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 05/02/2017

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

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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid second revisit to the standard abbreviated survey, conducted 3/7/17 through 3/8/17, was conducted 5/1/17 through 5/2/17. The first revisit to the standard abbreviated survey was conducted 4/4/17 through 4/5/17. 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. No complaints were investigated during the survey. The census in this 180 certified bed facility was 146 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents 201 through 214).	{F 000}	Preparation and submission of this plan of correction by **Charlottesville Pointe Rehabilitation and Healthcare Center, 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 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 280	(1) Resident #212 comprehensive care plan was reviewed and revised by the MDS Coordinator on 5/1/17 to include non-pharmacological interventions for pain. (2) An audit of current residents' care plans was completed on 5/9/17 by the MDS Coordinators and the Director of Nursing to ensure care plans have been reviewed and revised to include non –pharmacological interventions.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5-11-17

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 280	Continued From page 1 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 280	(3) Licensed Nursing Staff were reeducated by 5/9/17 by the Staff Development Coordinator to ensure that nonpharmacological interventions are included on care plans. (4) Director of Nursing or Unit Managers will complete an audit of 5 residents care plans from each of the 3 units weekly for 4 weeks and monthly for 2 months to ensure care plans continue to include non-pharmacological interventions 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.	05/10/17

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(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on, staff interview and clinical record review, the facility staff failed to review and revise a comprehensive care plan for one of 14 residents. Resident #212.

Resident #214 pain care plan was not revised to include non-pharmacological interventions.

Findings include:

Resident #212 was admitted to the facility on 1/18/17 with diagnoses including pain.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/21/17. Resident #212 was

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assessed as being cognitively intact.

Resident #212's electronic record was reviewed on 5/1/17 and evidenced, via comprehensive MDS dated 1/25/17, section "V" that Resident #212 had triggered for a care plan for pain. Section "J" on the current quarterly care plan dated 4/21/17 evidenced that Resident was coded as having pain "Frequently."

Review of Resident #212's nursing progress notes (dated 4/26/17 through 5/1/17) indicated that Resident #212 was receiving pain medication (Tramodol) up to 4 times a day. The nursing notes did not evidence that the facility staff were performing any non-pharmacological interventions for pain.

Resident #212's active care plan was reviewed for pain. Interventions for Resident #212's pain care plan included: Administer analgesic medications, ask the physician to review medications if side effects persist, and refer to therapy. There was no documentation of any Non-pharmacological interventions.

On 5/2/17 at 12:00 p.m. the MDS coordinators (identified as license practical nurse, LPN #2, and registered nurse, RN#2) were interviewed. Both MDS coordinators reviewed Resident #212's "pain" care plan for interventions in regards to the lack of non-pharmacological interventions. LPN #2 verbalized that she was not sure why other interventions were not in place, but verbalized there should be.

On 5/2/17 at 1:30 p.m. the above finding was brought to the attention of the director of nursing and administrator during a meeting.

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No further information was presented prior to exit conference on 5/2/17.

F 314 SS=E 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

(b) Skin Integrity -

(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-

(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable, and

(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed to accurately assess a pressure ulcer (multiple times) for one of 14 residents in the survey sample, Resident # 204

The facility failed to accurately assess a pressure related wound on Resident # 204's right heel, the area was first identified as an intact blister on 04/06/17 and on 04/26/17, the wound was identified as an unstageable, acquired pressure area with eschar.

F 314 (1) Resident #204 area to the right heel was re-assessed and the Braden's assessment was updated by the RN wound care nurse and reviewed by the Director of Nursing on 5/2/17.

(2) An audit of current residents with pressure ulcers was completed on 5/9/17 by the Director of Nursing and Staff Development Coordinator to ensure pressure ulcers are assessed and documented to reflect the resident's current status as required.

(3) Licensed Nursing Staff will be reeducated by 5/9/17 by Staff Development Coordinator and the Director of Nursing related to the requirements of completing pressure ulcers assessment and documentation to reflect the resident's current status.

(4) Director of Nursing and Assistant Director of Nursing will complete an audit of 5 current resident pressure ulcers weekly for 4 weeks and monthly for 2 months to ensure pressure ulcers assessments and documentation continue to be completed as required.

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Findings include:

Resident # 204 was admitted to the facility originally on 03/31/17, with the most current readmission on 04/06/17. Diagnoses for Resident # 204 included, but were not limited to: hypothyroidism, DM (diabetes mellitus), history of UTI (urinary tract infection), HTN (high blood pressure), hypothyroidism, CHF (congestive heart failure) and history of CVA (stroke).

The most current MDS (minimum data set) was an admission assessment dated 04/13/17. Resident # 204 was assessed with a cognitive score of 9, indicating moderate impairment in daily decision making skills. The resident was also assessed as requiring extensive to total assistance from at least one staff person for transfers, dressing, toileting, hygiene and bathing. This MDS did not document that the resident had any pressure related areas or skin issues. The resident did trigger in the CAAS (care area assessment summary) section of this MDS for pressure ulcers.

During clinical record review on 05/01/17, Resident # 204's nursing progress notes were reviewed.

A nursing note dated 04/26/17 and timed 6:30 p.m., documented that the resident was 'found with a pressure area to the left heel that is open and with eschar.'

A "Weekly Wound Information Sheet" was reviewed dated 04/27/17 and timed 9:46 p.m., documented that the resident had a wound on the left heel, acquired (found on 04/26/17), pressure, unstageable, 3.5 cm (centimeters) in length by 3

F 314 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. 05/10/17

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cm wide. with no depth, small amount of serous drainage, no odor. and a necrotic wound bed.

A Norton Plus Pressure Ulcer Scale form was located in the resident's clinical record. This form was completely blank.

Resident # 204's interim (admission-dated 04/06/17) CCP (comprehensive care plan) was then reviewed and documented, "...Weekly skin audits by the charge nurse, daily skin care with ADL's....watch for skin tears, bruising or reddening of the skin..."

The resident's CCP documented, "...04/25/17 (date initiated) Float heels when in bed turn/ position as needed, administer analgesics as ordered...04/26/17 (date initiated) treatment and dressing to right heel as ordered..."

No other information was found regarding Resident # 204's pressure ulcer in the resident's clinical record

On 05/02/17 at approximately 7:45 a.m., Resident # 204 was observed in her room eating breakfast. The resident was sitting in her w/c, with a foam cushion in the seat and a lift sling under the resident. The w/c had bilateral leg rest and the resident had calf high, wool type socks on. The resident had on black, open toed (specialty) shoes that closed over top of each foot with velcro. The resident was asked about her shoes and stated that they were new, but didn't know when or where she got them. The resident was then asked about her heels, and was asked if there was a wound on her left heel, the resident stated, no that she had a place on the right. The resident stated that she had hurt her left leg on

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the bus, but could not provide details as to when or how. The resident was asked if she knew how her right foot developed a pressure related area on the heel. The resident stated that when she hurt her left leg on the bus, that it (pain/injury) jumped over into the right leg and went down to her foot.

At approximately 8:40 a.m., LPN (Licensed Practical Nurse) # 1 was interviewed regarding Resident # 204's pressure ulcer on the right foot. LPN # 1 was asked how often skin assessments are completed on residents, the LPN stated, , "Weekly." LPN # 1 then stated that she thought the pressure wound was on the resident's left foot and that she (the LPN) thought that PACE [program of all inclusive care for the elderly] was doing dressing changes on the wound and would call them to try to get some information. LPN # 1 was also asked for assistance in locating any other skin assessments for Resident # 204 LPN # 1 was then asked to visualize Resident # 204's feet, with this surveyor

At approximately 8:55 a.m., LPN # 1 wheeled Resident # 204 into a private area to observe the resident's feet. LPN # 1 removed the resident's left shoe and sock, the resident was observed with a small horizontal/linear area approximately 1 inch long on the outer, lateral aspect of the resident's left heel. LPN # 1 then removed Resident # 204's right shoe and sock, the resident grimaced and stated that her right foot was very tender. The resident had a kling wrap around the foot and ankle. LPN # 1 removed the cling wrap and dressing exposing the right heel. The wound was on the posterior (back) portion of the right heel, the wound was approximately the size of a silver dollar and was black.

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At approximately 10:30 a.m., LPN # 1 presented a weekly body audit form, in addition to information from PACE.

The weekly body audit form documented the following:

"04/06/17...intact blister rt. [right] heel...RLE [right lower extremity] edema..."
"04/12/17...intact blister rt. [right] heel...RLE [right lower extremity] edema..."
"04/19/17...skin warm and dry no new area [sic] seen at this time."

A PACE note documented, "...04/10/17...pressure ulcer of right heel, stage 2...R [right] heel ruptured serous blister, measures approximately 5.5 cm X 10 cm...signature of NP [nurse practitioner]."

A PACE note documented, "04/17/17...semi annual assessment...she [resident] has an ulcer on the right heel which needs dressing changes every 3 days...marked RLE edema...exquisitely tender to even light touch...dressings to both heels...signature of physician."

A PACE note documented, "04/24/17...wound assessment...right heel 5 cm X 10 cm...purplish non-blanching...continue with foam dressing and change every 3 days and PRN [as needed]...signature of NP."

At approximately 1:30 p.m., the administrator and DON (director of nursing) were made aware of the above information and concerns that the facility staff were not accurately assessing Resident # 204's pressure ulcer on the right heel and was not changing the dressing to the right

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heel. The DON was asked what the relationship was between the facility and PACE. The DON stated that the Dr. at PACE is the resident's doctor at the facility and will see the resident at the facility and at PACE, but confirmed that if orders for the resident or important clinical information is completed at PACE, it doesn't always get communicated to the facility and if it does, it is often not timely. The DON was asked about Resident # 204's dressing changes to the right heel and was shown the April and May 2017 TARs (treatment administration records) for Resident # 204's dressing change. The DON did not know if the documentation on the TARs (treatment administration records) for Resident # 204's dressing change was for the dressing change (here at the facility) or if this was just a verification by facility staff that a dressing was in place to the right heel (that was actually changed by PACE). The DON stated that she would find out.

At approximately 2:40 p.m., the DON, administrator and RN (Registered Nurse) # 1 met with the survey team. RN # 1 stated that she completed the weekly wound information sheet on 04/26/17, when the pressure ulcer was discovered open and necrotic. The RN stated that she documented the wrong heel on the form, it should have been the right heel instead of the left. The RN further stated that the documentation on the TARs for the dressing changes for the right heel ulcer was only a verification by facility staff that the resident had a dressing in place, the facility staff were not changing the resident's dressing. The DON, administrator and RN # 1 were made aware of the concerns related to the lack of assessment for Resident # 204's heel and concerns over the

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dressing not being changed by staff. RN # 1 stated that on 04/26/17, Resident # 204 had a spot on her bed from her right heel dressing and noticed that the dressing to the right heel was wet with drainage and she then took off the dressing and assessed for the first time. The RN stated that she is scheduled to look at the wound on Wednesday (weekly) for reassessment and measurement and that PACE was still doing dressing changes every 3 days.

No further information and or documentation was presented to evidence that the facility staff were accurately assessing and/or caring for Resident # 204's right heel pressure ulcer prior to the exit conference on 05/02/17 at 3:30 p.m.