PRINTED: 04/12/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard abbreviated survey conducted 3/7/17 through 3/8/17 was conducted on 4/4/17 through 4/5/17. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. Two complaints were investigated during the survey. The census in this 180 certified bed facility was 155 at the time of the survey. The survey sample consisted of fourteen current resident reviews (Residents 101 through 114) and two closed record reviews (Residents 115 and 116).	F 000	Preparation and submission of this plan of correction by **Charlottesville Pointe Rehabilitation and Healthcare, LLC**, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	
F 252 SS=D	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 252	1. Resident #103 wheelchair, support bars and wheelchair cushion were cleaned by the Unit Manager on 4/5/17. The mangled set of Venetian window blinds, butter knife, broken plastic hanger, metal hook clothes hanger, dirty sock, push pin, and accumulation of dirt and debris were removed from the floor of the closet area by the Charge Nurse and the Housekeeping Staff on 4/5/17. The heater/AC unit and window blinds were replaced on 4/5/17 by the maintenance department.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admitr — (X6) DATE: 4-21-17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 1 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to maintain a clean, safe, homelike environment for one of 16 residents in the survey sample. Resident #103's wheelchair was dirty with food crumbs, accumulated lint and dirty support bars. A broken set of corded window blinds, a broken, sharp clothes hanger and a knife were in the floor of the resident's closet in addition to accumulated dirt, lint and debris. The resident's room had no closet door in place and no window blinds/shade over the window. The temperature knob on the air conditioning/heat unit was missing. The findings include: Resident #103 was admitted to the facility on 12/21/12 with diagnoses that included psychosis, anxiety, adult failure to thrive, seizures, and high blood pressure. The minimum data set (MDS) dated 2/12/17 assessed Resident #103 with short and long-term memory problems and severely impaired cognitive skills. On 4/4/17 at 1:00 p.m. Resident #103 was observed seated in her wheelchair in her room unsupervised. The resident had a cushioned "lab buddy" positioned across her lap. The resident's wheelchair was dirty with crumbs and lint accumulated on horizontal surfaces of the	F 252	New doors will be place over the closet by 4/24/17 by the Maintenance Director. 2. An audit will be completed by the Administrator and Department Managers on 4/19/17 to ensure resident rooms are safe, clean, comfortable and homelike. 3. Staff will be reeducated by the Staff Development Coordinator by 4/24/17 related to ensuring resident's rooms remain safe, clean, comfortable and homelike. 4. The Administrator and Department Managers will conduct audits of 5 rooms on each of the 3 nursing units weekly for 4 weeks and monthly for 2 months to ensure residents' rooms remain safe, clean, comfortable and homelike. The Administrator will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator will be responsible for monitoring and follow up.	04/25/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 2	F 252		

support bars. Lint strands were hanging around the edge of the seat cushion with crumbs and debris hanging in the lint. The support bars of the wheelchair were dirty with a dried dripped substance and lint. The closet area had no door. In the floor of the closet area was a mangled set of cordec Venetian type window blinds, a stainless knife, a broken plastic clothes hanger with a jagged edge, a clothes hanger with a metal hook and a dirty sock. A push pin was positioned in the floor mounted door tracks along with heavy accumulation of dirt and debris. The knife was the type provided by the kitchen on meals trays to residents. The temperature knob on the air conditioning/heat unit was missing.

On 4/4/17 at 1:25 p.m. the licensed practical nurse (LPN #1) caring for Resident #103 was interviewed about the resident's room. LPN #1 stated the resident had aggressive behaviors and had pulled the blinds off the window. LPN #1 stated Resident #103 had flipped chairs in her room, took the mattress off her bed and broke the closet door. LPN #1 stated the resident broke the clothes hanger and had removed the knob from the air conditioning/heat unit. LPN #1 stated the blinds and closet door were not replaced because the resident pulled those items down. LPN #1 did not know why the broken blinds and hangers were left in the floor of the closet area and not discarded. LPN #1 stated the items were not safe and should be discarded. LPN #1 did not know how or why the knife was in the floor.

On 4/5/17 at 8:25 a.m. the unit manager (LPN #2) was interviewed about Resident #103's dirty wheelchair and unsafe room items. LPN #2 stated wheelchairs were supposed to be cleaned once per month or as needed. LPN #2 stated

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 3 Resident #103 pulled the blinds from the window. LPN #2 stated she did not know why the blinds and broken hangers were left in the floor of the closet area. When asked when the resident pulled the blinds down, LPN #2 stated she was not sure but she thought the blinds were on the window on Monday (4/3/17). The resident's care plan indicated the blinds were removed on 2/21/17. On 4/5/17 at 7:43 a.m. accompanied by LPN #2, Resident #103's room was observed. LPN #2 was shown the push pin still positioned in the closet floor tracking. LPN #2 removed the push pin and stated the pin should have been cleaned from the room. LPN #2 stated she did not know how the knife got left in the floor as Resident #103 was fed by staff and was not routinely left alone with her meal tray. LPN #2 stated the broken hanger should have been removed from the room. These findings were reviewed with the administrator and director of nursing during a meeting on 4/5/17 at 1:00 p.m.	F 252		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21	F 279	1. Resident # 103 comprehensive care plan was updated by the Activities Director on 4/5/17 to include a recreational activities care plan. 2. An audit of the current residents' care plans will be completed by the MDS Coordinators and Clinical Reimbursement Specialist by 4/24/17 to ensure care plan have been developed for identified care areas.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 4 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provice as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 279	3. The interdisciplinary team will be reeducated by the Regional Clinical Reimbursement Specialist by 4/24/17 to ensure identified care areas on the residents' comprehensive assessment have been care planned as required. 4. The MDS Coordinators and Director of Nursing will audit 5 care plans from each of the 3 units weekly for 4 weeks and monthly for 2 months to ensure identified care areas on the residents' comprehensive assessment continue to be care planned as required. The Director of Nursing will submit a report to the Quality Assurance committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up.	04/25/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495328	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 5	F 279		

whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one of 16 residents in the survey sample. Resident #103 had no care plan developed regarding recreational activities.

The findings include:

Resident #103 was admitted to the facility on 12/21/12 with diagnoses that included psychosis, anxiety, adult failure to thrive, seizures, and high blood pressure. The minimum data set (MDS) dated 2/12/17 assessed Resident #103 with short and long-term memory problems and severely impaired cognitive skills.

Resident #103's clinical record documented an annual MDS assessment dated 2/12/17 indicating activities as a care assessment area requiring a comprehensive plan of care. The resident's care plan (revised 2/21/17) listed the resident had dementia with communication problems and stated, "Provide a program of activities that accommodates the residents communication abilities." (sic) Resident #103's care plan included no problems, goals and/or interventions regarding activities.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

X4. ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 6 On 4/4/17 at 5:20 p.m. the activities director was interviewed about Resident #103's care plan. The activities director stated she reviewed the care plan and did not see any specific entries regarding activities. These findings were reviewed with the administrator and director of nursing during a meeting on 4/5/17 at 1:00 p.m.	F 279		
F 281 SS=G	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- ( ) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, family interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to follow professional standards of nursing for one of 16 residents, Resident #116. The facility staff failed to thoroughly assess Resident #116 following a period of weakness during a shower on December 19, 2016. Facility documentation and staff interviews differed on what actually occurred in the shower room. Per facility documentation, Resident #116 was lowered to the floor during her shower. Per staff interview, the resident became weak and unresponsive and was transferred from the shower chair to the wheelchair and then taken to the nurse. Per a family interview, Resident #116	F 281	1. Resident # 116 was discharged from the facility on 12/22/16. 2. An audit of resident falls and changes in condition in the past 30 days will completed by 04/24/17 by the Unit Managers to ensure residents are thoroughly assessed and follow up completed after a fall or change in condition. 3. The Licensed Nurses will be reeducated by the Staff Development Coordinator by 04/24/17 related to the requirements of completing a thorough assessment and follow up when a resident has a fall or changes in condition. 4. The Unit Managers will complete an audit of 5 residents from each of the 3 units weekly for 4 weeks and monthly for 2 months to ensure residents continue to be thoroughly assessed and follow up completed	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 7 repeatedly stated "Don't touch my leg" during a visit on the evening (Following her shower) of December 19, 2016, which was reported to the nursing staff. The nurse's notes from December 19, 2016, recorded Resident #116 complaining of "hurting all over' and receiving medication for pain. An assessment including range of motion was not done. Per facility documentation and staff (CNA-certified nursing assistant) interview, Resident #116 complained of pain upon movement on December 21, 2016 and was unable to stand. This was reported to the staff nurse. The nurse did not document an assessment for Resident #116 on 12/21/2016. On December 22, 2016, the same CNA cared for Resident #116 and stated the pain was worse for the resident and she reported it to a different staff nurse. Resident #116 was assessed and sent to a local hospital. She was diagnosed with a right hip fracture and repair. The facility staff failed to assess Resident #116 for a significant change in condition with resulting harm. This is a complaint deficiency. Findings were: Resident #116 was added to the survey sample as a closed record in response to a complaint investigation. The facility had submitted an FRI (facility reported incident) to both the OLC (Office of Licensure and Certification) and APS (Adult Protective Services). The FRI included information that on the morning of 12/22/2016, Resident #116 was found to have pain with movement to her right leg/hip. She was sent out to the local hospital where a right hip fracture was diagnosed. The facility determined that the resident transferred herself and fell without staff being aware. There was no evidence of abuse or	F 281	when there is a fall or on changes in condition. The Director of Nursing will submit a report to the Quality assurance Committees monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up.	04/25/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 8	F 281		

neglect. On 03/08/2017 additional information was reported to the APS office and subsequently submitted to OLC. The additional information was submitted by a family member via a complaint portal for APS. The additional information included the following: "[Name of Resident #116] fell at [name of facility] and later passed away. On December 19th 2016 around 5:00pm or 5:30 pm my grandmother [Name] (88) fell while taking a shower unassisted at: [facility name and address]. Personnel had cleaned her up from the fall when my cousin arrived [cousin name] and placed her back in bed. It was a male nurse or aid and she was his patient for the night. My cousin asked if she should go to the hospital, he stated 'No she was just shaken up." My grandmother was complaining about her hip. After several days laying in bed and pain, she was finally transported to [hospital]...my grandmother had fractured her right hip...she had surgery to repair her hip...she passed away on 29 Dec 16 [12/29/2016] due to complications from Pneumonia, Hip Fracture and Ground level fall per her death certificate." The additional information submitted to APS via the portal was submitted to OLC and the complaint was generated.

Resident #116 was originally admitted to the facility on 08/20/2016 with the following diagnoses but not limited to: Alzheimer's Disease, History of Falling, Cognitive Communication Deficit, Hypothyroidism, Chronic Kidney Disease, Anxiety, Adult Failure to Thrive, Dementia with Behavioral Disturbances, Generalized Osteoarthritis, Hypertension, and Generalized Muscle Weakness.

A quarterly MDS (minimum data set) with an

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 9	F 281		

assessment reference date of 11/25/2016, assessed Resident #116 as having a cognitive summary score of "02", indicating severe impairment with her cognitive status. Section G, Functional Status, assessed Resident #116 as a 3/3 (Physical help in part of bathing activity/Two + persons physical assist) for bathing (G0120).

The clinical record was reviewed on 04/05/2016 beginning at 9:15 a.m. The nurse's note section was reviewed.

On 12/19/2016 the following notes were written:

"2 pm Resident had moderate amount yellowish liquid vomit this afternoon, X [times] 1 occurrence. Bowel sounds presents [sic], abdomen soft nondistended. Ate lunch w/o [without] difficulty. Large BM [bowel movement] yesterday."
"1630 [4:30 p.m.] Resident taken to shower. Staff member reported that resident became weak after shower and bowel movement on floor. Resident became unresponsive with foaming sputum from mouth. Resident taken to room and layed down in bed, Resident become [sic] responsive and talking- V.S. [vital signs] T 97.1 p 65 Resp 24 B/p 106/84. Resident had vomiting on previous shift and vital signs normal. Appetite good @ this time. + [positive] bowel sounds in all 4 quads."
"1800 [6:00 p.m.] Resident had projectile vomiting X 1 with yellow bile and particles of food. No further vomiting @ this time. Resident given medications and is resting at this time. Medicated X 2 for pain this evening as resident stated she was hurting all over."

Also observed in the nurse's note section was an

D-PARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 10	F 281		

SBAR (Situation, Background ,Appearance, Review and Notify) form dated 12/19/2016. The form was divided into sections and questions were available for staff to answer. The unit manager of the floor where Resident #116 resided, LPN (licensed practical nurse) # 2 completed the form. Questions determined to be applicable to the situation are listed below with the staff answers underlined:

SITUATION
The change in condition, symptoms, or signs observed and evaluated is/are n/v [nausea/vomiting], Fall
This started on 12/19/16
This condition, Symptom or sign has occurred before: No (checked as the answer)
Other relevant information Lowered to floor while in shower with staff

BACKGROUND
Primary Diagnoses Alzheimer, FTT [failure to thrive], History of Fall, Dementia with behaviors Allergies and vital signs were also recorded.

Resident Evaluation
Mental Status Evaluation (compared to baseline; check all changes that you observe) "No change" was checked.
Functional Status (compared to baseline; check all changes that you observe) "Falls (one or more) Weakness (general)" were checked.
Behavioral Evaluation "No changes observed" was checked.
Respiratory Evaluation "No changes observed" was checked.
Cardiovascular Evaluation "No changes observed" was checked.
Abdominal/GI Evaluation date of last BM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

X4(ID) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 11	F 281		

12/19/16
GU/Urine Evaluation "No changes observed" was checked.
Skin Evaluation "No changes observed" was checked.
Pain Evaluation: "Not clinically applicable to the change in condition being reported" was checked.
Does the Resident have pain? "No" was checked.
Neurological Evaluation "No changes observed" was checked.

APPEARANCE
Summarize your observations and evaluation N/V Weakness Lowered to Floor by staff In shower room

REVIEW AND NOTIFY
Primary Care Clinical Notified [Physician Name]
Date 12/19/16 Time 6pm

Nursing Notes (for additional information on the Change in Condition) Resident had episode of N/V. Was in the shower room became weak staff lowered her to the floor, Resident taken to her room Given a cup of water. Resident became responsive and is at her baseline.

The CNA documentation in the clinical record regarding ADL (activities of daily living) care was reviewed. On 12/19/2016 Resident #116 was coded "D SH 1", meaning shower, Dependent, and one person help which was not consistent with the MDS assessment of 3/3 (Physical help in part of bathing activity/Two + persons physical assist).

The medication administration record for 12/19/2016 was reviewed. Resident #116 had

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039[illegible]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 12	F 281		

orders for "Norco Tablet 5-325 Give 1 tablet by mouth two times a day related to PAIN, UNSPECIFIED...and Give 1 tablet by mouth every 6 hours as needed for pain". Resident #116 received a PRN (as needed dose) dose of Norco on 12/19/2016 at 4:00 p.m., There was not an assessment of the pain scale or pain level was documented on the MAR or the nurse's notes for the PRN administration. The nurse's entry on the back of the MAR was "12/19/2016 1600 [4:00 p.m.] Norco 5/325 po [by mouth] "all over pain' and the nurse's initials. Resident #116 also received her regularly scheduled dose of Norco at 2100 [9:00 p.m.]. Other pain medication for Resident #116 was a scheduled dose of "Tylenol Tablet 325 mg, Give 2 tablet [650 mg], by mouth two times a day related to PAIN, Unspecified..." Resident #116 also received the scheduled Tylenol at 1700 [5:00 p.m.] on 12/19/2016. The MAR contained a question "Is this resident in pain? 0 = No Pain; 1-3 = mild; 4-6 = Moderate; 7-10 = Severe every shift Follow MD orders" Pain levels for Resident #116 were documented as "0" every day and every shift.

Additional Nurse's notes reviewed in the clinical record listed by date were:

12/20/2016
"0630 [6:30 a.m.] No vomiting this shift. Resident at baseline. Res rested comfortably during night. No c/o [complaints of] pain or discomfort @ this time. + bowel sounds all 4 quads. Took a.m. med without difficulty."

12/21/2016
"0600 [6:00 a.m.] Res vomited X 1 yellow bile with loose stools X 2. Bowel sounds all 4 quads..."

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 13	F 281		

12/22/2016
"0630 Res with no vomiting [sic] or stools this shift. Rested comfortably with eyes closed. No s/s (signs symptoms) of pain or discomfort."
"0830 [8:30 a.m.] Resident in bed, assisted to sitting position to eat breakfast, resident attempted to eat but vomited [sic] small amount of yellow liquid. Attempted to drink water and vomited [sic] a moderate amount of brownish liquid. Poor skin turgor & dry lips noted. Skin color pale. Responds to verbal & tactile stimuli. Notified NP, received order to give Promethazine [antinausea medication] 25 mg/1 ml, give 1 ml IM [intramuscularly] X 1 dose now. Injection given without difficulty. Appears to be in pain with movement will attempt po [by mouth] pain medications as orcered. Abdomen soft, nondistenced. Appears to be in pain with movement/rotation of right leg and hip. NP [nurse practitioner] notified and will come see resident..."

Orders were obtained for mobile xrays for bilateral hips, pelvis and right leg but were canceled as resident was sent to the emergency room where she was subsequently admitted for a right hip fracture.

The facility investigation/information regarding the above was requested and received. Included in the information was an "INVESTIGATION ACTION PLAN". Information contained included but was not limited to: "PROBLEM REPORTED: Staff observed resident with change in behavior and pain to Right leg/pelvis when touched. What actually occurred? resident was observed making facial grimaces when being positioned in bed. How did the event likely occur? Resident was lowered to floor on 12/19/16 by staff. Also

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 14	F 281		

gets OOB [out of bed] unassisted ambulates without assist. Why did the event occur? Resident became weak while in shower lowered to floor by staff. OOB unassisted ambulates without assist. Resident sent to ER.

Included in the facility investigation were interviews with staff who cared for Resident #116 on 12/20-22/2016. There were no interviews with the nurse who cared for Resident #116 after she was lowered to the floor in the shower room or the CNA who had given her the shower on 12/19/2016.

This surveyor contacted LPN #6 via telephone on 04/05/2017 at 11:20 a.m. LPN #6 had cared for Resident #116 on 12/19/2016 following the shower incident. He was asked to walk this surveyor through the events of the evening. He stated that Resident #116 had a vagal nerve response in the shower. He was asked if the CNA had told him that the resident had been lowered to the floor. He stated, "I don't remember being told she was lowered to the floor...the CNA said she just went out, like she fainted and had a BM...I made a note." He was asked to describe what he saw when the resident was brought out of the shower room. He stated, "She was pale, she wasn't walking, she was in the shower chair, she was awake."LPN #6 was asked if he remembered speaking with Resident #116's family that evening and saying the resident was "Shaken up". He stated, "I didn't say shaken up, I told them that she had a vagal nerve response and fainted in the shower." He stated that he did not remember who the CNA was that had given Resident #116 a shower that night. He also stated that Resident #116 did not get out of the bed anymore that night, but they did sit her up for

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 15	F 281		

dinner. He was asked if he had seen the resident up walking after that night. He stated, "I was on leave after that, I don't know if I worked with her again."

The APS office was then contacted and the telephone number of the family member listed as seeing the resident on 12/19/2016 was obtained.

The family member was contacted on 04/05/2017 at approximately 12:00 noon. She was asked about her visit on 12/19/2016 with Resident #116. She stated, "I got there that evening and her male nurse, he had a bun in his hair and a mole on his face [LPN #8] told me that [name of Resident #116] had fallen in the shower and had messed all over herself and that she was upset....I went in the room and [name of Resident #116] said 'Don't touch my leg'...I went out and told the male nurse that I had been talking to...he said she was just upset about the fall...he didn't even come in there...[name of Resident #116] had on a diaper and a pajama top...she kept saying 'Don't touch my leg.' I asked the male nurse if she needed to go to the hospital and he said no, she's just upset about the fall...I wish I had called the rescue squad myself...I'll live with that the rest of my life."

The telephone number of the CNA (CNA #8) who had given Resident #116 a shower on 12/19/2016 was requested from the DON. The DON brought the information to this surveyor at 12:15 and stated, "This is the CNA who bathed the resident on 12/19/2016...I just talked to her and she said that the resident didn't faint but became weak. She transferred her from the shower chair to the wheelchair and took her to the nurse...she said she didn't lower her to the floor she just moved her from showerchair to wheelchair...that's a

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 28	Continued From page 16	F 281		

change of plane, but I consider that a fall...I didn't get a statement from her or the nurse regarding the incident on 12/19/16...I was thinking that on December 22 she was having pain...I don't think I was here on December 19 and I wasn't linking the two. [Name of the unit manager (LPN #2)] didn't do an incident report on the shower incident."

CNA #6 was contacted by this surveyor at 12:35 p.m. She was asked to walk this surveyor through the events of 12/19/2016. She stated, "I noticed she was feeling weak, like she was going to faint...her head went back, I was calling her name but she didn't respond...she looked like she was looking at me but she wasn't talking...she had a small BM...I moved her from the shower chair to the wheelchair, I didn't lower her to the floor." CNA #6 was asked how she transferred the resident. She stated, "I stood her up and transferred her." CNA #6 was asked if Resident #116 was responsive at the time of the transfer. She stated, "No...I stood her up and transferred her and then I took her to the nurse. We took her to her room and lifted her to the bed." CNA #6 was asked why they lifted the resident at that time. She stated, "I don't know we just did and then I left."

The unit manager, LPN #2 came to the conference room at approximately 12:45 and stated, "I can't find an incident report from the shower incident on 12/19/2016...I looked in the [name of new system and name of the old system], I cant find it. LPN #2 was asked if the witness statements would still be available if they had been obtained. She stated, "Yes, I'll ask [name of DON].

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 17	F 281		

Review of the witness statements written on 12/22/2016, the day Resident #116 was sent to the hospital were reviewed. One statement written on 12/22/2016 by CNA #5 contained the following information: "I [name] was giving [resident name] a bath yesterday [12/21/2016], so I stood her up to wash her. And I noticed she was not standing too well. SO I put her back in bed. And she started complaining about her leg was hurting, and everytime I tried [sic] to turn her over to change she hollowed [sic] out in pain. So I reported it the [name of LPN #6] the charge nurse. She gave her pain medication. The second time I got her [LPN #6] to come in and checked [sic] her leg out. And she said that she [Resident #116] had been having problems with her leg and that it had already been charted."

CNA #6 was interviewed at 1:15 p.m. on 04/05/2017. She was asked if she remembered bathing [name of Resident #116] and her having pain. She stated, "Oh yes I remember. I went in to do her bath. When I stood her up beside the bed she wasn't very steady...she couldn't stand at all. She had arthritis but this was very different..I went and told [name of LPN #6] about it. She came in the room and stretched out [Name of Resident #116] leg and she hollered out in pain..." CNA #6 was asked which leg it was...she stated, 'Let me see the bed was facing this way and it was the leg to the wall, so it was her right leg...anyway I think [name of the nurse] thought it was her arthritis so she didn't do anything that day...but I came back in the next day [12/22/2016] and she was worse. I told [name of nurse working that day] and she came in and looked at [name of Resident #116]...She [nurse] knew something wasn't right and [name of Resident #116 went to the hospital...her hip was broke...I

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 18	F 281		

miss her."

LPN #6 was interviewed on 04/05/2016 at 3:45 p.m. She was asked about the above information. She stated "The CNA came and told me the resident was having pain...I went in and assessed her. I moved her legs but I don't remember he hollering out in pain...the resident hac issues with leg pain..I would think I wrote a note about it even if the was nothing out of the ordinary going on....she was in the bed, I know I assessed her, including range of motion...it wasn't out of the ordinary for her to have pain everyday." The MAR (medication administration record) was reviewed with LPN #6. It was notec that the pain scale for Resident #116 was coded as "0" everyday, every shift, including 12/21/2016. She stated, "The pain scale is in relation to her schedulec dose of Norco...if she is having pain we don't chart that...we give her the Norco that is scheduled twice a day. If it is effective then we write down a "0" that she isn't having pain because the scheduled dose works." LPN #6 was asked if there would be a note anywhere other than the clinical record as no note had been observed from her on 12/21/2016. She stated, "No."

The DON was interviewed on 04/05/2017 regarding the above information. She was asked if there were any policies in the facility regarding assessments for a change in resident condition. She stated that if a CNA identified a change they filled out a "Stop and Watch Early Warning Tool" for the nurse or told her verbally. She stated that since CNA #5 had spoken to LPN #6 directly on 12/21/2016 the form wouldn't have been done. She stated there was no policy regarding assessment for a change in condition of a

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 19	F 281		

resident. The DON was asked what her expectation was for assessing Resident #116 following the shower incident on 12/19/2016 and the report to the nurse on 12/21/2016. She stated, "I would expect to see a documented complete assessment, including vital signs, and range of motion, and physician notification."

The Lippincott Manual of Nursing Practice 10th edition on page 6 defines the nursing process as "a deliberate, problem-solving approach to meeting the health care and nursing needs of patients. It involves assessment (data collection), nursing diagnosis, planning, implementation, and evaluation, with subsequent modifications used as feedback mechanisms to promote the resolution of the nursing diagnosis." Page 16 of this reference states, "Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion, follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record ..." Page 17 of this reference states departure from standards of care includes, "Failure to monitor or observe a patient's clinical status adequately ...Failure to monitor or observe a change in a patient's clinical status ...Failure to communicate or document a significant change in a patient's condition to appropriate professional ..." (1)

A meeting was held with the DON and the administrator at approximately 4:00 p.m. on 04/05/2017. The conversation with LPN #8 was discussed with the DON and the DON was asked if the information regarding how the pain scale

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 20 was coded was correct. The DON stated, "There will be inservicing on that...they shouldn't write a zero if the resident is having pain...that will not be an option when we change to [name of computer system]. The survey team voiced concerns of possible harm due to the lack of assessment done by the nursing staff for the shower incident on 12/19/2016 and CNA's report to the nurse on 12/21/2016 of Resident #116 having increased pain. Resident #116 was not thoroughly assessed until 12/22/2016 at which time it was determined that the resident should be sent to the emergency room. She was diagnosed with a right hip fracture, underwent surgical repair and passed away on 12/29/2016. No further information was obtained from the facility staff prior to the exit conference on 04/05/2017. This is a complaint deficiency. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.	F 281		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	1. Resident # 103's broken corded window blinds, broken clothes hangers, push pin, and knife that was on the floor of closet area was removed by the charge nurse on 4/5/17. 2. An audit will be completed by the Administrator and Department	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 21 (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure an environment free of accident hazards for one of 16 residents in the survey sample. A broken set of corded window blinds, a broken clothes hanger with a jagged edge, a push pin and a knife were in the floor of the Resident #103's closet area. The findings include: Resident #103 was admitted to the facility on 12/21/12 with diagnoses that included psychosis, anxiety, adult failure to thrive, seizures, and high blood pressure. The minimum data set (MDS) dated 2/12/17 assessed Resident #103 with short and long-term memory problems and severely impaired cognitive skills. On 4/4/17 at 1:00 p.m. Resident #103 was observed seated in her wheelchair in her room	F 323	Managers on 4/19/17 to ensure resident rooms are safe, clean and free of accident hazards. 3. The staff will be reeducated by the Staff Development Coordinator by 04/24/17 related to ensuring residents' environment remain free of accident hazards. 4. The Administrator and Department Managers will complete an audits weekly for 4 weeks and monthly for 2 months to ensure the residents' environment continues to be free from accident hazards. The Administrator will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator will be responsible for monitoring and follow up.	04/25/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 22	F 323		

unsupervised. The resident had a cushioned "lap buddy" positioned across her lap. The closet area in the room had no door. In the floor of the closet area was a mangled set of corded Venetian type window blinds, a stainless knife, a plastic clothes hanger with the hook broken off that had a jagged edge and a clothes hanger with a metal hook. A push pin was positioned in the floor mounted door tracking. The knife was the type provided by the kitchen on meals trays to residents.

The resident's plan of care (revised 2/21/17) documented the resident had behaviors that included grabbing, pulling and pushing caregivers during care, rummaging, bumping into walls, taking things from the nursing station, turning over furniture, pulling on window blinds and tearing them down, pulling items off the wall and pulling down closet doors. Interventions to prevent injury included, anticipating resident's needs, closet doors removed for safety, dressers removed from room for safety, modifying environment for safety, remove window blinds for safety and intervene before resident becomes agitated.

On 4/4/17 at 1:25 p.m. the licensed practical nurse (LPN #1) caring for Resident #103 was interviewed about the resident's room. LPN #1 stated the resident had aggressive behaviors and had pulled the blinds off the window. LPN #1 stated Resident #103 had flipped chairs in her room, took the mattress off her bed and broke the closet door. LPN #1 stated the resident broke the clothes hangers. LPN #1 stated the blinds and closet door were not replaced because the resident pulled those items down. LPN #1 did not know why the broken blinds and hangers were

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 23	F 323		

left in the floor of the closet area and not discarded. LPN #1 stated the items were not safe and should be discarded. LPN #1 did not know how or why the knife was in the floor. When asked if other cemented residents wandered on the unit, LPN #1 stated, "Yes."

On 4/5/17 at 6:25 a.m. the unit manager (LPN #2) was interviewed about the unsafe items in Resident #103's room. LPN #2 stated Resident #103 pulled the blinds from the window. LPN #2 stated she did not know why the blinds and broken hangers were left in the floor of the closet area. When asked when the resident pulled the blinds down, LPN #2 stated she was not sure but she thought the blinds were on the window on Monday (4/3/17). The resident's care plan indicated the blinds were removed on 2/21/17.

On 4/5/17 at 7:43 a.m. accompanied by LPN #2, Resident #103's room was observed. LPN #2 was shown the push pin still positioned in the closet floor tracking. LPN #2 removed the push pin and stated the pin should have been cleaned from the room. LPN #2 stated she did not know how the knife got left in the floor as Resident #103 was fed by staff and was not routinely left alone with her meal tray. LPN #2 stated the sharp broken hanger should have been removed from the room.

On 4/5/17 at 9:30 a.m. the director of nursing (DON) was interviewed about the unsafe items in Resident #103's room. The DON stated she did not know how the broken, sharp items got in Resident #103's closet area but the items should have been removed and not left in the room. The DON stated in addition to Resident #103, there were other demented residents on that living unit

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 that wandered about the unit. These findings were reviewed with the administrator and director of nursing during a meeting on 4/5/17 at 1:00 p.m.	F 323		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be	F 328	1. Resident #104 was re-assessed by the Charge Nurse on 4/5/17 with no change in condition noted. The physician was notified on 4/6/17 by the Unit Manager related to current oxygen levels and orders with no new orders noted. 2. The Unit Managers will complete an audit of the current resident oxygen orders by 4/24/17 to ensure oxygen is administrated per physicians' ordered. 3. The Licensed Nurses will be reeducated by 4/24/17 by the Staff Development Coordinator related to the requirement of administering oxygen per physicians' orders. 4. The Unit Managers will complete an audit weekly for 4 weeks and monthly for 2 months to ensure oxygen continue to be administered per physicians' as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 25 administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. () Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. () Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to ensure oxygen was administered as ordered by the physician. Resident #104 was observed with oxygen running at 2.5 liters per minute (lpm) when the physician's order required 4.0 liters per minute. The findings include: Resident #104 was admitted to the facility on 1/6/11 with a re-admission on 10/9/14. Diagnoses for Resident #104 included Alzheimer's, pneumonia, high blood pressure,	F 328	The Director of Nursing will be responsible for monitoring and follow up.	04/25/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 26	F 328		

deep vein thrombosis and depression. The minimum data set (MDS) dated 3/13/17 assessed Resident #104 with severely impaired cognitive skills.

On 4/4/17 at 1:50 p.m. Resident #104 was observed in bed with oxygen running at 2.5 liters per minute. The resident was observed again on 4/4/17 at 2:20 p.m. with oxygen administered at 2.5 lpm.

Resident #104's clinical record documented a physician's order dated 12/12/16 for oxygen to be administered at 4 liters per minute as needed for shortness of breath. The record documented the resident was diagnosed with pneumonia on 3/28/17 and was receiving the antibiotic Ceftin 500 mg (milligrams) twice per day for 7 days for treatment.

Nursing notes documented oxygen administered at 2 lpm instead of the ordered 4 lpm. A note dated 4/1/17 stated, "Res. [resident] cont. [continues] Ceftin...for pneumonia...on 2 L [liters] O2 [oxygen] via NC [nasal cannula]..." A note dated 4/3/17 documented, "...He [Resident #104] is on 2 L of O2..." A note dated 4/4/17 documented, "Res. continues on po [oral] ABT [antibiotic] - pneumonia...on O2 @ 2 L..."

On 4/4/15 at 2:20 p.m., accompanied by the licensed practical nurse (LPN #1) caring for Resident #104, the resident's oxygen rate was observed at 2.5 lpm. LPN #1 stated, "It's [oxygen rate] on 2.5 [lpm]." LPN #1 stated the resident's roommate had a habit of "playing with" the oxygen concentrator. LPN #1 stated she did not know why the oxygen rate was set on 2.5 lpm.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From: page 27 These findings were reviewed with the administrator and director of nursing during a meeting on 4/5/17 at 1:00 p.m.	F 328		