure changes are made in a timely manner. An ISP Changes Needed Binder will be kept in the Nursing office for staff to place copies of new orders, discontinued orders for home health services, hospice services, equipment changes, level of care changes, diet changes, allergy changes, family providing supplies, etc. to ensure ISP?s are kept up to date. ISP Changes Needed Binder will be brought to weekly Plan of Care Meeting to ensure changes are made in a timely manner.

Standard #:	22VAC40-73-450-D
Description:	Based on record review and staff interview, the facility failed to ensure when hospice care is provided to a resident, the services provided shall be included on the individualized service plan for a resident. Evidence: 1. Resident #2?s record documented physician?s order dated 1-5-2021 recertifying resident?s hospice services with a local agency for 01-31-21 to 0-3-03-21. Resident?s individualized service plan (ISP) dated 6-3-20 and updated 7-7-20 did not document resident receiving hospice care services reflecting a change in the resident's condition. 2. Staff #1 acknowledged resident #2?s ISP did not include hospice care services.
Plan of Correction:	Nursing staff will be in-serviced by RN (Nurse Overseer) on the importance of relaying information required to be included on resident?s ISP?s to Administrator, Assistant Administrator and RN to ensure changes are made in a timely manner. An ISP Changes Needed Binder will be kept in the Nursing office for staff to place copies of new orders, discontinued orders for home health services, hospice services, equipment changes, level of care changes, diet changes, allergy changes, family providing supplies, etc. to ensure ISP?s are kept up to date. ISP Changes Needed Binder will be brought to weekly Plan of Care Meeting to ensure changes are made in a timely manner.