FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD B. WING	ING	(X3) DATE SURVEY COMPLETED C 09/11/2017
NAME OF PROVIDER OR SUPPLIER CHARLOTTESVILLE POINTE	REHABILITATION AND HEALTH	CA	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901	03/1//2017
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION

F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid standard survey was conducted 09/05/17 through 09/11/17. Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey.

The census in this 180 certified bed facility was 152 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents 1 through 21) and three closed record reviews (Residents 22 through 24).

F 155 483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO SS=D REFUSE; FORMULATE ADVANCE DIRECTIVES

483.10

- (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.
- c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.
- (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
- (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.

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 155 F155:

- 1. Resident #2 's physician orders and care plan were corrected on 9 /6/2017 by licensed nurse.

 Resident #2 was also assessed by a Registered Nurse on 9/27/17 and physician notified regarding order and resident right to refuse medication by a licensed nurse.
- 2. A 100% audit of current residents was completed on 9/13/2017 by the regional nurse consultant related to any other physician orders related to administration of intra-muscular medication as a result of medication refusal. No negative findings noted.
- 3. Licensed Staff will be reeducated by Staff Development Coordinator or designee by 10/3/2017 related to ensuring residents rights regarding medication refusals are upheld.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

DEPARTMENT OF HEALTH					FORM APPROVED
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F 155 Continued From pa	ge 1	F 1	55		
facility's policies to it and applicable State (iii) Facilities are perentities to furnish the legally responsible for requirements of this time of admission and information or articular executed an admay give advance of an advance of admission of a decident and admay give advance of an advance of a decident and admay give advance of an advance of a decident and admay give advance of an advance of a decident and a decident and advance of a decident and a decid	rmitted to contract with other is information but are still for ensuring that the			rights related to r upheld. The findings of the forwarded to the Committee for 3	for 4 weeks and onths to ensure resident medication refusals are these reports will be Quality Assurance months for s of any follow up that
provide this information or she is able to reconstruct the information to the appropriate time. 483.24 (a)(3) Personnel provincient of the information to the appropriate time. 483.24 (a)(a) Personnel provincient of the information of the i	t relieved of its obligation to ation to the individual once he seive such information. The session is the series of the individual directly at the sovide basic life support, resident requiring such for to the arrival of emergency and subject to related the resident's advance.			Cosignation of the second of t	

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medications (Resident #2).

Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff denied one of 24 residents in the survey sample the right to refuse

by:

Event ID: VWGC11

Facility ID: VA0079

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	anti-anxiety medical order was obtained by injection if refuse administered eight injection after one predication orally. The findings include						
	anti-anxiety medical order was obtained by injection if refuse administered eight injection after one predication orally.	#2 refused an oral dose of the ation Lorazepam, a physician's I to administer the medication ed orally. Resident #2 was doses of Lorazepam by prior refusal to take the The clinical record ionale for the injected					
	7/13/17 with diagnor disorder, history of (excess sodium in potassium concent depression, diabete anxiety, osteoporos minimum data set	dmitted to the facility on oses that included bipolar catatonia, hypernatremia the blood), hyperkalemia (high ration in the blood), es, high blood pressure, sis and dementia. The (MDS) dated 7/26/17 assessed everely impaired cognitive					
	physician's order d	cal record documented a ated 7/13/17 for Lorazepam 2 be administered three times					

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per day for management of anxiety. The resident's medication administration record (MAR) for July 2017 documented the medication was administered as ordered until 7/28/17. The

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

495326

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

C **09/11/2017**

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE

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

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 155 Continued From page 3

MAR documented the resident refused to take the Lorazepam at 9:00 a.m. on 7/28/17 and at again at 2:00 p.m. on 7/29/17.

A nursing note dated 7/28/17 at 2:16 p.m. documented, "Resident refuse meds [medications] not talking daughter in spoke with... [community day program] md [physician] new order obtain for im [intramuscular] Ativan [Lorazepam] if resident refuse po [oral]..." (sic) The record documented a physician's order dated 7/28/17 stating, "Lorazepam Solution 2 mg/ml [milligrams per milliliter] Inject intramuscularly three times a day...if resident refuses po."

Resident #2's MAR documented the resident was administered eight doses of Lorazepam by injection. Lorazepam injections were administered to Resident #2 on 7/28/17, 7/29/17, 7/30/17 (3 doses), 7/31/17 and 8/1/17 (2 doses). The July 2017 MAR documented only one dose of oral Lorazepam refused by the resident prior to the order and administration of injectable Lorazepam. Nursing notes documented no behaviors demonstrated by the resident during July 2017 or August 2017 and documented no rationale for obtaining the order for injectable Lorazepam other than the resident's refusal to take the medication by mouth. The record documented no progress notes from the resident's physician indicating why the resident's right to refuse medication was not honored or any rationale for the injected Lorazepam.

Resident #2's plan of care (revised 8/9/17) documented the resident at times refused to go to community day programming and refused to eat meals but made no mention of any refused of medications.

F 155

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					M APPROVED
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	#3) caring for Residenth the order for Loraze he had no issues we medications by more occasionally refuse after encourageme occasionally turned shut when offered of stated when the resident are medications he returned to the resident are medicines. RN #3 was cooperative and #3 stated Resident demonstrated no as stated he did not known to resident and the resident demonstrated and the resident demonstrated no as stated he did not known the resident demonstrated and the resident demonstrated no as stated he did not known the resident demonstrated and the resident demonstrated no as stated he did not known the resident demonstrated and the resident demonstrated he did not known the resident demonstrated and the resident demonstrated he did not known the resident demonstrated and the resident demonstrated he did not known the resident demonstrated and the resident demonstrated and the resident demonstrated he did not known the resident demonstrated and the resident demonstrated he did not known the resident demonstrated demonstrated he did not known the resident demonstrated demonstrate	.m. the registered nurse (RN dent #2 was interviewed about epam injections. RN #3 stated ith Resident #2 taking ath. RN #3 stated the resident d but usually took medications nt. RN #3 stated the resident her head and held her mouth oral medications. RN #3 sident refused to take oral arned at a later time, talked and encouraged her to take the stated most times the resident d took the medications. RN #2 was "always pleasant" and aggressive behaviors. RN #3 now why the order was a Lorazepam by injection.					
	(revised 7/03) state adequate and appreinformed, by a physunless medically codocumented, by a precord), is afforded in the planning of h to participate in exprefuse medication a	regarding resident rights d a resident, "Is assured of opriate medical care, is fully sician, of his medical condition ontraindicated (as obysician, in his medical the opportunity to participate is medical treatment, to refuse perimental research, and to and treatment after being fully derstanding the consequences					

administrator and director of nursing during a meeting on 9/5/17 at 5:00 p.m. F 157 483.10(g)(14) NOTIFY OF CHANGES

These findings were reviewed with the

SS=G (INJURY)DECLINE/ROOM, ETC)

F157:

F 157

1. The physician for Resident# 14 was notified of the wound on 9/6/2017. Resident #14 was also assessed by a

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		AND HUMAN SERVICES				FORM APPROVED
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F 157	consult with the res consistent with his or representative(s) w (A) An accident inversults in injury and physician intervention in the status in either life-included complication (C) A need to alter a need to discontinutreatment due to accommence a new f (D) A decision to transident from the fas §483.15(c)(1)(ii). (ii) When making not the control of the section all pertinent informations.	of Changes. mediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is- blying the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial threatening conditions or	F 18	57	Registered Nurse on 9/6/1 status of current wounds; resident#14 was also revie 9/6/17 regarding wounds. 2. An 100% audit of all curreskin was completed on 9/Licensed Nurse. The physical notified of new skin related during audit process. 3. The nursing staff will be at the Staff Development Conduction designee related to notificate to skin related issues by 1. 4. The Director of Nursing of will conduct audits of 5 reweekly for 4 weeks and a months to ensure physicial of wounds. The findings of these report of the server forwarded to the Quality.	care plan for ewed on ent residents 10/2017 by sician has been ed issues found reeducated by pordinator or eation related 0/3/2017. For designee esidents monthly for 2 an is notified ents will be Assurance hs for any
	physician. (iii) The facility mus resident and the res	at also promptly notify the sident representative, if any,			i ukoko katon li	

Facility ID: VA0079

(A) A change in room or roommate assignment

when there is-

		AND HUMAN SERVICES & MEDICAID SERVICES					FOR	D. 09/19/2017 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION			ATE SURVEY DMPLETED
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F 157	Continued From pa		F 1	57				
	State law or regular (e)(10) of this section (iv) The facility must update the address	st record and periodically (mailing and email) and						
	This REQUIREMENT by: Based on observation interview, facility do record review, the following physician of a change of the physician of the	ne resident representative(s). NT is not met as evidenced tion, resident interview, staff ocument review, and clinical facility staff failed to notify the age in condition for one of 24 t #14. This resulted in harm.						
	Resident #14's left dressing over the worder. The physicia wound's presence survey team. The an unknown length	nember identified a wound on leg stump, and placed a wound without a physician's an was not notified of the until it was identified by the dressing remained in place for of time and when removed on und was an unstageable						
	Findings were:							
	05/05/2016. His di limited to: Bilateral	admitted to the facility on agnoses included but were not BKA (below the knee I fibrillation, hypertension,						

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and acute respiratory failure.

diabetes mellitus with diabetic polyneuropathy,

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/27/2017. Resident #14 was

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TAG

assessed as having a cognitive summary score of "04", indicating severe impairment with his cognitive status. However, Resident #14 answered the survey team's questions appropriately during a resident interview and during verbal interaction with the survey team members. Resident #14 was very hard of hearing and while this hindered his ability to understand, if spoken to directly and into his ear he answered and carried on a conversation with no difficulty.

Resident #14 was interviewed by a member of the survey team on 09/05/2017 at approximately 2:30 p.m. During the interview he pulled up his left pants leg to show the surveyor a dressing on his left leg stump. He stated that he had been asking for three weeks to go to the "leg doctor'...that his prosthetic leg had rubbed a spot on his stump.

On 09/06/2017 at approximately 8:00 a.m., Resident #14's clinical record was reviewed. There were no entries in the clinical record regarding a wound for Resident #14.

At approximately, 9:00 a.m., RN (registered nurse) #4 who was one of the wound nurses at the facility was in the conference room to speak with a member of the survey team. She was asked if she was doing dressing changes for (Name of Resident #14). She stated that she was not doing any dressing changes with him and was not aware that he had a wound.

This surveyor went to the unit where Resident #14 resided. Resident #14 was asked if he had a dressing on one of his legs. Resident #14 stated, "Yeah", and pulled up his pants leg on his left leg

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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(X3) DATE SURVEY COMPLETED

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B. WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE

CHARLOTTESVILLE, VA 22901

(X4) ID PRÉFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION

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stump. Observed was a square border gauze dressing. An area of drainage was observed on the bandage. The was no date, time or initials to indicate when the dressing had been applied or who had applied it. Resident #14 was asked who put the dressing on his leg and how long it had been there. He stated, "It's been on there for three days... one of the girls here put it on there, I don't remember which one... it's came from trying to wear my legs... you want to see it? I'll take it Ithe dressing off of there." Resident #14 was asked to leave the dressing in place until this surveyor could get a staff person in the room to assist him.

This surveyor went out into the hallway and asked RN #7 if she knew anything about a dressing on Resident #14's leg. She stated, "I've worked here since last Thursday... this is the first time I have been on this hall, I don't know anything about these residents, I am just giving medications." This surveyor then went to the other side of the unit. RN # 3 was observed in an office with his cell phone in hand. He came out to speak with this surveyor. He was asked if he knew anything about Resident #14. He stated that he did not work that end of the hall. He was asked who the unit manager was. He stated "We don't have a unit manager so [Name of the Director of Nursing] is who we go to."

This surveyor went to the DON's office. The DON was asked who could discuss the dressing on Resident #14's leg. She directed this surveyor to RN #2, who was the other wound nurse at the facility. RN #2 was busy with another resident.

At approximately 10:00 a.m., this surveyor met RN #2 in the hallway. RN #2 was asked if she

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

495326

B. WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE

CHARLOTTESVILLE, VA 22901

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CROSS-REFERENCED TO THE APPROPRIATE
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knew anything about a dressing over a wound on Resident #14's leg. She stated, "I just heard about that." This surveyor, RN #2 and the medical director went to Resident #14's room. The dressing had been removed from his left lea stump. The wound was covered with a scab. The medical director, lifted the scab up stating. "This is a mobile scab." The wound nurse was asked to measure the wound. She measured the area underneath the scab and stated, "It is 1.2 X 1 X .2" She was asked what the yellow area covering the bottom of the wound was. She stated, "That's slough". The edges of the wound were rolled and bright pink in color. The wound nurse was asked what she would stage the wound as. She stated, "A three." The medical director stated, "I would call it a stage 2 or a Stage 3...it's about the depth." The physician was asked if he had been made notified of the wound prior to that morning (09/06/2017). He stated, "No." He was asked if he would expect to be notified when an open wound was discovered on a resident. He stated, "Yes.

The above information was discussed with the administrator, the administrator in training (AIT), the DON, and other facility staff during an end of the day meeting on 09/07/2017. The DON was asked what her expectation would be if a pressure ulcer was identified by staff. She stated, "The doctor should be notified and orders obtained for treatment." A copy of any facility policy/protocol for physician notification was requested.

On 09/11/2017, at approximately 9:00 a.m., the Administrator and the AIT came to the conference room to present additional information to the survey team. Included in the information was a

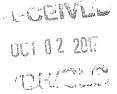
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Event ID: VWGC11

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		hange in Condition". The			1	
		e following instruction: "In			10 T	
		e resident's safety, a				
		n condition will be collected mely mannerThe nursing				
	•	Physician about significant				
		n" The administrator asked				
		ed is what should have been				
		vound on Resident #14's left				
	leg stump was originally identified by facility staff					
	and covered withou	t an order. She stated, "Yes."			2	
					· .	
	No further informati	on was presented prior to the			130 °C	
	exit conference on					
F 225	483.12(a)(3)(4)(c)(1	I)-(4) INVESTIGATE/REPORT	F 2	225	Service of the servic	
SS=D	ALLEGATIONS/IND	DIVIDUALS			F225	
•	400 40/ \ Tt = f==!!!	t				estigated and reported
	483.12(a) The facili	ty must-			the alleged unu	sual occurrence for
	(2) Not ampley or a	therwise engage individuals			Resident #3 on	9/11/2017.
	who-	r otherwise engage individuals		1	The facility inve	estigated and reported the
	WHO-				•	occurrence with
	(i) Have been found	guilty of abuse, neglect,			Resident #2 on 9	
		propriation of property, or			Rosident #2 on	7/12/12017.
	mistreatment by a c	court of law;			2 Are avalit was as	anduated by the Degianal
						onducted by the Regional
	(ii) Have had a findi	ng entered into the State			·	ant on 9/14/2017 of all
		concerning abuse, neglect,				last 30 days to determine
		atment of residents or				s meet the requirement of
	misappropriation of	their property, or			Federal/State re	eporting guidelines and
	(iii) Llovo a dissiplia	any action in effect against his			are investigated	d thoroughly. No negative
	(III) mave a disciplin	ary action in effect against his license by a state licensure			findings noted.	
		a finding of abuse, neglect,		**	illian 50 nova.	
		atment of residents or				
	misappropriation of	resident property.		İ	Library Control	
	imouppi opilation of				the en	
	(4) Report to the Sta	ate nurse aide registry or			Part	
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	- -			t. 1, 1	

FRINIED, USITSIZUTI FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X4) ID

PREFIX

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(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

C

09/11/2017

495326

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 225 Continued From page 11

licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

- (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:
- (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.
- (2) Have evidence that all alleged violations are thoroughly investigated.
- (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.
- (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate

F 225

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- 3. The Administrator was re-educated by the Regional Nurse Consultant on 9/27/17 related to guidelines for reportable events according to Federal/State guidelines. Licensed staff will be inserviced by 10/03/17 related to conducting a thorough investigation related to incidents.
- 4. Audits related to any incidents will be conducted by the Administrator weekly 24 E.S. 24 E.S.

If continuation sheet Page 12 of 135

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	·			OMB NO	<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		ATE SURVEY OMPLETED
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CHARLO	ITTESVILLE POINTE	REHABILITATION AND REALTH		CH	HARLOTTESVILLE, VA 22901		
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F 225	Continued From pa	age 12	F 2	225			
	corrective action m This REQUIREMEI by: Based on staff inter facility document re investigation, the far and report an incide two of 24 residents (Resident #3 and F) 1. Resident #3 volument the facility for a term the facility, the resident was found consciousness; the	ust be taken. NT is not met as evidenced erview, clinical record review, eview and during a complaint acility staff failed to investigate ent with potential neglect for in the survey sample					
	admitted for treatm report this to the st conduct an investig 2. Resident #2 bed	tent. The facility staff did not ate agency and did not gation into the matter. came entrapped by a side rail ility staff failed to report and					
	Findings include: 1. Resident #3 vol the facility for a ten the facility, the resiresident was found consciousness; the emergency departr admitted for treatm report this to the st						

Resident #3 was originally admitted to the facility on 10/11/16, with a current readmission on

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					DBI 1812U I PPROVEI	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		495326	B. WING			09/1	1/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
			.	1150 NORTHWEST DRIVE				
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTHO	,A	CHARLOTTESVILLE, VA 22901				
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F 225	but were not limited disorder, depressio amputation of the le weakness, difficulty cellulitis of the left le lymphedema and o	es for Resident #3 included, I to: diabetes mellitus, anxiety n, complete traumatic eft great toe, muscle walking, unsteadiness, ower limb, cough,	F 2	225				
	assessment with C summary) was a sign	AAS (care area assessment gnificant change assessment						

dated 07/18/17. This MDS assessed the resident as having a cognitive score of '12', indicating resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring limited assistance from one staff person for transfers, ambulation and bathing. The resident was assessed on this MDS to have cellulitis with infection and a surgical wound present. Additionally it was documented on this MDS, the resident received insulin injections in the 7 day look back period and also received IV ABX (intravenous antibiotics) during the 7 day look back. The resident triggered for cognition, ADL's (activities of daily living) and falls in the CAAS section of this MDS.

A 14 day admission MDS assessment was reviewed for comparison, dated 08/21/17. This MDS assessed the resident to have a cognitive score of '13', indicating the resident was cognitively intact for decision making skills. The resident was assessed as requiring supervision with setup for transfers and ambulation. The resident was also assessed as receiving IV ABX and insulin during the 7 day look back.

During a complaint investigation on 09/5/17 through 09/07/17, Resident #3's clinical record

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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09/11/2017

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING					
CENTERS FOR MEDICARE & MEDICAID SERVICES							

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2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
BUILDING	C

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE

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 225. Continued From page 14 was reviewed.

> ED [emergency department] provider notes for Resident #3 were reviewed for 8/4/17, timed for 6:15 a.m. documented, '...found altered by ems [emergency medical services] under a bridge, unknown down time or last seen normal, elevated blood sugar by fingerstick...history of alcohol abuse, cardiac arrest...seizure...he was non-responsive but able to talk upon EMS arrival...per [name of long term care facility] patient signed himself out at 4:30 p.m...[history] was admitted to gerontology for osteomyelitis due to diabetic foot ulcer from 7/3/17-7/7/17...6 weeks of IV vancomycin, ceftriaxone and oral flagyl...PICC was placed in left basillic vein for IV antibiotics...[current] glucose 641...ethanol 222... It was documented that the resident received 10 units of IV insulin, IV fluids, insulin infusion protocol initiated and MICU [medical intensive care unit) was consulted. The resident was admitted to the MICU, the PICC line was removed on admission due to the PICC line ports inability to flush or infuse. The PICC was cultured with no growth at time of discharge on 8/7/17. A new PICC line was placed on 8/7/17.

Nursing notes were reviewed from August 1, 2017 through August 10, 2017.

On 08/02/16 at 3:28 a.m., it was documented that the resident 'continues on abx via picc [peripherally inserted central catheter]...purple port flushes well, but red port is occluded...'

08/02/17 at 2:02 p.m., it was documented, '...antibiotic iv for wound L [left] foot cellulitis resident ambulates on off unit using walker...' F 225

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE	E & MEDICAID SERVICES		C	MB NO. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
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	495326	B. WING		09/11/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			1150 NORTHWEST DRIVE	
CHARLOTTESVILLE POINTE	REHABILITATION AND HEALTH	CA	CHARLOTTESVILLE VA 22001	

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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 225 Continued From page 15

08/02/17 at 6:31 p.m., it was documented, '...continues on IV...for wound infection...'

08/03/17 at 2:31 a.m., it was documented, '...continues on IV...for infection and surgical removal of left great toe...'

A 'late entry' nursing note dated 8/3/17 and timed 10:19 a.m. [created on 8/14/17 at 10:26 p.m.] documented, '...located under a bridge, and later went to the hospital. SS [social services] created an APS referral as the facility staff feels he is a danger to himself as a reflection of his choices while signed out of the facility.'

A nursing note dated 8/4/17 and timed 7:08 a.m., documented, 'Reesident [sic] sign self out on 8/3/17 at 4:30 p.m. and did not return. at this time [name of hospital] called to ask if resident stay here [sic] and was told yes Nurse stated he was found under bridge and brough [sic] to ER [emergency room] Social worker states walker is with him and they will try to clear clog picc line ER [sic]...'

A 'late entry' nursing note dated 8/8/17 and timed 10:26 a.m. [created on 8/14/17 and timed 10:27 a.m.l documented, '...returned to the facility yesterday, and the APS referral was submitted to APS on today as the staff feels his recent choices while signed out could make him a danger to himself.'

On 9/5/17 at 5:00 p.m., the AA (acting administrator) was asked for a policy on residents signing themselves out of the facility.

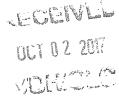
On 9/6/17 at approximately 10:40 a.m., the AA and DON (director of nursing) were made aware F 225

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VWGC11

Facility ID: VA0079

If continuation sheet Page 16 of 135



FORM APPROVED

OMB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES		Ol	<u>MB NO. 0938-0</u>	<u> 1391</u>
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	495326	B. WING		09/11/2017	<u>, </u>
NAME OF PROVIDER OR SUPPLIER CHARLOTTESVILLE POINTE	REHABILITATION AND HEALTHO	SA	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901		
PREEIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION	BE COMPLE	TION

F 225 Continued From page 16

of concerns regarding the above information and that this was not reported to the state agency. The facility's investigation on Resident #3 regarding the above information was requested at this time, along with a policy on resident's signing out of the facility, in addition to a policy on reportable incidents.

At approximately 3:45 p.m., the AA stated, '...we would not have reported to state, he is alert and oriented and goes out on LOA [leave of absence], goes out quite often, he was homeless..." The AA stated that the facility did not conduct an investigation for Resident # 22 regarding the above information and the facility does not have a policy on leave of absence and stated that the facility reported it to APS. The AA then stated, there may be something in the admission packet about resident's signing themselves out of the facility.

A policy was presented and reviewed on 'conducting a thorough investigation', which documented, 'When an actual and/or potential care and service failure occurs involving a resident, it is necessary for facility administration to initiate an investigation to determine the facts and then act upon or respond accordingly to the findings. Examples of issues that would require investigation...falls with injury or non-injury, allegations of abuse, injuries of unknown origin...elopement....The administrator is always the individual in the facility who has overall responsibility for ensuring that the investigation is conducted and that a conclusion is reached. The administrator, however may not always be the individual who will conduct the investigation. It is very important to determine who the responsible individual will be so that the investigation is

F 225

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

495326

B. WING

C **09/11/2017**

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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)

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 225 Continued From page 17

completed in a timely and efficient manner..."

This policy did not document time frames as to when an investigation should be initiated and/or completed.

A policy was presented and reviewed on 'reporting abuse to state agencies and other entities' documented, 'All suspected violations and all substantiated incidents of abuse will be immediately reported...the facility administrator or his/her designee will promptly notify the following persons or agencies...a. The state licensing/certification agency responsible for surveying/licensing the facility..."

On 9/7/17 at approximately 3:20 p.m., the administrator, the AA, and DON were made aware of the above information and concerns surrounding the incident with Resident #3 and that the incident was not reported to the state agency and was not investigated.

On 9/11/17 at 11:50 a.m., the administrator stated that, 'as far as time frames' for reporting and investigating the regulations state 'immediately' and went on to say that is what the facility should be following.

No further information and/or documentation was presented prior to the exit conference on 9/7/17 at 4:30 p.m., to evidence that the facility conducted an investigation and/or reported this incident to the state agency.

F 225

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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F 225	Continued From pa	•	F 2	225			
	and conduct a thore Resident #2 was fo wedged between the mattress. There was	d to report to the state agency bugh investigation after und on the floor with her head be bed rail and the air as no effort made by the if Resident #2's entrapment					

Resident #2 was admitted to the facility on 7/13/17 with diagnoses that included bipolar disorder, hypernatremia (excess sodium in the blood), hyperkalemia (high potassium concentration in the blood), depression, diabetes, high blood pressure, anxiety, osteoporosis and dementia. The minimum data set (MDS) dated 7/26/17 assessed Resident #2 with severely impaired cognitive skills.

incident involved neglect.

Resident #2's clinical record documented a nursing note dated 7/17/17 at 3:05 a.m. stating. "Resident was observed with her bottom sitting on the floor and her head in between the bed rail and the air mattress. Resident stated she was trying to get up out of the bed. No c/o [complaints of pain..."

The physician was notified of the resident's entrapment on 7/17/17 and ordered the resident to go the emergency room for evaluation and treatment. The emergency room discharge summary dated 7/17/17 documented, "Patient coming from nursing home, found half way out of bed with legs on the ground by neck and head caught within the railings. Complaining of anterior neck pain. Denies LOC [loss of consciousness]... Pt's [patient's] pain is moderate throbbing, without radiation and unchanged from onset. Worse with palpatioin [palpation], not worse with movement. No associated swelling or

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

С

495326

B. WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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)

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 225 Continued From page 19

shortness of breath, no dysphagia...No evidence of acute cervical spine fracture...minor trauma to anterior right neck, no expanding mass, minimally tender...Imaging reveals no acute injury...A diagnosis of Neck pain was also pertinent to this visit..."

The resident returned to the facility from the emergency room on 7/17/17. A nursing note dated 7/17/17 at 5:24 p.m. documented, "...returned from ED [emergency department]... with no new orders...Resident observed with bruise to back. Resident reports that she hit her back when she attempted to walk and fell to floor from bed. Resident was in pain...order obtained for Tylenol 325 mg [milligrams] two tablets by mouth q. [every] 6 hours. Resident reports pain management is effective..."

The clinical record documented no prior assessment to ensure safe use of bed rails or a physician's order for the specialty air mattress prior to the entrapment incident on 7/17/17. There was no evidence of informed consent from Resident #2's responsible party (RP) or review with the RP of benefits and/or risks of side rail use prior to the entrapment. The resident's admission assessment dated 7/13/17 documented the resident was alert and oriented to person but not place, time or situation and was at risk for falls. This assessment documented the resident was independent with walking using an ambulation device and required total assistance of one person for safe transfers. This admission assessment documented side rails were not in use by the resident at the time of admission.

The resident's plan of care prior to the fall (dated 7/17/17) listed the resident was at risk for falls.

F 225

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _______

(X3) DATE SURVEY COMPLETED

B. WING

C **09/11/2017**

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

495326 B.

STREET ADDRESS, CITY, STATE, ZIP CODE

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 225 Continued From page 20

Interventions to prevent falls included low bed position, alternate periods of activity with rest, participate in activities, call light within reach and a clutter free environment. There was no mention of side rail use or a specialty air mattress prior to the entrapment incident on 7/17/17.

There was no facility investigation of Resident #2's entrapment on 7/17/17. The facility's incident form documented the resident had an unwitnessed fall on 7/17/17 at 3:00 a.m. and was found with the side rails in the up position but made no mention the resident was found with her head wedged between the bed rail and the air mattress. The incident form did not include the length of the rails in use at the time or the area of the bed where the resident was wedged. Staff members caring for the resident around the time of the incident were not identified. There were no witness statements and/or interviews from staff members caring for the resident. This incident was not reported to the state agency. There was no evidence the facility made any attempts to determine if the entrapment incident involved neglect of Resident #2.

On 9/6/17 at 3:45 p.m. the administrator was interviewed about reporting Resident #2's entrapment to the state agency and any investigation of the incident. The administrator stated she found no facility investigation of the incident. The administrator stated she was new and was not aware of the entrapment incident until it was brought up during the current survey. The administrator stated, "As an administrator I would have reported and investigated this incident." The administrator stated the previous administration listed the incident as a fall and not an entrapment. The administrator stated the

F 225

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CHARLOTTESVILLE, VA PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	OF CORRECTION (X5) ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 225	coordinator not to reporting was not in The administrator is been reported and The facility's policy Stage Agencies an 2013) documented all substantiated in immediately reporte agencies and other be required by law or substantiated in unknown source, or esident abuse) be Administrator, or hinotify the following and written) of succlicensing/certificatic surveying/licensing notices to agencies twenty-four (24) ho incidentThe Administrator agencies the following and written agencies the following and written agencies to agencies the following and service days of the occurre policy defines negligoods and service	or told the staff development eport the incident and eeded because it was a fall. stated the incident should have	F 2:	25	

These findings were reviewed with the administrator and director of nursing during meetings on 9/5/17 at 4:25 p.m. and on 9/6/17 at 4:45 p.m.

This was a complaint deficiency. F 226 483.12(b)(1)-(3), 483.95(c)(1)-(3)

F 226

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PRÉFIX

TAG

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING _

(X3) DATE SURVEY COMPLETED

C

495326

B. WING

09/11/2017 STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

COMPLETION DATE

F 226 Continued From page 22

SS=D DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC **POLICIES**

483.12

- (b) The facility must develop and implement written policies and procedures that:
- (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,
- (2) Establish policies and procedures to investigate any such allegations, and
- (3) Include training as required at paragraph §483.95,

483.95

- (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-
- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.
- (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property
- (c)(3) Dementia management and resident abuse prevention.

This REQUIREMENT is not met as evidenced

Based on staff interview, clinical record review, facility document review and during a complaint investigation, the facility staff failed to follow

F 226

F226:

1. The facility developed a policy on Leave of Absences on 9/18/2017.

DEFICIENCY)

- 2. All residents have the potential to be effected.
- 3. The LOA policy was presented to the OA committee for review, acceptance, and was adopted by Medical Director and Committee. The staff will be educated about Leave of Absence Policy by Staff Development Coordinator / designee by 10/3/2017.
- 4. Audits related to LOA incidents will be conducted by the Administrator or designee weekly for 4 weeks and monthly for 2 months to ensure awareness of residents rights. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
- 5. Completed by 10/3/2017

FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES
AND DLAN O	E CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	
A. BUILDING	_

(X3) DATE SURVEY COMPLETED

495326

B. WING			

C **09/11/2017**

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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)

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION DATE

F 226 Continued From page 23

and/or implement policies and procedures for reporting and investigating allegations of abuse and neglect for two of 24 residents in the survey sample, Resident #3 and Resident #2.

- 1. Resident #3 voluntarily signed himself out of the facility for a temporary leave of absence from the facility, the resident did not return; the resident was found under a bridge with loss of consciousness; the resident was taken to the emergency department and subsequently admitted for treatment. The facility staff did not report this incident to the state agency and did not conduct an investigation into the matter.
- 2. Facility staff failed to follow policies requiring a report to the state agency and a thorough investigation after Resident #2 was found on the floor with her head wedged between the bed rail and the air mattress. There was no effort by the facility to follow policies to determine if Resident #2's entrapment incident involved neglect.

Findings include:

1. Resident #3 voluntarily signed himself out of the facility for a temporary leave of absence from the facility, the resident did not return; the resident was found under a bridge with loss of consciousness; the resident was taken to the emergency department and subsequently admitted for treatment. The facility staff did not report this incident to the state agency and did not conduct an investigation into the matter.

Resident #3 was originally admitted to the facility on 10/11/16, with a current readmission on

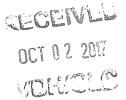
F 226

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VWGC11

Facility ID: VA0079

If continuation sheet Page 24 of 135



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		& MEDICAID SERVICES					M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) D	ATE SURVEY DMPLETED
		495326	B. WING			0	C 9/11/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTH	CA		50 NORTHWEST DRIVE HARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Κ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 226	Continued From pa		F 2	26			
	but were not limited disorder, depressio amputation of the le						
	assessment with Command was a sign dated 07/18/17. The as having a cognitive resident had moder decision making sk assessed as required one staff person for bathing. The resident have cellulitis with wound present. Add on this MDS, the reinjections in the 7 direceived IV ABX (in the 7 day look backs)	AAS (care area assessment gnificant change assessment is MDS assessed the resident rescore of '12', indicating rate impairment in daily ills. The resident was also ing limited assistance from transfers, ambulation and ent was assessed on this MDS in infection and a surgical ditionally it was documented sident received insulin ay look back period and also travenous antibiotics) during the transfers of daily living) and falls in of this MDS.					
	reviewed for compa MDS assessed the score of '13', indica cognitively intact for resident was asses for transfers and ar	a MDS assessment was arison, dated 08/21/17. This resident to have a cognitive ting the resident was decision making skills. The sed as supervision with setup abulation. The resident was ecciving IV ABX during the					

During a complaint investigation on 09/5/17 through 09/07/17, Resident #3's clinical record

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

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495326

R WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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)

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION DATE

F 226 Continued From page 25 was reviewed.

F 226

ED [emergency department] provider notes for Resident #3 were reviewed for 8/4/17, timed for 6:15 a.m. documented, '...found altered by ems [emergency medical services] under a bridge, unknown down time or last seen normal, elevated blood sugar by fingerstick...history of alcohol abuse, cardiac arrest...seizure...he was non-responsive but able to talk upon EMS arrival...per [name of long term care facility] patient signed himself out at 4:30 p.m...was admitted to gerontology for osteomyelitis due to diabetic foot ulcer from 7/3/17-7/7/17...6 weeks of IV vancomycin, ceftriaxone and oral flagyl...PICC was placed in left basillic vein for IV antibiotics...glucose 641...ethanol 222...' It was documented that the resident received 10 units of IV insulin, IV fluids, insulin infusion protocol initiated and was MICU [medical intensive care unit] was consulted. The resident was admitted to MICU, PICC line was removed on admission and cultured with no growth at time of discharge. A new PICC line was placed on 8/7/17.

Nursing notes were reviewed from August 1, 2017 through August 10, 2017.

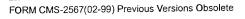
On 08/02/16 at 3:28 a.m., it was documented that the resident 'continues on abx via picc [peripherally inserted central catheter]...purple port flushes well, but red port is occluded...'

08/02/17 at 2:02 p.m., it was documented, '...antibiotic iv for wound I [left] foot cellulitis resident ambulate on off unit using walker...'

08/02/17 at 6:31 p.m., it was documented, '...continues on IV...for wound infection...'

FORM APPROVED
OMB NO 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		_	0	<u>MB NO.</u>	<u>0938-0391</u>
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG			E SURVEY PLETED
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	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTHO	SA	STREET ADDRESS, CITY, ST 1150 NORTHWEST DRIVE CHARLOTTESVILLE, V	•		
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F 226	Continued From pa	ge 26	F 22	26			
		m., it was documented, .for infection and surgical t toe'					
	[created on 8/14/17 'located under a bhospital. SS [social referral as the facility]	g note dated 8/3/17 10:19 a.m. at 10:26 p.m.] documented, oridge, and later went to the I services] created an APS ty staff feels he is a danger to ion of his choices while signed					
	documented, 'Rees 8/3/17 at 4:30 p.m. [name of hospital] of here [sic] and was found under bridge [emergency room]	and 8/4/17 and timed 7:08 a.m., sident [sic] sign self out on and did not return. at this time called to ask if resident stay told yes Nurse stated he was and brough [sic] to ER Social worker states walker is will try to clear clog picc line ER					
	10:26 a.m. [created a.m.] documented, yesterday, and the APS on today as the	g note dated 8/8/17 and timed from 8/14/17 and timed 10:27 'returned to the facility APS referral was submitted to be staff feels his recent choices all make him a danger to					
	On 9/5/17 at 5:00 p was asked for a po themselves out of t	o.m., the acting administrator licy on residents signing he facility.					
	(acting administrate	ximately 10:40 a.m., the AA or) and DON (director of e aware of concerns regarding					



the above information and that this was not

Event ID: VWGC11

Facility ID: VA0079

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	IO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		OATE SURVEY COMPLETED
		495326	B. WING _				C 09/11/2017
	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTHO	CA	1150	EET ADDRESS, CITY, STATE, ZIP CODE) NORTHWEST DRIVE ARLOTTESVILLE, VA 22901		7071172317
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F 226	Resident #3 regard requested, along winvestigating incide At approximately 3: administrator stated reported to state, higoes out on LOA [lequite often, he was that the facility does absence and stated APS. The AA was occurred on 8/3/17 until 8/8/17, five da A policy was presel investigation, which actual and/or poten occurs involving a reacility administrated determine the facts accordingly to the fithat would require in or non-injury, allegations abuseelopement the individual in the responsibility for erconducted and that administrator, howe individual who will overy important to de individual will be so completed in a time. A policy was present.	e agency, the investigation on ing the above was then ith a policies on reporting and nts. 45 p.m., the acting d, 'we would not have e is alert and oriented and eave of absence], goes out homeless" The AA stated is not have a policy on leave of d that the facility reported it to made aware that the incident and was not reported to APS ys after the incident. Inted on 'conducting a thorough the documented, 'When an intial care and service failure resident, it is necessary for on to initiate an investigation to and then act upon or respond indings. Examples of issues investigationfalls with injury eations ofThe administrator is always a facility who has overall insuring that the investigation is a conclusion is reached. The ever may not always be the conduct the investigation. It is etermine who the responsible of that the investigation is eatly and efficient manner"	F 2:	26 :			
	state agencies and 'All suspected viola	other entities' documented, itions and all substantiated					

Facility ID: VA0079

incidents of abuse will be immediately

PARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

		MEDICAID SERVICES						0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			ONSTRUCTION	(X3) DA	TE SURVEY MPLETED
AND PLAN O	CORRECTION	ibertin io, trient io.	A. BUILDI	ING				С
		495326	B./WING				09	9/11/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTH	CA			NORTHWEST DRIVE RLOTTESVILLE, VA 22901		
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F 226	Continued From pa	ae 28	F 2	226	} [!]			
1 220	reportedthe facilit designee will prompersons or agencie licensing/certification surveying/licensing	y administrator or his/her ptly notify the following esa. The state on agency responsible for the facility"						
	administrator, the A aware of the above surrounding the incident was	ximately 3:20 p.m., the AA, and DON were made information and concerns cident with Resident #3 and as not reported to the state of investigated, per the facility's						
	that, 'as far as time investigating the re	O a.m., the administrator stated a frames' for reporting and a state 'immediately' that is what the facility should						
	presented prior to at 4:30 p.m., to evi	tion and/or documentation was the exit conference on 9/7/17 dence that the facility staff y and procedure of reporting investigation for Resident #3.						
	report to the state investigation after floor with her head and the air mattres facility to follow po	ed to follow policies requiring a agency and a thorough Resident #2 was found on the wedged between the bed rail as. There was no effort by the licies to determine if Resident acident involved neglect.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Resident #2 was admitted to the facility on 7/13/17 with diagnoses that included bipolar

Event ID: VWGC11

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	. 09/19/201 APPROVEI . 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION NG) COM	E SURVEY MPLETED
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	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTHO	CA	STREET ADDRESS, CITY, STATE, ZIP COI 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901	DE	
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F 226	blood), hyperkalem concentration in the high blood pressure dementia. The min 7/26/17 assessed Fimpaired cognitive series and the air mattress trying to get up out off pain" The physician was entrapment on 7/17 to go the emergency treatment. The emsummary dated 7/1 coming from nursing bed with legs on the caught within the raanterior neck pain. consciousness] Fithrobbing, without ronset. Worse with	emia (excess sodium in the ia (high potassium e blood), depression, diabetes, e, anxiety, osteoporosis and imum data set (MDS) dated Resident #2 with severely	F 22	26		

The resident returned to the facility from the emergency room on 7/17/17. A nursing note dated 7/17/17 at 5:24 p.m. documented,

shortness of breath, no dysphagia...No evidence of acute cervical spine fracture...minor trauma to anterior right neck, no expanding mass, minimally tender...Imaging reveals no acute injury...A diagnosis of Neck pain was also pertinent to this

visit..."

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		AND HUMAN SERVICES					M APPROVED	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		495326	B. WING			0:	C 9/11/2017	
	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTHO	CA	1150	EET ADDRESS, CITY, STATE, ZIP CODE) NORTHWEST DRIVE ARLOTTESVILLE, VA 22901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 226	"returned from EI with no new orders bruise to back. Reback when she atter from bed. Residen for Tylenol 325 mg mouth q. [every] 6 management is effect to ensphysician's order for prior to the entrapm. There was no evide Resident #2's responsible to the entrapm. There was no evide Resident #2's responsible to the entrapm. There was no evide Resident #2's responsible to the entrapm. There was no evide Resident #2's responsible to the entrapm. There was no evide Resident #2's responsible to the entrapm. There was no evide Resident #2's responsible to the entrapm. There was independent to person but not particised to the resident was independent was independent was independent to person for sassessment documuse by the resident. The resident's plan 7/17/17) listed the resident in activition, alternate participate in activity a clutter free environmention of side rail	D [emergency department]Resident observed with sident reports that she hit her empted to walk and fell to floor it was in painorder obtained [milligrams] two tablets by hours. Resident reports pain ective" documented no prior ure safe use of bed rails or a or the specialty air mattress hent incident on 7/17/17. ence of informed consent from consible party (RP) or review efits and/or risks of side rail rapment. The resident's		226				

Facility ID: VA0079

There was no facility investigation of Resident #2's entrapment on 7/17/17. The facility's incident form documented the resident had an

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE	& MEDICAID SERVICES
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING _

(X3) DATE SURVEY COMPLETED

C

495326

B. WING

09/11/2017 STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PRÉFIX 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

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unwitnessed fall on 7/17/17 at 3:00 a.m. and was found with the side rails in the up position but made no mention the resident was found with her head wedged between the bed rail and the air mattress. The incident form did not include the length of the rails in use at the time or the area of the bed where the resident was wedged. Staff members caring for the resident around the time of the incident were not identified. There were no witness statements and/or interviews from staff members caring for the resident. This incident was not reported to the state agency. There was no evidence the facility made any attempts to determine if the entrapment incident involved neglect of Resident #2.

On 9/6/17 at 3:45 p.m. the administrator was interviewed about reporting Resident #2's entrapment to the state agency and any investigation of the incident. The administrator stated she found no facility investigation of the incident. The administrator stated she was new and was not aware of the entrapment incident until it was brought up during the current survey. The administrator stated, "As an administrator I would have reported and investigated this incident." The administrator stated the previous administration listed the incident as a fall and not an entrapment. The administrator stated the former administrator told the staff development coordinator not to report the incident and reporting was not needed because it was a fall. The administrator stated the incident should have been reported and investigated.

The facility's policy titled, "Reporting Abuse to Stage Agencies and Other Entities (dated March 2013) documented, "All suspected violations and all substantiated incidents of abuse will be

F 226

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VWGC11

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FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB N						MB NO.	0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495326	B. WING		_		C 11/2017
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	SA	STREET ADDRESS, CITY, ST. 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA			
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F 252	agencies and other be required by law. or substantiated in unknown source, or resident abuse) be Administrator, or his notify the following and written) of such licensing/certification surveying/licensing notices to agencies twenty-four (24) hor incidentThe Administrator appropriate agencies findings of the invedays of the occurre policy defines neglicy defines	ed to appropriate state entities or individuals as may Should a suspected violation cident of neglect, injuries of an r abuse (including resident to reported, the facility s/her designee, will promptly persons or agencies (verbally incidentThe State on agency responsible for the facility Verbal/written will be made within curs of the occurrence or such inistratorwill provide the eswith a written report of the estigation within five (5) working ince of the incident" This ect as, "failure to provide in necessary to avoid physical ish, or mental illness." ereviewed with the irrector of nursing during at 4:25 p.m. and on 9/6/17 at ant deficiency.	F 2				

Facility ID: VA0079

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

C

495326

B WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE

CHARLOTTESVILLE, VA 22901

PRÉFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

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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 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

Based on observation, and staff interview, the facility failed to ensure a clean homelike environment.

Multiple vents in common areas were observed with dust and debris.

The Findings Include:

On 9/7/17 during general observation rounds, exhaust vents were observed as part of a complaint allegation. The following ventilation units were observed with large amount of dust and debris:

1st floor vent near to room 100.

Exhaust vent in library.

Exhaust vent near to nurses station on 2nd floor. Exhaust vent in shower room on second floor.

Damper vent on 3rd floor next to room 300.

F 252 F252

1. Ist floor vent near room 100, exhaust

vent in library, exhaust vent near nurses' station on 2nd floor, exhaust vent in shower room on 2nd floor and damper vent on 3rd floor next to room 300 were

- 2. An audit was completed by Facility Maintenance and Environmental Services Manager on 9/10/2017 of facility vents. Any vents found to be dirty were cleaned.
- 3. Maintenance and Housekeeping staff were reeducated on cleaning schedules of facility vents by Administrator on 9/10/2017.
- 4. The Maintenance Director or designee will conduct audits of 5 facility area vents weekly for 4 weeks and monthly for 2 months to ensure cleanliness of vents. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
- 5. Completion date 10/3/17

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FORM APPROVED OMB NO. 0938-0391

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495326	B. WING	i			C 11/2017
NAME OF F	ROVIDER OR SUPPLIER		1	S-	TREET ADDRESS, CITY, STATE, ZIP CODE	1 007	11/2017
NAME OF P	ROVIDER OR SUPPLIER			1	150 NORTHWEST DRIVE		
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTH		REHABILITATION AND HEALTHO	:A		HARLOTTESVILLE, VA 22901		
							246)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 252	Continued From pa	ge 34	F2	252			
F 278 SS=D	(other staff, OS #10 the vents. OS #10 been at the facility for taking notes and is ventilation system in On 9/7/17 at 4:00 purpose of the attendirector of nursing in This surveyor point library at this time. No other information conference on 9/11 This is a complaint 483.20(g)-(j) ASSE ACCURACY/COOF (g) Accuracy of Assimust accurately reful (h) Coordination A registered nurse each assessment with participation of head (ii) Certification	deficiency. SSMENT RDINATION/CERTIFIED sessments. The assessment lect the resident's status. must conduct or coordinate with the appropriate lth professionals.	F	278			
	(2) Each individual assessment must sthat portion of the a	who completes a portion of the sign and certify the accuracy of assessment.					

FORM APPROVED
OMB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRU A. BUILDING	CTION	(X3) DATE SURVEY COMPLETED
				С
	495326	B. WING	<u> </u>	09/11/2017
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE, ZIP CODE	
CHARLOTTESVILLE POINTE	A	WEST DRIVE ESVILLE, VA 22901		

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 278 Continued From page 35

PREFIX

TAG

- (i) Penalty for Falsification
- (1) Under Medicare and Medicaid, an individual who willfully and knowingly-

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or
- (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.
- (2) Clinical disagreement does not constitute a material and false statement.

 This REQUIREMENT is not met as evidenced by:

Based on clinical record review and staff interview, the facility staff failed for one of 24 residents in the survey sample (Resident # 9) to ensure a complete and accurate Quarterly Minimum Data Set. Resident # 9's bowel and bladder status was incorrectly assessed on the most recent Quarterly Minimum Data Set.

The findings were:

Resident # 9 in the survey sample, a 55 year-old female, was admitted to the facility on 4/6/12 with diagnoses that included dementia with behavioral disturbances, hyperlipidemia, Vitamin D deficiency, candidiasis, dysphagia, pain, depressive disorder, diabetes mellitus, rheumatoid arthritis, and Non-Alzheimer's Dementia. According to the most recent Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/30/17, and the most recent Quarterly MDS, with an ARD of 7/30/17,

F 278 F 278

- 1. Resident #9's Bowel and Bladder status on the minimum data set (MDS) was corrected by MDS Coordinator on 9/06/17.
- 2. An audit of current resident's bowel and bladder section of MDS was conducted and any finding corrected by on 9/14/2017.
- 3. The Minimum Data Set coordinators were reeducated regarding proper coding of MDS's related to bowel and bladder by regional clinical reimbursement specialist on 9/15/2017 and 9/19/2017.
- 4. The Minimum Data Set Coordinator or designee will conduct audits of 5 residents MDS for correct bowel and bladder entries weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
- 5. Completion date 10/3/2017

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Facility ID: VA0079

If continuation sheet Page 36 of 135

FORM APPROVED OMB NO. 0938-0391

CENTER	49 LOK MEDICAKE	& MEDICAID SERVICES				OIMP IAC	<i>J.</i> 0930-039 i
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRU			ATE SURVEY DMPLETED
		495326	B. WING	***************************************		09	C 9/11/2017
	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTH	CA	1150 NORTH	DRESS, CITY, STATE, ZIF HWEST DRIVE TESVILLE, VA 2290		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EA	PROVIDER'S PLAN OF C ACH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 278	(Cognitive Patterns term memory problem daily decision making According to the Arrassessed under Seas being always incomplete as being always continent of At 11:35 a.m. on 9/Nurse), one of three interviewed regarding and bowel assessment of always assessment of always bowel was incorrect.	sessed under Section C) as having short and long ems with severely impaired ng skills. Inual MDS, Resident # 9 was action H (Bladder and Bowel) continent of bladder and bowel. Ost recent Quarterly MDS, the sed under Section H as being bladder and bowel. 6/17, RN # 6 (Registered e MDS Coordinators, was ng the discrepancy in bladder ments between the Annual and after checking her records, and one of the other MDS 6 said the Quarterly ays continent of bladder and t. RN # 6 went on the say that		278			
F 280 SS=D	been the same as ti.e., always inconting a meeting a included the Admin Administrator in Tra Nursing, and the su assessment of Res status was discussed 483.10(c)(2)(i-ii,iv,v) PARTICIPATE PLA 483.10(c)(2) The right to p	at Section H should have he Annual MDS at Section H, ent of bladder and bowel. It 4:30 p.m. on 9/6/17, that istrator in Training, the aining Mentor, the Director of cryey team, the incorrect ident # 9's bladder and bowel ed. In (3),483.21(b)(2) RIGHT TO NNING CARE-REVISE CP articipate in the development of his or her person-centered		280 :			

FORM APPROVED OMB NO. 0938-0391

A٦	EMENT OF	DEFICIENCIES
ID	PLAN OF C	ORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

С

495326

B. WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE 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

F 280

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 280 Continued From page 37 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.
- (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

F280

- 1. Resident #9's plan of care was revised to address continuing weight loss by the Minimum Data Set Coordinator on 9/14/17.
 - Resident #3's care plan was updated by Minimum Data Set Coordinator on 9/20/2017 to include physician order for leave of absence.
- 2. A facility wide audit of the plan of care for current residents who are at risk for weight loss was conducted by Minimum Data Set Coordinator on 9/09/2017. Any negative findings were corrected at that time. A facility wide audit for current residents having physician orders related to permission for leave of absence was completed on 9/22/2017 by a registered nurse. Any negative findings were corrected at that time.
- 3. Licensed nurses to include Minimum Data Set department will be reeducated related to weight loss care planning and leave of absence by on 9/19/2017.
- 4. The Minimum Data Set Coordinator or designee will conduct audits of 5 residents with weight loss's plan of care and for leave of absence for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
- 5. Completion date 10/3/2017

FORM APPROVED OMB NO. 0938-0391

CENTER	O LOU MEDIOWILE	A MEDICAID SERVICES				1VID 110. 0000 0001		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495326	B. WING		·	C 09/11/2017		
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTH		STRE 1150	EET ADDRESS, CITY, STATE, ZIP CODE NORTHWEST DRIVE ARLOTTESVILLE, VA 22901	1 09/11/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION		
F 280	(ii) Developed within the comprehensive (iii) Prepared by an includes but is not lie. (A) The attending processed in the resident. (B) A registered nurresident. (C) A nurse aide wiresident. (D) A member of force (E) To the extent processed in the resident and the An explanation murmedical record if the and their resident root practicable for resident's care plant (F) Other appropriate disciplines as deterior as requested by (iii) Reviewed and it team after each as comprehensive and assessments.	re care plan must be- n 7 days after completion of assessment. interdisciplinary team, that limited to ohysician. rse with responsibility for the th responsibility for the od and nutrition services staff. racticable, the participation of eresident's representative(s). It is to encluded in a resident's representative is determined the development of the number of the number of the resident. attention of the resident's needs the resident. revised by the interdisciplinary sessment, including both the discussion of the number of	F 2	280				
	by: Based on clinical r	NT is not met as evidenced record review and staff record failed for two of 24						

Facility ID: VA0079

residents in the survey sample (Residents # 3

		AND HUMAN SERVICES				FORM A	09, 19,20 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495326	B. WING				C 11/2017
NAME OF PROVIDER OR CHARLOTTESVILLE		REHABILITATION AND HEALTHO	CA	11	TREET ADDRESS, CITY, STATE, ZIP CODE 50 NORTHWEST DRIVE HARLOTTESVILLE, VA 22901		
PREEIX (EACH [DEFICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
care. For revise the and perso Absences 9, the facil	eview an Resident plan of c nal respo taken by ity failed	age 39 ad revise the residents' plan of t # 3, the facility failed to are to address expectations onsibilities regarding Leaves of the resident. For Resident # to revise the plan of care to angloss of weight.	F 2	280			
1. The fac	cility faile	d to revise the plan of care of dress a continuing loss of					

The findings include:

weight.

1. The facility failed to revise the plan of care of Resident # 9 to address a continuing loss of weight.

2. The facility staff failed to review and revise the

interventions concerning Resident #3 Leave of

CCP (comprehensive care plan) with

Absences without supervision.

Resident #9 in the survey sample, a 55 year-old female, was admitted to the facility on 4/6/12 with diagnoses that included dementia with behavioral disturbances, hyperlipidemia, Vitamin D deficiency, candidiasis, dysphagia, pain, depressive disorder, diabetes mellitus, rheumatoid arthritis, and Non-Alzheimer's Dementia. According to the most recent Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/30/17, and the most recent Quarterly MDS, with an ARD of 7/30/17, the resident was assessed under Section C (Cognitive Patterns) as having short and long

If continuation sheet Page 40 of 135

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		AND HUMAN SERVICES				FORI	M APPROVED
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	D. 0938-0391 ATE SURVEY OMPLETED
		495326	B. WING			0!	C 9/ 11/2017
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	:A	115	REET ADDRESS, CITY, STATE, ZIP CODE 50 NORTHWEST DRIVE HARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	daily decision making Under Section G (F) Annual and Quarter assessed as totally physical assist for expression of the section	ems with severely impaired ng skills. Functional Status) on the rly MDS's, the resident was dependent with one person eating, indicating Resident # 9 herself and needed to be fed e plan, with an initiation date of the following problem in the Potential for alteration in metabolic imbalance r/t is type 2 with a, resident with weight loss." oblem was, "Resident will tolerated consistency during	F 2	80			

Review of the weight record in Resident #9's Electronic Health Record revealed the resident's

Resident # 9 had a CCD (Controlled

10/24/16.

Carbohydrate Diet) with pureed texture and large portions at all meals. The resident also had an order for Magic Cup, a dietary supplement, four times a day. The Magic Cup order was dated

FORM APPROVED

OMB NO 0938-0391

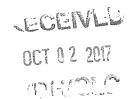
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	·			OMB N	<u> </u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495326	B. WING			0:	C 9/11/2017	
NAME OF	PROVIDER OR SUPPLIER		·	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
CHADIC	TTERVILLE DOINTE	REHABILITATION AND HEALTHO	.	1	1150 NORTHWEST DRIVE			
CHARLO	THESVILLE POINTE	REHABILITATION AND REALTHO	,,,	(CHARLOTTESVILLE, VA 22901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 280	Continued From pa	ngo 41	F 3	280				
1 200		· ·	i Z	200	,			
		as 154 pounds, and on 10/3/16 I.6 pounds, for a loss of 37.6						
	pounds (19.6%) in							
	,	•						
		plan for nutrition, initiated on						
		ffer pro-active interventions to						
	address the weight loss of 37.6 pounds in 180 days. The intervention "Receives supplements							
	per order" was for the Magic Cup, which had							
	been in place since	- ·						
		t 4:30 p.m. on 9/6/17, that						
		istrator in Training, the aining Mentor, the Director of						
		urvey team, the lack of						
		tions to address Resident # 9's						
	weight loss was dis	scussed.						
	_							
		failed to review and revise the						
	CCP (comprehensi	re care plan) with erning Resident #3 Leave of						
	Absences without s							
		·						
		himself out of the facility on						
		ately 4:30 p.m. and did not						
		nt was found the next morning 5 hours later) under a bridge						
	by EMS (emergence	cy medical services) with loss						
		The resident was taken to the						
	emergency departn	nent and subsequently						
	admitted for 4 days							
	During a complaint	investigation on 95/17 through						
		B's clinical record was						
	reviewed.							
	Resident #3's curre	ent POS (physician's order						
	sheet) was reviewe	d. The POS included an order						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VWGC11

Facility ID: VA0079

If continuation sheet Page 42 of 135



FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICARD SERVICES				Ui'	CIVID IVO. U930-U3	
IDENTIFICATION NUMBER			(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED	
					С	
		495326	B. WING _		09/11/2017	
	OVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	CA	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	

F 280 Continued From page 42

for, but not limited to: "...May go out on pass: Yes () No () With meds () without meds () May have annual flu vaccine: Yes (X) No () May have pneumococcal vaccine: Yes (X) No () PPD: Yes (X) No ()..." The date for this order was dated 7/11/17 and was listed as an 'Active' order.

The area to be marked [by an X] to indicate if the resident was able to go out on pass was blank, therefore the resident did not have a current physician's order for the resident to be able to leave the facility with or without medications.

The resident did not have a current active physician's order to go out on pass with or without medications.

Resident #3's CCP (comprehensive care plan) prior to 8/3/17 (the day the resident signed himself out of the facility) was reviewed and documented, '...4/4/17...activity...he is a smoker and socializes in the gazebo...5/11/17...instruct resident about smoking risks and hazards and about smoking cessation, instruct resident about the facility smoking policy, locations, times, safety concerns, notify charge nurse immediately if it is suspected resident has violated facility smoking policy, the resident requires SUPERVISION while smoking...encourage resident to maintain communication with his family, SW [social worker] and his relationships with his peers in the facility...7/11/17...IV medications...administer antibiotic via PICC...'

The resident's current CCP after 8/3/17 was reviewed and documented, '...4/5/17 he is a smoker and socializes in the gazebo...05/11/17...instruct resident about

F 280

FORM APPROVED OMB NO 0938-0391

	10 I OI INEDIONIL	A MEDICAID SERVICES				VIVID IVC	7. 0930 - 039 i
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		405000	D MING				С
		495326	B. WING			09	/11/2017
NAME OF I	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
				1150	NORTHWEST DRIVE		
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTHO	A		ARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	cessation, instruct resmoking policy, local notify charge nurse resident has violate resident requires Sismoking8/9/17 reappointment out of symptoms, non-corrof building with PIC my feelings about the risk of my non-comeself out while having (PICC)notify my repractitioner of any hypractices as needed practices/behaviors	hazards and about smoking resident about the facility ations, times, safety concerns, immediately if it is suspected at facility smoking policy, the UPERVISION while isident refused to go to facility8/9/17behavioral impliance with signing self out C lineallow me to verbalize the situation, educate me on plianceexplain risk of signing g IV access device epresentative, physician/nurse mazardous items/unsafe dobserve me for any unsafe	F 2	80			
	to reflect any inform regarding the reside without supervision regarding the reside facility for any type leaving the grounds supervision. On 9/6/17 at approx DON were made as the resident's CCP. CCP had been upd	was not reviewed and revised nation and/or documentation ent leaving the facility with or and no interventions ent signing himself out of the of LOA, for a pass, or for s of the facility without eximately 4:50 p.m., the AA and ware of concerns regarding. The DON stated that the ated for Resident #3.					

F 281 483.21(b)(3)(i) SERVICES PROVIDED MEET

Facility ID: VA0079

F 281

If continuation sheet Page 44 of 135



		I AND HUMAN SERVICES E & MEDICAID SERVICES				FRINTED. 09/19/20 FORM APPROVE OMB NO. 0938-03:
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		495326	B. WING		<u> </u>	09/11/2017
	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTHO	DA	1150	ET ADDRESS, CITY, STATE, NORTHWEST DRIVE RLOTTESVILLE, VA 22	ZIP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	< ·	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	OTION SHOULD BE COMPLETIC OTHE APPROPRIATE DATE
F 281 SS=D	Continued From pa		F 2	81		
	(b)(3) Comprehens			F281 1.	Resident #18 med	ication was labeled
	The services provice as outlined by the comust-	ded or arranged by the facility, comprehensive care plan,			#18 discharged from	ve outcome. Resident
	This REQUIREMENT by: Based on medicating staff interview, and facility staff failed to	al standards of quality. NT is not met as evidenced on pass and pour observation, facility document review, the o follow professional standards ving medications for one of 24 : #18.			to labeling on 9/19	as conducted by /2017. vere re-educated on istration as it pertains
	09/06/2017, a medi 50 MG TABLET" (a was labeled with ina administration infor physician orders or Findings were: A medication pass conducted on 09/06 approximately 8:05	pass and pour observation on ication card for "ATENOLOL blood pressure medication), accurate medication mation as compared to the the electronic medical record. and pour observation was 6/2017 beginning at a.m. LPN (licensed practical erved preparing medications		4.	to medication adn emphasis on prop The Director of N conduct audits of medications for co for 4 weeks and n to ensure complia	er labeling. urses or designee will 5 residents orrect labeling weekly nonthly for 2 months ance. The findings of be forwarded to the

nurse) # 1 was observed preparing medications for Resident #18.

Resident #18 was admitted to the facility on 03/10/2017. His diagnoses included but were not limited to: Cerebrovascular disease with hemiplegia, hypertension, osteoporosis and osteopathic.

The initial MDS with an ARD (assessment

months for any follow up that may be

5. Completion date 10/3/2017

needed.

\$ to 2 4 Chapta 3333

Facility ID: VA0079

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

С

495326

B. WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE

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 45

reference date) of 03/17/2017. Resident #18 was assessed as having a cognitive summary score of "13", indicating he was cognitively intact.

During the preparation of medications for Resident #18, the medication card for Atenolol was pulled by LPN # 1. Directions on the card were listed as "ATENOLOL 50 MG TABLET give 1 tab by mouth every day". LPN # 1 donned a pair of nonsterile gloves, popped a pill out of the medication card, broke it in half, threw half away and put the other half in the medication cup. This surveyor asked her what she just did. LPN # 1 stated, "The order on the computer is for 25 mg, I have 50 mg tablets. I just broke it in half to give him the 25 mg he needs and I threw the other half away." LPN # 1 was asked how she knew which source was correct, the medication card or the computer. She stated, "I always go by the computer... it is the most updated order." She was asked when the order changed from 50 mg to 25 mg. She looked at the computer and stated, "It looks like it changed around August 24th...we normally use the card up if we can before they send us a new one." LPN # 1 looked in the medication cart drawers and stated, "We have stickers to put on there when it changes, but I don't see any in here [medication cart drawers]."

The DON (Director of Nursing) was in the conference room at approximately 10:00 a.m., and the above information was discussed. She stated, "There should be a sticker on the card that the order changed, otherwise the nurse should verify with the physician which order is correct."

A policy/procedure regarding the use of the medication label stickers was requested and

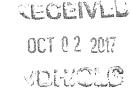
F 281

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VWGC11

Facility ID: VA0079

If continuation sheet Page 46 of 135



DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ **B WING** 495326 09/11/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1150 NORTHWEST DRIVE CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA CHARLOTTESVILLE, VA 22901 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID COMPLÉTION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 281 F 281 Continued From page 46 received. The policy "Reordering, Changing, and Discontinuing Orders", contained the following information: "Change Orders: ... If pharmacy receives a new order that changes the strength or dose of a medication previously ordered, and there is adequate supply on hand: ...Facility should notify Pharmacy not to send the medication and attach a "Change in Directions" sticker to the existing quantity of medications." The above information was discussed during meeting with the DON and the administrator on 09/06/2017 at approximately 5:15 p.m. The administrator stated, "We found the stickers, they are in the cart now.' No further information was obtained prior to the exit conference on 09/11/2017. F 314 F 314 483.25(b)(1) TREATMENT/SVCS TO SS=G 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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED C

09/11/2017

495326

STREET ADDRESS, CITY, STATE, ZIP CODE

1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

NAME OF PROVIDER OR SUPPLIER CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

TAG

ID SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX

REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX TAG

F 314

(X5) COMPLETION

F 314 Continued From page 47

This REQUIREMENT is not met as evidenced by:

Based on observation, resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to provide treatment and services for the prevention of pressure ulcers for two of 24 residents, Resident #14 and Resident #4.

- 1. The facility failed to prevent a facility acquired medical device related pressure ulcer for one of 24 residents, Resident #14. An unknown staff member placed a dressing over a wound on Resident #14's left leg stump. The dressing remained in place for an unknown length of time and when removed on 09/06/2017 the wound was an unstageable pressure ulcer . The most recent weekly skin observation sheet was dated 08/27/2017 and indicated no new skin issues. This resulted in harm.
- 2. The facility staff failed to provide weekly skin assessments for Resident # 4 for four weeks.

Findings were:

1. The facility failed to prevent a facility acquired medical device related pressure ulcer for one of 24 residents, Resident #14. An unknown staff member placed a dressing over a wound on Resident #14's left leg stump. The dressing remained in place for an unknown length of time and when removed on 09/06/2017 the wound was an unstageable pressure ulcer . The most recent weekly skin observation sheet was dated 08/27/2017 and indicated no new skin issues.

1. New wound assessments were done for Resident #14 and Resident #4 on 9/22/17 by a registered nurse also Resident#4 on 9/18/17. NA new RN Wound Care Nurse has been designated as of 9/22/17.

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

- 2. On 9/22/2017, the Director of Nurses / designee conducted an audit of all current residents for completed wound assessments. A 100% skin audit was completed by licensed nurses with the physician being notified of any new skin related issues found during audit process.
- 3. The Nursing Staff will reeducated on conducting timely and accurate wound assessments by Staff Development Coordinator or designee by 10/3/17. A protocol was initiated on 9/29/17 related to residents with prosthetic devices. A licensed nurse will evaluate the skin prior to and at removal of prosthetic device. Any changes in skin will be communicated to the physician. Licensed nurses will be inserviced beginning 9/29/17 regarding the protocol related to residents with prosthetic devices.
- 4. The Director of Nurses or designee will conduct audits of 5 residents wound assessments weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
- 5. Completion date 10/3/2017

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STATEMENT	OF	DEFICIE	NCIES
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	
A. BUILDING	

(X3) DATE SURVEY COMPLETED

495326

B. WING _____

09/11/2017

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE 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

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This resulted in harm.

Resident #14 was admitted to the facility on 05/05/2016. His diagnoses included but were not limited to: Bilateral BKA (below the knee amputations), atrial fibrillation, hypertension, diabetes mellitus with diabetic polyneuropathy, and acute respiratory failure.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/27/2017. Resident #14 was assessed as having a cognitive summary score of "04", indicating severe impairment with his cognitive status. However, Resident #14 answered the survey team's questions appropriately during a resident interview and during verbal interaction with the survey team members. Resident #14 was very hard of hearing and while this hindered his ability to understand, if spoken to directly and into his ear he answered and carried on a conversation with no difficulty.

Resident #14 was interviewed by a member of the survey team on 09/05/2017 at approximately 2:30 p.m. During the interview he pulled up his left pants leg to show the surveyor a dressing on his left leg stump. He stated that he had been asking for three weeks to go to the "leg doctor'...that his prosthetic leg had rubbed a spot on his stump.

On 09/06/2017 at approximately 8:00 a.m., Resident #14's clinical record was reviewed. Observed on the electronic physician orders was an order for weekly body audits. The TAR (treatment administration record) was reviewed. Two entries were checked off on 09/01/2017 and F 314

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED C
		495326	B. WING_			09	/11/2017
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F 314	Review of the program provide a correspondates regarding any Observation assess electronic record with assessment being "OBSERVATIONS" documented: "Doe issues?". The question of the conducted in September 2 was made assessments compared to the conducted in September 2 was in the with a member of the conducted in September 2 was not doing any owas not aware that This surveyor went #14 resided on 09/6	dy audits were completed. ress note section did not anding note for either of those by skin issues. Weekly Skin sments were observed in the ith the last recorded 08/27/2017. Under the section, the following information was as the resident have any skin stion was answered "No." ekly Skin Observation oleted for the body audits ember. 2:00 a.m., RN (registered one of the wound nurses at the conference room to speak the survey team. She was being dressing changes for #14). She stated that she dressing changes with him and the had a wound. 1:06/2017 at approximately 9:15	F3	14:			
	dressing on one of "Yeah", and pulled stump. Observed of dressing. An area the bandage. Ther to indicate when the	was asked if he had a his legs. Resident #14 stated, up his pants leg on his left leg was a square border gauze of drainage was observed on the was no date, time or initials the dressing had been applied or Resident #14 was asked who					

Facility ID: VA0079

put the dressing on his leg and how long it had been there. He stated, "It's been on there for three days...one of the girls here put it on there, I don't remember which one...it's came from trying to wear my legs....you want to see it? I'll take it [the dressing] off of there." Resident #14 was

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(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

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495326

B. WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE

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

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asked to leave the dressing in place until this surveyor could get a staff person in the room to assist him.

This surveyor went out into the hallway and asked RN # 7 if she knew anything about a dressing on Resident #14's leg. She stated, "I've worked here since last Thursday...this is the first time I have been on this hall, I don't know anything about these residents, I am just giving medications." This surveyor then went to the other side of the unit. RN # 3 was observed in an office with his cell phone in hand. He came out to speak with this surveyor. He was asked if he knew anything about Resident #14. He stated that he did not work that end of the hall. He was asked who the unit manager was. He stated "We don't have a unit manager so [Name of the Director of Nursing] is who we go to."

This surveyor went to the DON's office. The DON was asked who could discuss the dressing on Resident #14's leg. She directed this surveyor to RN #2, who was the other wound nurse at the facility. RN #2 was busy with another resident.

At approximately 10:00 a.m., this surveyor met RN #2 in the hallway. RN #2 was asked if she knew anything about a dressing over a wound on Resident #14's leg. She stated, "I just heard about that." This surveyor, RN #2 and the medical director went to Resident #14's room. The dressing had been removed from his left leg stump. The wound was covered with a scab. The medical director, lifted the scab up stating, "This is a mobile scab." The wound nurse was asked to measure the wound. She measured the area underneath the scab and stated, "It is 1.2 X 1 X .2" She was asked what the yellow area

F 314

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F 314	stated, "That's slou were rolled and brig nurse was asked w wound as. She sta director stated, "I w Stage 3it's about director asked Residressing had been days" The medic if he knew what day #14 stated, "It's We September 6th or 7	n of the wound was. She gh". The edges of the wound ght pink in color. The wound that she would stage the ted, "A three." The medical rould call it a stage 2 or a the depth." The medical ident #14 how long the in place. He stated, "Three tal director asked Resident #14 y it was or the date. Resident ednesday isn't iteither	F 3	14			
	extremity]. Resident nurse. Resident hat area. MD gave dressing change (coleanser, apply hydrogauze q [every] day MD gave consult rewith amputation clirevaluation and trea MD educated resid time" A copy of the facility the staging of pressived. According	nt was assessed by MD and as stag [sic] II pressure ulcer to be treatment order for daily leanse area with wound lrogel and cover with border of shift and PRN [as needed]). Eferral to resident to follow up nic at [name of office] for the to not wear shrinker at this by reference and guidelines for sure ulcers was requested and ag to the document provided, ion Guide-2016 NPUAP					

[National Pressure Ulcer Advisory Panel]" a stage II Pressure ulcer is described as: "The

moist...Granulation tissue, slough and eschar are not present." A stage III pressure ulcer is

wound bed is viable, pink or red,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

495326

B. WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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)

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

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(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION DATE

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described as: "...granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible." An unstageable pressure ulcer is described as: "Extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If the slough or eschar is removed, a Stage III or Stage IV pressure injury will be revealed."

During an end of the day meeting on 09/06/2017, the staging of Resident #14's pressure ulcer was discussed with RN #2, the administrator and the DON. RN #2 stated, "The doctor called it a 2 so that's what I wrote." RN #2 was asked based on the facility guidelines what would she stage the pressure ulcer as. She stated, "A three or unstageable." RN #2 was asked if she would discuss the wound with the medical director and let this surveyor know the following morning what had been decided regarding the staging of the wound. RN #2 agreed.

On 09/07/2017 at approximately 8:00 a.m., the administrator was in the conference room speaking with the survey team. She was asked if RN #2 was ready to speak with this surveyor regarding the staging of Resident #14's pressure ulcer. The administrator stated, "Oh, yesterday was her last day...she doesn't work here anymore...we can call her if you want to talk to her." This surveyor voiced concern that RN #2 was suppose to discuss Resident #14's pressure wound that morning. The administrator stated, "Oh she talked to [name of physician] about it last night...we are sending him [Resident #14] to the wound clinic today."

The medical director came to the conference room to speak with the surveyors at

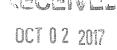
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FORM APPROVED OMB NO. 0938-0391

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

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B. WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE

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)

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approximately 10:00 a.m. Resident #14's pressure ulcer was discussed. He stated that a wound specialist was coming in to look at the wound and would determine how it should be staged but he (medical director) felt it should be classified as unstageable.

At approximately 12:15 p.m., the wound specialist arrived at the facility. This surveyor accompanied him to Resident #14's room. He removed the bandage and stated, "It's unstageable...you cant stage that." He lifted up the scab that was present and pulled it off. He stated, "I'm just debriding this a little." He then looked at the underlying wound. He stated, "It's all about the base...the base of this wound is covered with slough...there is some granulation tissue but it is mainly slough...we don't know what is under there...it's unstageable and if we had to give it a stage it would minimally be a three....this is a medical device related pressure ulcer that has come from his prosthetic legs."

The above information was discussed with the administrator, the administrator in training (AIT), the DON, and other facility staff during an end of the day meeting on 09/07/2017. Concerns of were voiced that the wound had been covered without treatment orders by someone in the facility, not reported to the physician, and when discovered by the survey team was determined to be unstageable by the wound specialist. The DON was asked what her expectation would be if a pressure ulcer was identified by staff. She stated, "The doctor should be notified and orders obtained for treatment." The facility staff were informed that due to the severity of the pressure ulcer at the time of discovery, the lack of weekly skin observation assessments and the initiation of F 314

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STATEMENT	OF DEFICIENCIES
AND PLAN O	F CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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(X3) DATE SURVEY COMPLETED

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B. WING _____

09/11/2017

NAME OF PROVIDER OR SUPPLIER

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STREET ADDRESS, CITY, STATE, ZIP CODE

1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

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DEFICIENCY)

(X5) COMPLETION DATE

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treatment by an unknown staff member without orders, the survey team had identified harm.

On 09/11/2017, at approximately 9:00 a.m., the Administrator and the AIT came to the conference room to present additional information to the survey team. Included in the information were facility policies for wound care, "Dressing, Dry/Clean" and "Skin and Wound Care Program". The "Dressing, Dry/Clean" policy contained the following instruction: "Verify that there is a physician's order for this procedure." The "Skin and Wound Care Program" policy contained the following statement: "The licensed nurse will assess skin weekly and report concerns to the Director of Nursing and the Physician." The administrator and the AIT were asked if any documentation associated with the skin audits checked off as completed on 09/01/2017 and 09/02/2017 had been located. The administrator stated, "Not at this time." A copy of all progress notes and orders from 09/07/2017 through 09/11/2017 were requested.

Review of the presented documentation from 09/07/2017 through 09/11/2017 contained a note from the wound specialist. The note contained the following information: "KEY FINDINGS: L [left] stump with 1.5 X .5 full thickness wound which debrided easily to a yellow/pink granulated bed 20/80% slough. No evidence of infection. ASSESSMENT AND PLAN: 1) Medical device related pressure injury unstageable. Start Silvasorb gel to area daily with border gauze. Resident should not wear prosthesis until wound closure. 2) Debility - -Continue LTC [long term care]. Have prosthetics and orthotics come in here to evaluated fitment of shrinker/device."

F 314

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FORM APPROVED OMB NO. 0938-0391

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		495326	B. WING			C 09/11/2017
	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTH	CA	1150	EET ADDRESS, CITY, STATE, ZIP CODE) NORTHWEST DRIVE ARLOTTESVILLE, VA 22901	
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F 314	Continued From pa No further informat exit conference on This is a complaint	ion was presented prior to the 09/11/2017.	F3	314		
	2. Resident #4 (R wound assessmen	4) did not have completed ts for four weeks.				
	Findings include: R 4 was admitted t readmission on 9/1 pressure ulcers.	o the facility on 2/11/17 with a /17 with diagnoses including				
	significant change (assessment refere	IDS (minimum data set) was a assessment with an ARD ence date) of 5/26/17. R 4 was severely cognitively impaired.	3			
	and evidenced, via (dated 7/14/17 and two pressure ulcer that were being tre documentation or assessments were through 8/21/17 (vi when R 4 had bee	cord was reviewed on 9/5/17 weekly wound care notes 7/20/17) that R 4 had stage s on the sacrum and left heel ated. There were no evidence that weekly wound being done after 7/20/17 felding 4 missed assessments) n discharged to the hospital. R with the same pressure ulcers				
	acting facility wour	a.m. an interview with the nd nurse took place (registered #4 verbalized that she works		ı		

Facility ID: VA0079

FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED				
		495326	B. WING			1	C / 11/2017	
NAME OF PROVIDER OR SUPPLIER CHARLOTTESVILLE POINTE REHABILITATION AND HEALTH			CA	1150	ET ADDRESS, CITY, STATE, ZIP CODE NORTHWEST DRIVE RLOTTESVILLE, VA 22901			
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F 314	Saturday, Sunday, RN #4 verbalized the electronic record and any assessments, documents the wood electronic record. If any paper document were done. RN 4 verbalized the other of document the assessments. RN went on leave for the and when she camplaced in a different not the wound nursing the second assessments.	ays RN #4 works are Tuesday, and Wednesday. That she wasn't familiar with the and was unable to document but another wound nurse and assessments in the RN #4 was asked if she had antation that the assessments werbalized that she did not wound nurse was supposed to	F	314				
F 322 SS=D	presented to the ac nursing. On 9/7/17 verbalized that she wound assessmen No other information conference on 9/11 This is a complaint 483.25(g)(4)(5) NG RESTORE EATING (g) Assisted nutrition (Includes naso-gase both percutaneous	on was provided prior to exit /17. deficiency. G TREATMENT/SERVICES - G SKILLS	F:	322				



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DEPARTMENT OF HEALTH AND HUMAN SERVICES						ORM APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·				3 NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(×	(3) DATE SURVEY COMPLETED	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	1G			
					and the second of the second o		С
		495326	B. WING				09/11/2017
NAME OF F	PROVIDER OR SUPPLIER				DRESS, CITY, STATE, Z	IP CODE	
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTH	CA		HWEST DRIVE FTESVILLE, VA 229	901	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E/	PROVIDER'S PLAN OF ACH CORRECTIVE ACT OSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIA	
F 322	(4) A resident who alone or with assist methods unless the demonstrates that indicated and cons (5) A resident who receives the approtorestore, if possib prevent complication but not limited to asyomiting, dehydraticand nasal-pharyng This REQUIREME by: Based on observation policy review and of facility staff failed to gastrostomy compining the survey sampfailed to check place prior to administrate determine the residual administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place prior to administration of movement of the survey sampfailed to check place place place prior to administration of the survey sampfailed to check place place place place place place plac	seed on a resident's sessment, the facility must ent- has been able to eat enough tance is not fed by enteral e resident's clinical condition enteral feeding was clinically ented to by the resident; and is fed by enteral means priate treatment and services ole, oral eating skills and to ons of enteral feeding including spiration pneumonia, diarrhea, ion, metabolic abnormalities, eal ulcers. NT is not met as evidenced ation, staff interview, facility clinical record review, the o provide care to prevent lications for one of 24 residents ole. For Resident #19, a nurse cement of the gastrostomy tube tion of medications; failed to dual volume prior to nedications; failed to administer redered; and pushed gh the gastrostomy with a allowing them to infuse by	6	F322 1. 2. 3.	Resident #19 w registered nurs outcome on 9/Resident #19 is appropriate gas All residents rehave the ability. Licensed nurse Staff Developed designee regargastrostomy careturn competer received 1:1 in medication administer on 9/21/The Director of conduct compelicensed nurses care weekly for 2 months to findings of the forwarded to the Committee for up that may be Completion data.	se with no not 15/2017. s currently is strostomy care equiring entry to be affected will be rement Coording appropare by 10/03 ency. Liceral service regiministration /17. of Nurses or etency testing or 4 weeks a consure conserving or 4 weeks a conserving or 4 we	receiving are. reral feeding eted. reducated by inator or oriate 8/2017 with east Nurse #2 garding a by Registered designee will eng of 5 gastrostomy and monthly empliance. The will be Assurance for any follow
	The findings include	de:					

Facility ID: VA0079

Resident #19 was admitted to the facility on

3/1/17 with a re-admission on 5/25/17.

Diagnoses for Resident #19 included paraplegia, anemia, neurogenic bladder, dysphagia with

FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495326		` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 09/11/2017			
		B. WING	***************************************					
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	:A	115	REET ADDRESS, CITY, STATE, ZIP CODE 0 NORTHWEST DRIVE ARLOTTESVILLE, VA 22901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Χ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 322	Continued From pa	ae 58	F3	322				
	gastrostomy, press	ure sores and cellulitis. The MDS) dated 8/2/17 assessed						
	9/6/17 at 8:20 a.m. (LPN) #2 administer #19. LPN #2 administer #19. LPN #2 administer #19. LPN #2 failed to check pube prior to administer determine residual medications and far for water flushes the between medication were pushed with a	observation was conducted on with licensed practical nurse bring medications to Resident instered medication to gh a gastrostomy tube. LPN blacement of the gastrostomy istering medications, failed to volume amount prior to giving iled to follow physician orders trough the tube prior to and ins. In addition the medicines a syringe into the gastrostomy the medications and water to						
	following medication Sulfate 325 mg (minus 5 mg. Magnesium)	a.m. LPN #2 prepared the ons for Resident #19: Ferrous Illigrams), Oxybutynin chloride oxide 400 mg, multivitamin and axative with Colace 50 mg (2						
	separate medicine resident's tube feed running at 60 cc's (and clamped the tufirst cup of crushed of water and stirred medicine mix from The gastrostomy tuchecked prior to ac LPN #2 did not det gastric contents pr	cup. LPN #2 disconnected the cup. LPN #2 disconnected the ding (Two Cal HN) that was (cubic centimeters) per hour ubing. LPN #2 then mixed the medicine with a small amount dit to mix. LPN #2 pulled the the cup into a large syringe. Ube placement was not diministering the medicines. Ermine any residual volume of for to giving medicines.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VWGC11

Facility ID: VA0079

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FORM APPROVED
OMB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES	<u> </u>	MD MO. 0930-039 I	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
	495326	B. WING		C 09/11/2017
NAME OF PROVIDER OR SUPPLIER CHARLOTTESVILLE POINTE	REHABILITATION AND HEALTH	CA	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIO X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
:				

F 322 Continued From page 59

first medicine mixture into the gastrostomy tube with the syringe. Without administering any water into the tube, the next crushed medicine mix was pushed into the gastrostomy tube with the syringe. LPN #2 followed the second medication mix with a small amount of water. LPN #2 proceeded to administer the other medicines pushing them with the syringe into the gastrostomy with each followed by a small amount of water.

Resident #19's clinical record documented a physician's order dated 4/28/17 for Two Cal HN tube feeding formula to infuse at 60 cc's per hour for 12 hours each day (on at 8:00 p.m. and off at 8:00 a.m.). The clinical record also documented a physician's order dated 4/28/17 stating, "Flush tube [gastrostomy] with 60 cc free water before and 30 cc between meds [medicines]." The resident's plan of care (revised 8/24/17) stated the resident had a PEG (percutaneous endoscopic gastrostomy) due to severe protein calorie malnutrition. Interventions for care of the gastrostomy included, "Check for tube placement and gastric contents/residual volume per facility protocol and record."

On 9/6/17 at 8:55 a.m. LPN #2 was interviewed about not checking placement or determining the residual, the lack of water flushes and pushing the medicines with a syringe with Resident #19's gastrostomy. LPN #2 stated she was supposed to check placement of the gastrostomy before giving the medications. LPN #2 stated she usually flushed the gastrostomy tube prior to starting medications and she was supposed to flush the tube between each medicine as ordered. LPN #2 stated she forgot and realized she missed the flushes part way through the

F 322

PRINTED: 09/19/2017 FORM APPROVED OMB NO. 0938-0391

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495326	B. WING	i		Į.	
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
CHVDIU	TTESVILLE DOINTE	REHABILITATION AND HEALTHO	:Δ		0 NORTHWEST DRIVE		
CHARLO	TIESVILLE TONTE	REHADICITATION AND TIEACTION		СН	ARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	flushes. Concernina syringe instead of gravity, LPN #2 state difficult to flow by g gastrostomy. LPN very slow so she has mixture to get them. The facility's policy (revised November gastric residual volutied feeding (for bolus at to administration of hours (for continuous toleranceDraw up into syringe and contube Verify for place tube	and then started with the water ag pushing the medicines with allowing them to flow by ted the medicine mix was ravity into Resident #19's #2 stated the gravity flow was ad to push the medicine a through the tube. Ititled Gastrostomy Feeding (2016) stated, "Check ume (GRV) before each and intermittent feedings), prior medications and every 6 to 8 us feedings) to monitor to 10 to 30 ml [milliliters] air nnect to end of feeding cement by inject air into the l, pull back slowly and aspirate extric contentsDo not when a single GRV teds 100 ml [milliliters]Notify rationsUse 5 cc of water to tionAdminister medication eeding tube after ording to physician order" The reviewed with the lirector of nursing during a lat 2:10 p.m. 1)-(3) FREE OF ACCIDENT		322			
	(d) Accidents. The facility must er	nsure that -					

Facility ID: VA0079

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				٢١	RINTED: 09/19/201 FORM APPROVE
		& MEDICAID SERVICES			, 18 , 18	0	MB NO. 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	TIPLE CONS			(X3) DATE SURVEY COMPLETED
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		495326	B. WING				09/11/2017
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, Z	IP CODE	
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTH	CA		RTHWEST DRIVE OTTESVILLE, VA 229	901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT ROSS-REFERENCED TO 1 DEFICIENC	TION SHOULE THE APPROP	BE COMPLETIO
F 323	Continued From pa	nge 61	F3	323			
	(1) The resident en	vironment remains as free			4.6		
	from accident haza	rds as is possible; and		F323			
	(2) Each resident re	eceives adequate supervision vices to prevent accidents.		1	Resident #3's me	dical reco	ard was
	and assistance dev	nces to prevent accidents.		1.	updated on 9/22/		
	(n) - Bed Rails. Th	e facility must attempt to use			physician's order		
	appropriate alterna	tives prior to installing a side or					
	bed rail. If a bed or	r side rail is used, the facility			Resident #2 phys	ician s or	ders were
	must ensure correct	et installation, use, and			updated to includ		
	maintenance of be	d rails, including but not limited			mattress. Reside		
	to the following eler	ments.			assessment condu		9/13/2017
		dent for risk of entrapment			by licensed nurse A wandering asse		vas completed
	from bed rails prior	to installation.			for resident # 3 o		
	(2) Review the risks	s and benefits of bed rails with			services.		•
	the resident or resi	dent representative and obtain			All residents have	e the pote	ential to be
	informed consent p	orior to installation.			effected by timely		
	(a) *** (l. 1.15 -	to de dimensione ero		2.	An audit of curren	nt resider	nt's medical
	(3) Ensure that the	bed's dimensions are resident's size and weight.			records for leave	of absence	ce orders on
	This REQUIREME	NT is not met as evidenced			9/22/2017 by reg		
	by:				of side rail assess	ments we	ere conducted
	Based on resident	interview, staff interview,			to assure complia		
	clinical record revie	ew and facility document			on 9/07/2017. Ar		
1	review, the facility	staff failed to supervise a leave				· ·	dan ioi can
	of absence for one	of 24 residents in the survey ulted in harm (Resident #3) and			AME I		
	failed to ensure one	e of 24 residents was safe for			क्षेत्रके ने हा त		
	the use side rails (I	Resident #2) and failed to			esca		
	answer call bells in	a timely manner per the group			ingent Anglikang kangan		
	meeting.	-			A William Commence		
	_				gagaest e gagaest e		
	 The facility staff 	failed to ensure that Resident			*		

If continuation sheet Page 62 of 135



#3 had a current physician's order to leave the facility on a leave of absence and failed to locate the resident, when the resident was away from the facility for an extended amount of time, as a

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STATEMENT	OF	DEFICIENCIES
AND DLAN O		OPPECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONS	STRUCTION
	4.5
A RUII DING	100

(X3) DATE SURVEY COMPLETED

C

09/11/2017

495326

ID

TAG

STREET ADDRESS, CITY, STATE, ZIP CODE

1150 NORTHWEST DRIVE

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

CHARLOTTESVILLE, VA 22901 PREFIX

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

PRÉFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 323 Continued From page 62

result the resident left the facility and did not return. The resident was found the next day (approximately 13.5 hours later) under a bridge by EMS (emergency medical services) with loss of consciousness. The resident was taken to the emergency department and subsequently admitted for 4 days.

- 2. Resident #2 was found on the floor with her head wedged between the bed rail and the air mattress. The resident had no prior assessment for safe use of the bed rails and no physician's order for the use of a specialty air mattress. The resident suffered pain and bruising to her neck and back from the entrapment and was sent to the hospital for evaluation.
- 3. During the Group Meeting, residents complained of a lack of call bell response.

Findings include:

1. The facility staff failed to ensure that Resident #3 had a current physician's order to leave the facility on a leave of absence and failed to locate the resident, when the resident was away from the facility for an extended amount of time, as a result the resident left the facility and did not return. The resident was found the next day (approximately 13.5 hours later) under a bridge by EMS (emergency medical services) with loss of consciousness. The resident was taken to the emergency department and subsequently admitted for 4 days.

Resident #3 was originally admitted to the facility on 10/11/16, with a current readmission on

F 323

bell response times will be conducted by 10/3/2017 by Activity Director.

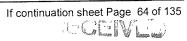
- 3. Nursing staff were reeducated on leave of absence orders and side rail assessments by licensed nurse by 10/3/2017. Staff will be reeducated on call bell responsiveness by Administrator or designee by 10/3/2017.
- 4. The Director of Nurses or designee will conduct audits of 5 residents medical records for LOA orders and side rail assessments weekly for 4 weeks and monthly for 2 months to ensure compliance. The Activity Director or designee will conduct 5 residents call bell responses weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
- 5. Completion date 10/3/2017

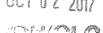
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		AND HUMAN SERVICES			FORM	M APPROVED D. 0938-0391
STATEMENT OF BELLOCETORS				TIPLE CONSTRUCTION	(X3) DA	TE SURVEY
		495326	B. WING			C 9/11/2017
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	:A	STREET ADDRESS, CITY, STATE 1150 NORTHWEST DRIVE		
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 323	but were not limited disorder, major dep amputation of the le weakness, difficulty cellulitis of the left I lymphedema and of the most current for assessment with C summary) was a siduted 07/18/17. The shaving a cognition resident had mode decision making shassessed as required one staff person for bathing. The residual walker and w/c (who resident was assessed the staff person for the previous 7 does not be received IV ABX (in the 7 day look bact triggered for cogniliving) and falls in the previous of the force of the score of '13', indicated in the previous of the score of '13', indicated in the previous of the score of '13', indicated in the previous of the score of '13', indicated in the previous of the score of '13', indicated in the previous of the score of '13', indicated in the previous of the score of '13', indicated in the score of '13', indicated in the previous of the score of '13', indicated in the s	es for Resident #3 included, d to: diabetes mellitus, anxiety pression, complete traumatic eft great toe, muscle walking, unsteadiness, ower limb, cough,	. F:	323		

resident was assessed as requiring supervision with setup for transfers and ambulation. The resident was assessed as using a walker for mobility. The resident was also assessed as receiving IV ABX and insulin during the previous 7





FORM APPROVED

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			C	<u>MB NO.</u>	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SUF	
		495326	B. WING				C 11/2017
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
CHARLO	TTECVILLE DOINTE	REHABILITATION AND HEALTHO		1150	NORTHWEST DRIVE		
CHARLO	1 1ESVILLE POINTE	REHABILITATION AND TICALITIE	<u> </u>	CHA	ARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 64	F 3	23 :			
	day look back.						
	complaint alleged in APS (adult protective (APS) received a case (emergency departed found under a bridge and highly intoxicate that the resident sign on 08/03/17 at appropriate that the resident has hospital. APS document that the resident has a complete fact that the resident in the fact that the resident is complete fact that	amed in a complaint. The in the intake information that we services) reported that they all from the hospital ED ment) that Resident #3 was see with loss of consciousness ed on 8/4/17. It was reported gned himself out of the facility roximately 4:30 p.m. The the facility to inform the facility deen admitted to the sumented concerns regarding plex medical history and that sident had a PICC (peripherally heter) in place and had left the inded amount of time and no y facility to attempt to locate the did not return in a service.					
	During a complaint through 09/07/17, F was reviewed.	investigation on 09/5/17 Resident #3's clinical record					
	for Resident #3 wer for 6:15 a.m. docur ems [emergency m bridge, unknown do elevated blood sug alcohol abuse, card non-responsive but [to hospital]per [n patient signed hims [08/03/17][history for osteomyelitis du	y department] provider notes re reviewed for 8/4/17, timed nented, 'found altered by edical services] under a own time or last seen normal, ar by fingerstickhistory of diac arrestseizurehe was able to talk upon EMS arrival ame of long term care facility] self out at 4:30 p.m. The was admitted to gerontology use to diabetic foot ulcer from eeks of IV vancomycin,					

Event ID: VWGC11

		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D. 09/19/2017 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495326	B. WING			0	C 9/11/2017
NAME OF PROVIDER OR SUPPLIER CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHO			:A	1150	ET ADDRESS, CITY, STATE, ZIP CODE NORTHWEST DRIVE		
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER'S PLAN OF CORRECTION SHOUNDER CROSS-REFERENCED TO THE APPROPRICE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	left basillic vein for glucose 641ethan It was documented units of IV insulin, I protocol initiated ar care unit] was consadmitted to the MIC	al flagylPICC was placed in IV antibiotics[current] nol 222' that the resident received 10 V fluids, insulin infusion nd the MICU [medical intensive sulted. The resident was CU, the current PICC line was	F3	323			
	not functioning and at time of discharge was placed on 8/7/ Resident #3's curre sheet) was reviewe for, but not limited Yes () No () Wit May have annual fl May have pneumon PPD: Yes (X) No (sion due to being completely I was cultured with no growth e on 8/7/17. A new PICC line 17 prior to discharge. ent POS (physician's order ed. The POS included an order to: "May go out on pass: h meds () without meds () u vaccine: Yes (X) No () coccal vaccine: Yes (X) No ())" The date for this order and was listed as an 'Active'					
	resident was able therefore the resident physician's order for leave the facility with the resident did not be able to the res	rked [by an X] to indicate if the to go out on pass was blank, ent did not have a current or the resident to be able to th or without medications. ot have a current active or go out on pass with or without					
	Resident #3's CCF	(comprehensive care plan)					

prior to 8/3/17 (the day the resident signed himself out of the facility) was reviewed and documented, '...4/4/17...activity...he is a smoker and socializes in the gazebo...5/11/17...instruct

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/19/2017

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		& MEDICAID SERVICES	1				<u> </u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUILI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				115	0 NORTHWEST DRIVE		
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTH	 	СН	ARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	about smoking cest the facility smoking concerns, notify chasuspected resident policy, the resident smokingencourage communication with worker] and his related facility7/11/17IV antibiotic via PICC. There was no inform in the resident's Containing permissional leave the facility with was no information himself out of the fact a pass, or for leaving without supervision. The resident's curreviewed and docust smoker and sociality gazebo05/11/17smoking risks and cessation, instruct a smoking policy, locustify charge nurse resident has violated.	king risks and hazards and sation, instruct resident about policy, locations, times, safety arge nurse immediately if it is has violated facility smoking requires SUPERVISION while ge resident to maintain his family, SW [social ationships with his peers in the medicationsadminister' mation and/or documentation CP regarding the resident and/or a physician's order to the or without supervision, there about the resident signing acility for any type of LOA, for any type of LOA, for any the grounds of the facility sent CCP after 8/3/17 was mented, '4/5/17 he is a zes in theinstruct resident about hazards and about smoking resident about the facility ations, times, safety concerns, immediately if it is suspected and facility smoking policy, the	F:	323	BEHOLING		
	resident requires S smoking8/9/17 re appointment out of symptoms, non-cor of building with PIC my feelings about trisk of my non-com	UPERVISION while esident refused to go to facility8/9/17behavioral mpliance with signing self out to lineallow me to verbalize he situation, educate me on uplianceexplain risk of signing g IV access device					

Facility ID: VA0079

(PICC)...notify my representative, physician/nurse

FRINIED. US/13/2011

		AND HUMAN SERVICES					M APPROVED D. 0938-0391	
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495326	B. WING		AMERICAN ACTION	09	C 9/ 11/2017	
NAME OF F	PROVIDER OR SUPPLIER		1	STF	REET ADDRESS, CITY, STATE, ZIP CODE			
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTHO	CA		0 NORTHWEST DRIVE ARLOTTESVILLE, VA 22901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 323	Continued From pa	age 67	F 3	323				
	practitioner of any had practices as neede practices/behaviors	nazardous items/unsafe dobserve me for any unsafe						
	in the resident's CC having permission leaving the facility there were not interesident signing hir	mation and/or documentation CP regarding the resident and/or a physician's order for with or without supervision, rventions regarding the mself out of the facility for any						
	grounds of the facilia A 'Wander Evaluation 5/4/17, which docu cognitively impaired skills (intermittent of decisions, etc.), and diagnosis of demeranxiety, delusions/lischizophrenia, and in communications documented that the would consist of exammary section of documented that the elopement or wand independently with glasseshas occa and major depression.	that the resident had deficits, vision or auditory. It was also he 'interventions' to be utilized kit/stairwell alarms. In the of this evaluation it was he resident 'is not an der risk ambulated his walker wears sional inattention has anxiety ion disorders'						
	on Resident #3 sin	ce 5/4/17. ents and/or evaluations could						

be located within the clinical record to evidence that Resident #3 was assessed by facility staff, as

FORM APPROVED OMB NO. 0938-0391

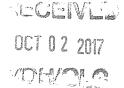
		& WEDICAID SERVICES	(V2) \$41 II	TID! E :	CONSTRUCTION	T	TE SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETE		
		495326	B. WING			00	C / 11/2017
NAME OF F	PROVIDER OR SUPPLIER	493320			REET ADDRESS, CITY, STATE, ZIP CODE	1 03	711/2017
					0 NORTHWEST DRIVE		
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTHO	A	CH	ARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 68	F	323			
	being a safe candid facility at anytime w	date to sign himself out of the with or without supervision.		The second second			
	Progress [nursing] August 1, 2017 thro	notes were reviewed from ough August 10, 2017.					
	the resident 'contin	8 a.m., it was documented that ues on abx via picc ed central catheter]purple ut red port is occluded'					
	'antibiotic iv for w	m., it was documented, ound L [left] foot cellulitis s on off unit using walker'					
	08/02/17 at 6:31 p. 'continues on IV.	m., it was documented,for wound infection'					
	08/03/17 at 2:31 a. 'continues on IV. removal of left great	m., it was documented,for infection and surgical at toe'					
	[created on 8/14/13] 'located under a hospital. SS [social referral as the facil himself as a reflect out of the facility.'	ig note dated 8/3/17 10:19 a.m. 7 at 10:26 p.m.] documented, bridge, and later went to the al services] created an APS ity staff feels he is a danger to tion of his choices while signed This note was created 11 days eft the facility and 7 days after eadmitted.					
	documented, 'Ree 8/3/17 at 4:30 p.m. [name of hospital] here [sic] and was found under bridge	ed 8/4/17 and timed 7:08 a.m., sident [sic] sign self out on and did not return. at this time called to ask if resident stay told yes, Nurse stated he was and brough [sic] to ER Social worker states walker is					:

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VWGC11

Facility ID: VA0079

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		AND HUMAN SERVICES					APPROVED
		& MEDICAID SERVICES				1	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION	COV	TE SURVEY MPLETED C
		495326	B. WING			1	/11/2017
NAME OF F	PROVIDER OR SUPPLIER		L	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
			.	1150	NORTHWEST DRIVE		
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTHO	A	CHA	ARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Κ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	[sic]' A 'late entry' nursing [created on 8/16/17 'was admitted on IV antibiotics wound diabetes education admission/readmissinformation' A 'late entry' nursing 10:26 a.m. [created a.m.] documented, yesterday, and the APS on today as the while signed out cohimself.' The resident's admand timed 6:03 p.m. 8/16/17) documented tobacco use: yes On 9/5/17 at 5:00 p administrator) was signing themselves On 9/6/17 at approximation of the process of the side of the process of the pr	g note dated 8/7/17 6:03 p.m. 1:37 a.m.] documented, 8/7/17 via stretchercontinue d care management of of health statesee sion evaluation for additional g note dated 8/8/17 and timed l on 8/14/17 and timed 10:27 'returned to the facility APS referral was submitted to e staff feels his recent choices uld make him a danger to ission evaluation dated 8/7/17 . (signed as completed on ed, 'alcohol use: yes, IVPICC' .m., the AA (acting asked for a policy on residents out of the facility. ximately 8:20 a.m., Resident	F 3	23	DEFICIENCY)		
	#3 was interviewed incident on 8/3/17, the facility. Reside signed himself, but 8/3/17. The reside	in his room regarding the when he signed himself out of nt #3 stated that he thought he couldn't remember for sure on nt stated that he had 'to get le' and stated that he was					

Facility ID: VA0079

extremely depressed during that time. The resident stated that his mother had passed away, as well as an uncle that he was very close to and

FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C
		495326	B. WING		09/11/2017
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	CA	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND SHOUN	JLD BE COMPLETION
F 323	uncle. The residen he was depressed. and stated that he is SW (social worker) here and wanted to move to assisted liviwon't try to help me stated that he is a chealth and that whe and drank 4 pints on he used to visit who stating he just need On 9/6/17 at approximation was no an investigation on above was then recresident's signing or requested. At approximately 3 administrator) state reported to state, he	e loss of his mother and/or t asked if he had told anyone. The resident stated, "Yes" had been speaking with the # 13 and that he did not like it try to get his own place or ving and that the SW # 13 e find a place.' The resident diabetic and isn't in the best en he left he was so depressed if Vodka and went to a bridge en he was a child, again ded to get away from it all. Eximately 10:40 a.m., the AA of nursing) were made aware ing Resident #3 and that this treported to the state agency, Resident #3 regarding the quested, again a policy on but of the facility was 145 p.m., the AA (acting ed, 'we would not have e is alert and oriented and	F 3	1	
	quite often, he was that time, the facilit leave of absence of themselves out of facility reported it to there may somethin about residents significantly. The admission pactors are survey team and described to the facility.	eave of absence], goes out homeless" The AA stated at y does not have a policy on a policy on residents signing the facility and stated that the APS. The AA then stated that ing in the admission packet ining themselves out of the exercise the provide any information is signing themselves out of the	t [:]		

Event ID: VWGC11

FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF	DEFICIENCIES
AND PLAN O	F C	ORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

X2) MULTIPLE CONSTRUCTION	
PHII DING	

(X3) DATE SURVEY COMPLETED

495326

B. WING

С 09/11/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1150 NORTHWEST DRIVE

CHARLOTTESVILLE, VA 22901

(X4) ID PRÉFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

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 71 facility for a LOA and/or a pass.

> A policy was presented on 'conducting a thorough investigation', which documented, 'When an actual and/or potential care and service failure occurs involving a resident, it is necessary for facility administration to initiate an investigation to determine the facts and then act upon or respond accordingly to the findings. Examples of issues that would require investigation...falls with injury or non-injury, allegations of abuse...elopement...."

A policy was presented on 'reporting abuse to state agencies and other entities' documented, 'All suspected violations and all substantiated incidents of abuse will be immediately reported...the facility administrator or his/her designee will promptly notify the following persons or agencies...a. The state licensing/certification agency responsible for surveying/licensing the facility..."

On 9/6/17 at 4:50 p.m., again concerns were raised by the survey team to the administrator, AA (assistant administrator), and DON regarding Resident #3 leaving the facility without being assessed as safe to sign out and that the resident was away from the facility and there was no evidence at all that staff attempted to locate the resident who had been away form the facility for approximately 13.5 hours. The facility staff were additionally made aware that there was no information in the admission packet regarding residents signing themselves out of the facility. The facility staff were also made aware that the sign out sheet that Resident #3 signed actually had another resident's name on top [a name similar to Resident #3] and that the sign out sheet clearly documented an area for 'signing [back] in'

F 323

FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF	DEFICIENCIES
AND PLAN O	F C	ORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

495326

B. WING

C **09/11/2017**

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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)

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

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 72

to the facility with a date, time and a signature of facility representative, that was completely blank.

No evidence was found that the facility attempted to locate the resident during the extended amount of leave from the facility. The facility had no policy and/or procedures to identify when a resident was gone from the facility for an extended amount of time or a policy and/or procedure to direct actions of staff in an event of this type. The facility staff did not assess the resident to determine if the resident was safe to leave the facility on a LOA and/or pass and the resident did not have a physician's order for the resident to leave the facility with or without supervision.

No further information and/or documentation was presented prior to the exit conference on 9/11/17 at 2:45 p.m.

The is a complaint deficiency.

2. Resident #2 was found on the floor with her head wedged between the bed rail and the air mattress. The resident had no prior assessment for safe use of the bed rails and no physician's order for the use of a specialty air mattress. The resident suffered pain and bruising to her neck and back from the entrapment.

Resident #2 was admitted to the facility on

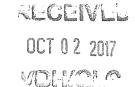
F 323

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Facility ID: VA0079

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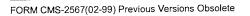


FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	: & MEDICAID SERVICES				JAID IAC). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED
		495326	B. WING			05	C 9/11/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTH	CA		0 NORTHWEST DRIVE ARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	7/13/17 with diagnor disorder, hypernatr blood), hyperkalem concentration in the high blood pressure dementia. The mir 7/26/17 assessed impaired cognitive	oses that included bipolar emia (excess sodium in the ia (high potassium e blood), depression, diabetes, e, anxiety, osteoporosis and himum data set (MDS) dated Resident #2 with severely skills.	F 3	.23			
	nursing note dated "Resident was obsorthe floor and he and the air mattres"	cal record documented a 7/17/17 at 3:05 a.m. stating, erved with her bottom sitting r head in between the bed rail s. Resident stated she was of the bed. No c/o [complaints					
	entrapment on 7/12 to go the emergence treatment. The em summary dated 7/12 coming from nursing the summary dated the su	notified of the resident's 7/17 and ordered the resident by room for evaluation and hergency room discharge 17/17 documented, "Patient ng home, found half way out of					
	caught within the ra anterior neck pain. consciousness] F throbbing, without onset. Worse with worse with movem shortness of breath of acute cervical spanterior right neck, tenderImaging re diagnosis of Neck visit"	e ground by neck and head ailings. Complaining of Denies LOC [loss of Pt's [patient's] pain is moderate radiation and unchanged from palpatiojn [palpation], not ent. No associated swelling or n, no dysphagiaNo evidence oine fractureminor trauma to no expanding mass, minimally eveals no acute injuryA pain was also pertinent to this					
	The resident return	ed to the facility from the					

emergency room on 7/17/17. A nursing note

		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()		CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED C
		495326	B. WING			09	9/11/2017
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	=	
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTHO	A		NORTHWEST DRIVE ARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOOD CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	"returned from EI with no new orders bruise to back. Res back when she atter from bed. Residen for Tylenol 325 mg mouth q. [every] 6 management is effect that the clinical record assessment for safe physician's order for prior to the entrapm. There was no evide Resident #2's responsible to the entrapm. There was no evide Resident #2's responsible to the entrapm. There was no evide Resident #2's responsible to the entrapm. There was no evide Resident #2's responsible to the entrapm. There is no evident admission assessment documented the resident was independent was independent was independent to the entrapm. The resident was independent to the entrapm. The resident splan 7/17/17) listed the resident to president to presi	24 p.m. documented, D [emergency department] Resident observed with sident reports that she hit her empted to walk and fell to floor t was in painorder obtained [milligrams] two tablets by hours. Resident reports pain ective" documented no prior the use of bed rails or a per the specialty air mattress then incident on 7/17/17. Thence of informed consent from the party (RP) or review efits and/or risks of side rail rapment. The resident's	F	323			
	a clutter free enviro	ies, call light within reach and nument. There was no use or a specialty air mattress					



prior to the entrapment incident on 7/17/17.

There was no facility investigation of Resident #2's entrapment on 7/17/17. The facility's

Event ID: VWGC11

Facility ID: VA0079

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		AND HUMAN SERVICES			FORM APPROVED
		& MEDICAID SERVICES	T		OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495326	B. WING		C 09/11/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE
CHARLO	OTTESVILLE POINTE	REHABILITATION AND HEALTH	.Δ.	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 323	unwitnessed fall on found with the side made no mention the head wedged between the resident of the rails in the bed where the resident of the entrapment inciresident's assessment for side air mattress. RN #3 siresident had been vails and the mattres clinical record and assessment for side air mattress. RN #3 assessment for side air mattress. RN #3 coordinator (RN #2 #2's entrapment was #2's entrapment was #2's entrapment was were residents.	ge 75 mented the resident had an 7/17/17 at 3:00 a.m. and was rails in the up position but he resident was found with her een the bed rail and the air dent form did not include the huse at the time or the area of resident was wedged. I.m. the registered nurse (RN dent #2 was interviewed about dent of 7/17/17 and the ent for bed rail use and the air tated he was not aware the wedged in between the side ass. RN #3 reviewed the stated he did not see an erail use or an order for the 3 stated he thought side rail done upon admission for all or. In the staff development at the time of the Resident as interviewed about any prior order for the side rails or the	F 323		
	air mattress. RN # prior assessment for	2 stated Resident #2 had no or safe use of side rails. RN not sure why the resident had			
	(DON) was intervie entrapment. The E specialty air mattre prior to use. The E safe use of bed rail	wed about Resident #2's ON stated the use of a ss required a physician's order ON stated assessment for s was supposed to be done on mission to the facility. The			

DON stated she was not aware of how or why the

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM ADDROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING C B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA (X3) DATE SURVEY COMPLETED C 09/11/2017 STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 09	
NAME OF PROVIDER OR SUPPLIER CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA INTEGRAL REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX TAG COntinued From page 76 resident had side rails in use with the air mattress. On 9/6/17 at 9:10 a.m. the administrator was interviewed about Resident #2's entrapment and lack of a prior assessment for side rail use or order for the specialty mattress. The administrator stated, "We [facility] don't have a policy about assessment for side rails." The administrator stated there was no side rail assessment for Resident #2 prior to the entrapment incident on 7/17/17. The administrator stated she was new and did not have access to all the policies but would continue looking for a side rail policy. On 9/6/17 at 2:10 p.m. the administrator stated	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '		(X3) DATE SU COMPLET	RVEY
The administrator stated there was no side rail assessment for Resident #2 prior to the entrapment incident on 7/17/17. The administrator stated there was no side rail species but would continue looking for a side rail policy. SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES PREFIX TAG) SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG) PREFIX TAG STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901 STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901 STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901 STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901 STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901 STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901 STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901 STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901 STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901 SUMMARY STATEMENT DRIVE CHARLOTTES			495326	B. WING		l l	2017
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE DATE DEFICIENCY) F 323 Continued From page 76 resident had side rails in use with the air mattress. On 9/6/17 at 9:10 a.m. the administrator was interviewed about Resident #2's entrapment and lack of a prior assessment for side rail use or order for the specialty mattress. The administrator stated the use of side rails was supposed to be triggered based upon the admission assessment. The administrator stated, "We [facility] don't have a policy about assessment for side rail assessment for Resident #2 prior to the entrapment incident on 7/17/17. The administrator stated she was new and did not have access to all the policies but would continue looking for a side rail policy. On 9/6/17 at 2:10 p.m. the administrator stated			REHABILITATION AND HEALTH	CA 1	150 NORTHWEST DRIVE		.017
resident had side rails in use with the air mattress. On 9/6/17 at 9:10 a.m. the administrator was interviewed about Resident #2's entrapment and lack of a prior assessment for side rail use or order for the specialty mattress. The administrator stated the use of side rails was supposed to be triggered based upon the admission assessment. The administrator stated, "We [facility] don't have a policy about assessment for side rails." The administrator stated there was no side rail assessment for Resident #2 prior to the entrapment incident on 7/17/17. The administrator stated she was new and did not have access to all the policies but would continue looking for a side rail policy. On 9/6/17 at 2:10 p.m. the administrator stated	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE CO	MPLETION
policy was titled "Side Rails" and had no effective or review dates listed. This policy stated, "Residents will be evaluated for indication of use of side rails by licensed nurse to determine if side rail is necessary to promote resident independence or safety on implementation and at least quarterly basis thereafter. Resident should be assessed to determine if side rails pose risk of restraint. Resident/responsible party should be provided education regarding risk versus benefit of use of side rails." On 9/7/17 at 9:10 a.m. the corporate admissions director was interviewed about any information concerning the source of Resident #2's specialty air mattress. On 9/7/17 at 11:00 a.m. the	F 323	resident had side ramattress. On 9/6/17 at 9:10 a interviewed about Flack of a prior asses order for the special administrator stated supposed to be trigadmission assessment for side stated, "We [facility] assessment for side stated there was not Resident #2 prior to 7/17/17. The adminant did not have accomply was titled "Side or review dates listed "Residents will be eof side rails by licentral is necessary to independence or saleast quarterly basis be assessed to deterestraint. Resident/provided education of use of side rails." On 9/7/17 at 9:10 a. director was interview concerning the sour	ails in use with the air .m. the administrator was Resident #2's entrapment and ssment for side rail use or alty mattress. The difference the use of side rails was gered based upon the ment. The administrator and don't have a policy about the rails." The administrator of side rail assessment for the entrapment incident on mistrator stated she was new the entrapment incident on mistrator stated she was new the entrapment incident on mistrator stated she was new the entrapment incident on mistrator stated she was new the entrapment incident on mistrator stated policy. In. the administrator stated policy about side rails. The de Rails" and had no effective and. This policy stated, really and had no effective sed. This policy stated, really on implementation of use sed nurse to determine if side promote resident as thereafter. Resident should be regarding risk versus benefit of the corporate admissions were about any information materials. The development incident in the corporate admissions were about any information materials.				

was admitted with poor intake and potential for skin breakdown. The corporate admissions

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

С

495326

B. WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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)

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

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 77

director stated the resident had a specialty mattress at the hospital so admissions "thought it would be best" for her to have one in the facility. The corporate admissions director stated the facility admissions director had initiated the paperwork to order for the mattress from their supplier based on her hospital history. The corporate admissions director stated there was no physician's order found for Resident #2's air mattress.

On 9/11/17 at 9:10 a.m. the administrator stated, "An assumption had been made that she [Resident #2] had a MD [physician] order for the air mattress." The administrator stated she did not find an order for the mattress.

The facility presented the air mattress manufacturer's product information guide related to the specialty air mattress in use with Resident #2 at the time of entrapment on 7/17/17. The air mattress product information guide documented warnings and danger of entrapment risks with use of the air mattress. Page 17 of the air mattress product information guide documented, "Danger: Evaluate Gaps...The mattress is designed to fit on a standard bed frame. The risk of entrapment can arise when the equipment is placed on bed frames that leave gaps of even a few inches between the mattress and the head panel, and bed or side rails. The equipment is NOT to be used when such gaps are present."

There was no evidence of a side rail assessment, no physician's order for the specialty air mattress and no evidence of gap measurements or any interventions to ensure Resident #2's bed environment was safe prior to the entrapment incident on 7/17/17.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	1. 09/19/2017 1APPROVED 1. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	CON	TE SURVEY MPLETED
		495326	B. WING	i			C / 11/2017
NAME OF F	PROVIDER OR SUPPLIER			1	EET ADDRESS, CITY, STATE, ZIP C		
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTH	CA		NORTHWEST DRIVE ARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 78	, F;	323			
	These findings were administrator and d meetings on 9/5/17 4:45 p.m.	e reviewed with the irector of nursing during at 4:25 p.m. and on 9/6/17 at					
	This was a complai	nt deficiency.					
		p Meeting, residents k of call bell response.					
	conducted with six residents. Prior to Council Minutes for meetings were revithe August 30, 201	/17, a Group Meeting was alert and oriented facility the meeting, the Resident the most recent three council ewed. Under Old Business, minutes included the sat times still problem. Call wered timely."					
F 325 SS=G	call bell response we bell and they come then they never corn Another resident strequests." "Call be need help when the Assistants) are pastime, or they will need bell response to the terms of the ter	INTAIN NUTRITION STATUS		325			

(g) Assisted nutrition and hydration.

(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's

FRINIED. USI ISIZU II FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

495326

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

B WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE 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)

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLÉTION DATE

F 325 Continued From page 79 comprehensive assessment, the facility must ensure that a resident-

- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;
- (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.

This REQUIREMENT is not met as evidenced

Based on clinical record review and staff interview, the facility staff failed to ensure acceptable nutritional parameters for two of 24 residents in the survey sample (Residents #9 and # 22), resulting in harm and failed to ensure a therapeutic diet was provided as ordered by the physician for one of 24 residents, Resident # 2.

- 1. The facility failed to address the Resident # 9's continued weight loss of greater than 10% over six consecutive 180 day periods between 9/4/17 and 10/3/16. The facility failed to address the resident's continued weight loss ranging from 10.7% over 180 days to 19.6% over 180 days, resulting in harm.
- 2. The facility staff failed to ensure interventions recommended by the Dietitian were implemented for Resident # 22, as written and failed to implement additional interventions to prevent a weight loss of 31.7 pounds (20.7%) in 6 months resulting in harm

F 325 F 325

- 1. Resident #9 were reassessed by Registered Dietitian on 9/22/2017 and Resident #22 reassessed by Registered Dietitian on 9/25/2017 with resulting recommendations communicated with resident's responsible party, physician, new orders received, medical record updated, care plans, and mds were modified with any changes. Resident #2 is receiving diet according to physicians order.
- 2. Registered Dietician reviewed nutritional therapy recommendations for time frame 7/28/17 thru 9/13/2017 to validate any recommendations were carried thru as indicated on 9/15/2017.
- 3. Nursing staff were reeducated on protocols for preventing weight loss by licensed nurse by 10/3/2017. Education was also provided to licensed nursing staff regarding the protocol for communicating diet changes to the dietary department by licensed nurse by 10/3/2017.

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Facility ID: VA0079

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495326	B. WING		1 vi 2 	C 09/11/2017
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO		1150	ET ADDRESS, CITY, STATE, ZIP COD NORTHWEST DRIVE RLOTTESVILLE, VA 22901	E
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F 325		h history of poor intake and	F 3	25	4. The Director of Nurs	ses or designee will
		otassium levels, was not assium diet as ordered by the			conduct audits of 5 r weight loss weekly f monthly for 2 month compliance.	esidents at risk for for 4 weeks and
	The findings include				The Director of Nur conduct audits of 5 perelated to diet change	ges to validate
	continued weight lo six consecutive 180 and 10/3/16. The f resident's continued	d to address the Resident # 9's ss of greater than 10% over day periods between 9/4/17 acility failed to address the dweight loss ranging from ys to 19.6% over 180 days,			dietary received con weeks and monthly vensure compliance. these reports will be Quality Assurance of months for any following	for 2 months to The findings of e forwarded to the Committee for 3
	female, was admitted diagnoses that includes that includes the disturbances, hyperedeficiency, candidate depressive disorder heumatoid arthritis	survey sample, a 55 year-old ed to the facility on 4/6/12 with uded dementia with behavioral rlipidemia, Vitamin D asis, dysphagia, pain, r, diabetes mellitus, and Non-Alzheimer's ng to the most recent Annual			5. Completion date 10)/3/2017

Under Section G (Functional Status) on the Annual and Quarterly MDS's, the resident was assessed as totally dependent with one person physical assist for eating, indicating Resident #9 was unable to feed herself and needed to be fed

Minimum Data Set (MDS), with an Assessment

Reference Date (ARD) of 4/30/17, and the most recent Quarterly MDS, with an ARD of 7/30/17,

the resident was assessed under Section C (Cognitive Patterns) as having short and long

daily decision making skills.

term memory problems with severely impaired

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If continuation sheet Page 81 of 135

LIMITED. VOLIVIZOTI

		AND HUMAN SERVICES & MEDICAID SERVICES					DRM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION) DATE SURVEY COMPLETED
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NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTH	CA		1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION E DATE
F 325	Continued From pa	ge 81	F 3	325	5 :		
	Review of the weight Electronic Health Review weight history:	ht record in Resident # 9's ecord revealed the following					
	and on 10/3/16 her	ht on 4/3/17 was 154 pounds, weight was 191.6 pounds, for ds, or 19.6% in 180 days.					
	pounds, and on 11/	tht on 5/1/17 was 148.8 1/16 her weight was 184.2 of 35.4 pounds, or 19.2% in					
	pounds, and on 12/	ght on 6/1/17 was 146.8 /6/16 her weight was 176.8 of 30 pounds, or 16.9% in 180					
	and on 1/2/17 her v	yht on 7/3/17 was 145 pounds, veight was 165 pounds, for a or 12.1 % in 180 days.					
	pounds, and on 2/1	ght on 8/1/17 was 144.6 /17 her weight was 162 of 17.4 pounds, or 10.7 % in					
	pounds, and on 3/1	ght on 9/4/17 was 142.2 /17 her weight was 163 of 20.8 pounds, or 12.7 % in					
	paper clinical recor	gress Notes in the resident's d, reviewed on 9/6/17, ing entry dated 8/28/17:					



"No recent behaviors, now bed bound, poor eye

Event ID: VWGC11

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FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

495326

B. WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE 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 (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLÉTION DATE

F 325 Continued From page 82

contact...Looks thinner to me...requires to be fed."

At 8:50 a.m. on 9/7/17, the facility's RD (Registered Dietician) was interviewed by telephone. The RD stated he started as the RD for the facility in mid-July (2017). Regarding Resident #9, the RD said, "Her monthly weights are stabilizing. I saw no need to put in any interventions.'

The resident's continued weight loss of greater than 10% over six consecutive 180 day periods between 9/4/17 and 10/3/16, and her use of a Magic Cup four times a day since 10/24/16 was discussed. When asked, based on that information, if new interventions should have been initiated, the RD said, "We should have. based on that information."

During a meeting at 4:30 p.m. on 9/7/17, that included the Administrator in Training, the Administrator in Training Mentor, the Director of Nursing, and the survey team, Resident #9's continued weight loss and the lack of new interventions was discussed.

2. The facility staff failed to ensure interventions recommended by the Dietitian were implemented for Resident # 22, as written and failed to implement additional interventions to prevent a weight loss of 31.7 pounds (20.7%) in 6 months resulting in harm

Resident # 22 had a documented weight loss of 31.7 lbs (pounds) in 6 months, without appropriate interventions to maintain an

F 325

Facility ID: VA0079

		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D. 03/13/2017 M APPROVED O. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION		ATE SURVEY DMPLETED	
		495326	B. WING _			0	9/11/2017	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 325	Continued From pa acceptable weight the Findings include:	-	F 32	25				
	originally on 4/12/10 readmission on 3/2 discharged on 9/2/20 Diagnoses for Resinot limited to: deprhistory of urinary tracelots in lower extremations of the state of the sta	admitted to the facility 6, with the most current 1/17. The resident was again 17 and returned late on 9/6/17. dent # 22 included, but were ression, anxiety, asthma, act infections, history of blood mities, atrial fibrillation, history ide weakness and difficulty						
	was a significant of 03/28/17, this MDS cognitive score of cognitively intact for the resident was a assistance from state of daily living) excessive supervision with or also triggered for the assessment summoutrition. The resident	all MDS (minimum data set) hange assessment dated assessed the resident with a 13', indicating the resident was r daily decision making skills. Iso assessed as extensive aff for most all ADL's (activities pt for eating, which was be person assist. The resident he CAAS (care area ary) section of this MDS for dent's height and weight was DS as 64' inches tall and						
	assessment dated	was reviewed. A quarterly 6/23/17 documented the a cognitive score of '10',						

indicating moderate impairment in daily decision making skills and as requiring extensive to total assistance from staff for most ADL's, including eating which was now extensive assistance with one person assist. The resident's height and weight were recorded on this MDS as 64' inches

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		AND HUMAN SERVICES & MEDICAID SERVICES			0	FORM APPRO -MB NO. 0938		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495326	B. WING_			C 09/11/201	7	
	ROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	SA	1150	EET ADDRESS, CITY, STATE, ZIP CODE NORTHWEST DRIVE ARLOTTESVILLE, VA 22901	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPL	ETION	
F 325	between the two M period. Resident # 22's we	ige 84 26 lbs. A difference of 24 lbs DS assessments, in a 3 month ight records were then aled the following weights.	F 3:	25				
	2/1/17-152.6 4/3/17-141.2 5/3/17-134.3 6/1/17-126.3 7/8/17-123.0 8/1/17-120.9							
	A total weight loss months.	of 31.7 lbs (20.7%) in 6						
	Resident # 22's CC was then reviewed	CP (comprehensive care plan)						
	resident requires a [3/30/17]Nutrition as needed signs at [difficulty swallowin coughing, drooling, refusing to eatwe in 6 monthsprovidus orderedmed p6/30/17]RD to ev	nted, "ADLeating: The ssistance by staff to eat halmonitor/document/report and symptoms of dysphasia g] pocketing, choking holding food in mouth, hight loss> [greater than] 10% de and serve diet supplements hass per order [revision on aluation and make diet changeweigh as indicated"						
	Resident # 22's prowere reviewed.	ogress notes were documented						
	documented: "13	note dated 5/12/17 34.311.99% X 90 day weight : House supplement/med nree times daily]. continue to						

Event ID: VWGC11

		AND HUMAN SERVICES & MEDICAID SERVICES				FOF	.D. 03, 13,201, RM APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		OATE SURVEY OMPLETED
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F 325	Continued From pa	ge 85	F 32	<u>.</u> 25	,		
	"123.319.49% I 120 cc BID [twice d good weight loss ha	ote dated 7/7/17 documented: oss x 6 monthsMed pass laily] started 5/14/17appetite as slowed over the last month. asing Med Pass to TID and will"					
	documented: "12 on 5/14/17, recommende on 7/7/17, incommende on	note dated 8/11/17 20.9Med Pass 120 cc started mendation to increase to TID creased to TID on 8/9/17will weights as receivedno new stime"					
	was reviewed and o'Ready Care 2.0 Gitimes a day for sup	OS (physician's orders sheet) documented an order for ve 120 cc by mouth three plement, the order date for s 7/8/17, but had listed on the of 8/9/17.					
	Resident # 22's did evaluations and/or located in the clinic	not have any nutritional assessments that could be all record.					
	administrator, DON were made aware Resident # 22's we	ximately 2:00 p.m., the I (director of nursing) and AA of concerns regarding ight loss and the fact that the nded in 5/12/17 for the resident					

Facility ID: VA0079

to receive 120 cc of supplement three times a day, which was started on 5/14/17 and only given

twice a day-not three times a day as recommended, and then on 7/7/17 the supplement was again recommended to be increased to at 120 cc three time a day and that was not initiated until 8/9/17. The staff were

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

495326

B. WING

C **09/11/2017**

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE

1150 NORTHWEST DRIVE

CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
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ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 325 Continued From page 86

asked for assistance in determining why the resident did not get the supplements as recommended.

On 09/11/17 at approximately 9:00 a.m., the resident's clinical record was again reviewed and documented a 'significant nutritional therapy evaluation' dated 9/11/17 and documented, which was "in progress." The evaluation did not have any pertinent data entered related to the resident's nutritional status or state, the evaluation was basically blank.

No further information and/or documentation was presented prior to the exit conference on 9/11/17 at 2:45 p.m., to clarify or explain why the resident did not get the recommended supplement to prevent weight loss in May and then again in July, and why no other interventions were implemented to prevent a significant weight loss for Resident # 22.

3. Resident #2, with history of poor intake and high sodium and potassium levels, was not provided a low potassium diet as ordered by the physician.

Resident #2 was admitted to the facility on 7/13/17 with diagnoses that included bipolar disorder, history of catatonia, hypernatremia (excess sodium in the blood), hyperkalemia (high potassium concentration in the blood), depression, diabetes, high blood pressure, anxiety, osteoporosis and dementia. The

F 325

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VWGC11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

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495326

B. WING

COMPLETED

09/11/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1150 NORTHWEST DRIVE

CHARLOTTESVILLE, VA 22901

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CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 325 Continued From page 87

minimum data set (MDS) dated 7/26/17 assessed Resident #2 with severely impaired cognitive skills and body weight of 107 pounds.

Resident #2's admission history and physical dated 7/14/17 documented the resident had poor intake and had diagnoses of hypernatremia and hyperkalemia. This physician's note stated the resident was prescribed a low potassium diet and ordered to be given at least 1500 cc's of fluid daily for management of hyperkalemia and hypernatremia.

Resident #2's clinical record documented a physician's order 7/13/17 for a regular pureed texture diet. A telephone physician's order dated 7/14/17 documented, "low K+ diet (low-potassium)."

Resident #2's diet requisition form dated 7/14/17 documented a regular pureed diet. The diet slip made no mention of the order for a low potassium diet.

The resident's plan of care (revised 8/8/17) documented the resident had potential for impaired nutrition due to dementia and underweight body mass index and refusals to eat meals. Interventions to maintain weight and prevent weight loss included, "Nutritional supplement as ordered d/t [due to] underweight...Observe daily po [oral] and fluid intake...Provide diet as ordered...Resident has been refusing meals at times, Encourage assist with meals..."

On 9/5/17 at 2:30 p.m. the registered nurse (RN #3) caring for Resident #2 was interviewed about the ordered low potassium diet. RN #3 stated he

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

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495326

B. WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE

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

F 325

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 325 Continued From page 88

was not aware of a low potassium diet. RN #3 stated the resident may have been discharged and readmitted with a new diet order.

The clinical record documented no re-admissions to the facility and no further diet orders since 7/14/17.

On 9/5/17 at 3:50 p.m. the dietary manager was interviewed about Resident #2's physician ordered low potassium diet. The dietary manager stated the resident had not received a low potassium diet since admission. The dietary manager stated the last diet communication form sent to the kitchen was dated 7/14/17 and listed a regular pureed diet with no mention of low potassium. The dietary manager stated the low potassium order was not sent or communicated to the kitchen. The dietary manager stated high potassium foods were avoided for residents with orders for a low potassium diet. The dietary manager stated the registered dietitian was on vacation but he would attempt to contact him regarding Resident #2.

On 9/5/17 at 4:40 p.m. the dietary manager stated he contacted the facility's registered dietitian by telephone about Resident #2's diet. The dietary manager stated the RD had no knowledge of any recommendation or orders for a low potassium diet for Resident #2.

These findings were reviewed with the administrator and director of nursing during a meeting on 9/5/17 at 5:00 p.m.

F 327 483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN

SS=E HYDRATION

FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

С

495326

B. WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE 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 327 Continued From page 89

(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

(2) Is offered sufficient fluid intake to maintain proper hydration and health.
This REQUIREMENT is not met as evidenced

Based on staff interview and clinical record review, the facility staff failed to ensure fluid intake as ordered by the physician and/or recommended by the registered dietitian (RD) for two of 24 residents in the survey sample. Facility staff failed to track and implement interventions to ensure Resident #2 received 1500 cc's (cubic centimeters) of daily fluid intake as ordered by the physician. Resident #9, totally dependent on staff for oral intake, was not provided fluid intake amounts as recommended by the registered dietitian.

The findings include:

1. Facility staff failed to track and implement interventions to ensure Resident #2 received 1500 cc's (cubic centimeters) of daily fluid intake as ordered by the physician.

Resident #2 was admitted to the facility on 7/13/17 with diagnoses that included bipolar disorder, history of catatonia, hypernatremia (excess sodium in the blood), hyperkalemia (high potassium concentration in the blood), depression, diabetes, high blood pressure, anxiety, osteoporosis and dementia. The

- 1. Resident #9 was reassessed by Registered Dietitian on 9/22/2017 with resulting recommendations communicated with Resident's responsible party, physician, medical record updated, care plans, and mds were modified with any changes. Resident #2 is receiving diet according to physcians orders.
 - 2. An audit of current residents' ADL records to assure compliance with accuracy of fluid consumption will be conducted by 10/3/2017 by licensed nurse or designee.
 - 3. Nursing staff were reeducated on protocols for recording of fluid consumption on ADL's by Staff Development or designee by 10/3/2017.
 - 4. The Director of Nurses or designee will conduct audits of 5 residents fluid consumption weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
 - 5. Completion date 10/3/2017

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

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09/11/2017

495326

B. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1150 NORTHWEST DRIVE

CHARLOTTESVILLE, VA 22901

(X4) ID PRÉFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 327 Continued From page 90

minimum data set (MDS) dated 7/26/17 assessed Resident #2 with severely impaired cognitive skills.

Resident #2's admission history and physical dated 7/14/17 documented the resident had poor intake and had diagnoses of hypernatremia and hyperkalemia. This physician's note stated the resident was prescribed a low potassium diet and ordered to be given at least 1500 cc's of fluid daily for management of hyperkalemia and hypernatremia.

Resident #2's clinical record documented a physician's order dated 7/14/17 stating, "Please assure at least 1500 cc fluid intake daily.'

Resident #2's most recent lab results dated 8/10/17 documented a high sodium level at 149 mmol/L (millimoles per liter) with normal range listed as 136 to 145 mmol/L and high potassium level of 5.2 mmol/L with normal range listed as 3.5 to 5.1 mmol/L.

Resident #2's clinical record documented no daily summary of the resident's fluid intake. The resident's activity of daily living (ADL) records documented fluid intake amounts for each meal and the evening snack but no other fluid intake amounts. In July 2017 Resident #2 was documented with fluid intake amounts ranging from 0 to 960 cc's per day. The August 2017 ADL record documented fluid intake amounts for Resident #2 ranging from 120 to 720 cc's per day. The September 2017 (from 9/1/17 through 9/8/17) documented fluid intake amounts from 300 to 620 cc's per day. The resident had no days from 8/1/17 through 9/8/17 with fluid intake amounts of 1500 cc's as ordered by the

F 327

Facility ID: VA0079

FORM APPROVED
OMB NO. 0938-0391

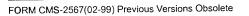
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NC). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	A	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901		- DAY MAN TO THE STATE OF THE S
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 327	tracking the resider tracking the resider on the resident's m Resident #2's plan the resident was "a imbalance" Interimbalance included with increased fluid resident's plan of caresident had potent dementia and under refusal to eat meals weight and prevent "Nutritional suppler underweightObseintakeProvide die	notes made no mention of nt's fluid intake. The order for nt's fluid intake was not listed edication or treatment records. of care (revised 8/8/17) listed trisk of alteration in fluid ventions to prevent fluid, "Provide me [Resident #2] intake as indicated." The are also documented the rial for impaired nutrition due to reweight body mass index and so. Interventions to maintain weight loss included, ment as ordered d/t [due to] erve daily po [oral] and fluid tas orderedResident has a sat times, Encourage assist	F3			
	#3) caring for Residenthe physician's orderintake. RN #3 state intake amount was medication or treat "We try to encourage resident's daily fluid tracked in some mathought the intake a clinical record. On 9/6/17 at 7:35 at (CNA #1) routinely interviewed about a	o.m. the registered nurse (RN dent #2 was interviewed about er for 1500 cc's of daily fluid ed the order regarding the fluid not listed on the resident's ment records. RN #3 stated, ge fluids." When asked if the dintake was summarized or anner, RN #3 stated he amounts were tracked in the caring for Resident #2 was any tracking of the resident's stated fluid intake amounts				

the ADL records only documented fluid intake at

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	Γ			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COM	E SURVEY MPLETED
		495326	B. WING		-{	C / 11/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
			.	1150 NORTHWEST DRIVE		
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTH	A	CHARLOTTESVILLE, VA 22901		
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F 327	Continued From pa	ge 92	F 327	7		
	meals and the ever	ning snack. CNA #1 stated				
	Resident #2 had ju	ice and water available to her				
		these amounts were not tated Resident #2 went out				
		munity day program and she				
	did not know if fluid	amounts were tracked while				
	the resident was ou	ut of the facility.				
	On 9/6/17 at 9:15 a	n.m. RN #3 was interviewed				
	again about how th	e facility ensured the resident				
	received the ordere	ed 1500 cc's of fluid daily. RN				
	#3 stated staff men	nbers encouraged the resident id as possible. RN #3 stated				
	he thought the fluid	provided on the resident's				
	meal trays was end	ough to meet the ordered				
	requirement. RN#	3 presented no daily				
	Resident #2.	daily intake amounts for				
	These findings wer	re reviewed with the				
	administrator and o	director of nursing during a at 4:15 p.m. The administrator				
	stated at this time t	the resident's community day				
	program did not tra	ick the resident's fluid intake.				
		d to maintain acceptable ration as recommended by the				
	Registered Dieticia					
	Resident # 9 in the	survey sample, a 55 year-old				
	female, was admitt	ed to the facility on 4/6/12 with				
	diagnoses that incl	uded dementia with behavioral rlipidemia, Vitamin D				
	deficiency, candidia	asis, dysphagia, pain,				
	depressive disorde	r, diabetes mellitus,				
	rheumatoid arthritis	s, and Non-Alzheimer's				



Dementia. According to the most recent Annual Minimum Data Set (MDS), with an Assessment

Event ID: VWGC11

Facility ID: VA0079

If continuation sheet Page 93 of 135



FORM APPROVED DMB NO. 0938-0391

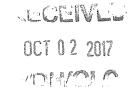
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		ATE SURVEY OMPLETED
		495326	B. WING			0,	C 9/11/2017
	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTH	CA	1150	EET ADDRESS, CITY, STATE, ZIP CODE) NORTHWEST DRIVE ARLOTTESVILLE, VA 22901		
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F 327	recent Quarterly MI the resident was as (Cognitive Patterns term memory probl daily decision maki Under Section G (F Annual and Quarte assessed as totally physical assist for e was unable to feed by staff. Review of the fluid	RD) of 4/30/17, and the most DS, with an ARD of 7/30/17, asessed under Section C) as having short and long ems with severely impaired	F3	527			
	fluid intake ranged centimeters) on 5/2 5/29/17.	lay 2017, Resident # 9's daily from a low of 50 cc (cubic 20/17, to a high of 580 cc on					
	fluid intake ranged	une 2017, Resident # 9's daily from a low of 100 cc on 6/12 igh of 720 cc on 6/3, 6/17 and					
	fluid intake ranged	uly 2017, Resident # 9's daily from a low of 200 cc on 7/3, a high of 840 cc on 7/21/17.					
	daily fluid intake ra	ugust 2017, Resident # 9's nged from a low of 240 cc on o a high of 840 cc on 8/27/17.					
	As on 9/11/17, the	date of record review, for the					

Event ID: VWGC11

month of September May 2017, Resident # 9's daily fluid intake ranged from a low of 340 cc on

FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	- ₁					. 0000 0001
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l .	TIPLE CONSTR			CON	E SURVEY MPLETED
		495326	B. WING				l	C / 11/2017
	ROVIDER OR SUPPLIER	REHABILITATION AND HEALTH		STREET ADI	DRESS, CITY, STATE, Z		1 09	111/2017
CHARLO	I IESVILLE POINTE	KERADILITATION AND REALTH	CA	CHARLO1	TTESVILLE, VA 229			· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF EACH CORRECTIVE ACT DSS-REFERENCED TO DEFICIENC	TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 327	Continued From pa	age 94	F 3	27				
	9/4/17, to a high of	720 cc on 9/1/17.						
	Practical Nurse) wa Resident # 9's fluid	7/17, LPN # 3 (Licensed as interviewed regarding intake. "She does not drink as to be offered (fluids). She N # 3 said.						
	(Registered Dieticial issue of Resident # discussed. "I would fluid) per day given said. Continuing, to need to be offered	e interview with the facility's RD an) at 8:50 a.m. on 9/7/17, the 4 9's fluid intake was d expect 1600 to 1900 cc (of her current weight," the RD he RD said, "Fluids would by staff since she is a feeder, she probably won't take fluids						
	included the Admir Administrator in Tr Nursing, and the sintake was discuss			332				
F 332 SS=D	483.45(f)(1) FREE RATES OF 5% OF	OF MEDICATION ERROR R MORE	1 ,	J32				
	(f) Medication Erro that its-	rs. The facility must ensure						
	greater; This REQUIREME	or rates are not 5 percent or						
	interview and clinic staff failed to ensu- less than 5%. The	cation pass observation, staff cal record review, the facility re a medication error rate of ere were two errors out of 30 lting in a medication error rate						



If continuation sheet Page 95 of 135

Facility ID: VA0079

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

С

495326

B. WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE 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 332 Continued From page 95 of 6.6%.

The findings include:

A medication pass observation was conducted on 9/6/17 at 8:20 a.m. with licensed practical nurse (LPN) #2 administering medications to Resident #19. LPN #2 administered medications to Resident #19 through a gastrostomy tube. LPN #2 failed to follow physician orders for water flushes through the gastrostomy tube prior to administering medications and failed to follow physician orders for water flushes through the gastrostomy between medications administered.

On 9/6/17 at 8:20 a.m. LPN #2 prepared the following medications for Resident #19: Ferrous Sulfate 325 mg (milligrams), Oxybutynin chloride 5 mg, Magnesium oxide 400 mg, multivitamin and natural vegetable laxative with Colace 50 mg (2 tabs). Each medicine was crushed and placed in a separate medicine cup. LPN #2 disconnected the resident's tube feeding (Two Cal HN) that was running at 60 cc's (cubic centimeters) per hour and clamped the tubing. LPN #2 then mixed the first cup of crushed medicine with a small amount of water and stirred it to mix. LPN #2 pulled the medicine mix from the cup into a large syringe. Without a prior check of the gastrostomy tube placement and without a prior water flush, LPN #3 pushed the first medicine mixture into the gastrostomy tube with the syringe. Without administering any water into the tube, the next crushed medicine mix was pushed into the gastrostomy tube. LPN #2 followed the second medication mix with a small amount of water. LPN #2 proceeded to administer the other medicines pushing them with the syringe into the gastrostomy with each followed by a small

F 332 F 332

1. Resident #19 was assessed by a

- registered nurse with no negative outcome on 9/15/2017. Resident #19 is currently receiving appropriate gastrostomy care.
- 2. All residents requiring enteral feeding have the ability to be affected.
- 3. Licensed nurses will be re-educated by Staff Development Coordinator or designee regarding appropriate gastrostomy care by 10/03/2017 with return competency. Licensed Nurses #2 received 1:1 in service regarding medication administration by Registered Nurse on 9/21/17.
 - 4. The Director of Nurses or designee will conduct competency testing of 5 licensed nurses regarding gastrostomy care weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
 - 5. Completion date 10/3/2017.

FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u> </u>). 0938-039 1
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION		TE SURVEY MPLETED
		495326	B. WING			06	C 9/11/2017
NAME OF F	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
		DELLA DULITATION AND LIE ALTU	.,	115	50 NORTHWEST DRIVE		
CHARLO	TESVILLE POINTE	REHABILITATION AND HEALTH	,A	CH	ARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 332	Continued From pa	age 96	F 3	332			
1 332	amount of water.	ige 50	, ,	.02			
	amount of water.						
	Resident #19's clin	ical record documented a					
	physician's order d	ated 4/28/17 stating, "Flush					
	tube [gastrostomy]	with 60 cc free water before					
	and 30 cc between	meds [medicines]."					
	On 9/6/17 at 8:55 a	a.m. LPN #2 was interviewed					
		rater flushes prior to and					
	between the first tv	vo medicines administered to					
	Resident #19. LPN	N #2 stated she usually flushes					
	the gastrostomy tu	be prior to starting medications					
	and she was suppo	osed to flush the tube between ordered. LPN #2 stated she					
	forgot and realized	she missed the flushes part					
	way through the m	edication pass and then					
	started with adding						
	The facility's policy	for medication administration					
	through a gastrosto	omy (revised November 2016)					
	stated, "Use 5 co	of water to dilute each					
		nister medication via					
	gravityFlush feed according to physic	ling tube after administration					
	according to physic	Sian order					
	These findings wer	re reviewed with the					
	administrator and	director of nursing during a					
	meeting on 9/6/17						
F 334	483.80(d)(1)(2) INI	FLUENZA AND	F:	334			
SS=D	PNEUMÓCÓCCAI	LIMMUNIZATIONS					
	(d) Influenza and p	neumococcal immunizations					
		facility must develop policies					
	and procedures to						
	(i) Potoro offering	the influenza immunization,					
	each resident or th	e resident's representative					
		•					

Facility ID: VA0079

FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CON	NSTRUCTION
A. BUILDING	

(X3) DATE SURVEY COMPLETED

С

495326

B. WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE 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 334 Continued From page 97

receives education regarding the benefits and potential side effects of the immunization;

- (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
- (iii) The resident or the resident's representative has the opportunity to refuse immunization; and
- (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
- (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
- (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.
- (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
- (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has

F 334 F334

- 1. Resident #2 received immunization on 9/28/2017.
- 2. An audit of current residents medical records were conducted to assure compliance with pneumococcal vaccinations by Medical records department on 9/22/2017.
- 3. Licensed nurses will be re-educated on protocols for pneumococcal vaccinations by Staff Development Coordinator by 10/3/2017.
- 4. The Director of Nurses or designee will conduct audits of 5 residents medical record weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
 - 5. Completion date 10/3/2017

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If continuation sheet Page 98 of 135

W.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

495326

(X2) MULTIPLE CONSTRUCTION A. BUILDING

OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

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B. WING

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE

CHARLOTTESVILLE, VA 22901

(X4) ID PRÉFIX 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 334 Continued From page 98 already been immunized;

- (iii) The resident or the resident's representative has the opportunity to refuse immunization; and
- (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
- (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
- (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

This REQUIREMENT is not met as evidenced

Based on staff interview, facility document review and clinical record review, the facility staff failed to determine the pneumococcal immunization status and/or offer the pneumococcal vaccine to one of 24 residents in the survey sample. Resident #2's clinical record failed to document if the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to a medical contraindication or refusal.

The findings include:

Resident #2 was admitted to the facility on 7/13/17 with diagnoses that included bipolar disorder, history of catatonia, hypernatremia (excess sodium in the blood), hyperkalemia (high potassium concentration in the blood), depression, diabetes, high blood pressure,

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

С

495326

B. WING _____

09/11/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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)

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 334 : Continued From page 99

anxiety, osteoporosis and dementia. The minimum data set (MDS) dated 7/26/17 assessed Resident #2 with severely impaired cognitive skills.

Resident #2's clinical record documented no information regarding the resident's pneumococcal immunization status. The clinical record tab for immunization status listed "no information." There was no documented pneumococcal immunization status, no documented education information provided to the resident's responsible party or any information regarding consent, risks and benefits of the immunization or of any reason the pneumococcal vaccine was not offered or administered. The resident's admission assessment dated 7/13/17 listed the resident's pneumococcal immunization status as "unknown."

On 9/5/17 at 2:30 p.m. the registered nurse (RN #3) caring of Resident #2 was interviewed about the resident's pneumococcal immunization status. RN #3 reviewed the clinical record and stated he did not see any information about immunizations. On 9/6/17 at 10:40 a.m. RN #3 stated he contacted the director of nursing (DON) and there was no record indicating if Resident #2 had been immunized for pneumonia.

The facility's policy titled Pneumococcal Immunization (revised 10/7/13) stated, "All residents will be offered the Pneumovax (pneumococcal vaccine) to aid in preventing pneumococcal infections (e.g., pneumonia)...Prior to or upon admission, residents will be assessed for eligibility to receive the Pneumovax (pneumococcal vaccine), and when indicated, will be offered the vaccination within thirty (30) days

F 334

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VWGC11

Facility ID: VA0079

If continuation sheet Page 100 of 135



		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495326	B. WING		09/11/2017
	ROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	;A	STREET ADDRESS, CITY, STATE, Z 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22	901
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F 371 SS=F	contraindicated or to vaccinated Asses vaccination status of (5) working days of conducted prior to a considered satisfact authorities. (i) This may include from local produce and local laws or refacilities from using gardens, subject to safe growing and for (iii) This provision from consuming for (i)(2) - Store, preparaccordance with provision safety.	facility unless medically the resident has already been sments of pneumococcal will be conducted within in five the resident's admission if not admission" The reviewed with the director of nursing during a set 5:00 p.m. The procure, and the procure of the sources approved or coordinate to the sources are sources as a source to the sources are sources are sources as a source to the sources are sources are sources as a source to the sources are sources as a source to the sources are sources are sources as a source to the sources are sources are		1. The wall in the was cleaned o and will be redesignee by 1. 2. An audit of the to assure abse by Health Ser 3. Staff were reedeprevention of Health Service 4. The Dietary Mean of the months to ensignee in the forwarded to	e kitchen was conducted nee of pests on 9/22/2017 vices Group. ducated on protocols for insect infestations by es Group on 9/18/2017. Manager or designee will so of the kitchen area weeks and monthly for 2 sure compliance. The lese reports will be the Quality Assurance or 3 months for any follow be needed.
	visitors to ensure shandling, and con-	safe and sanitary storage,			

Event ID: VWGC11

handling, and consumption.
This REQUIREMENT is not met as evidenced

FORM APPROVED MB NO. 0938-0391

CENTERS FOR MEDICA	RE & MEDICAID SERVICES				OMB NO). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLI	ER			REET ADDRESS, CITY, STATE, ZIP CODE		
CHARLOTTESVILLE POIN	TE REHABILITATION AND HEALTH	CA		0 NORTHWEST DRIVE ARLOTTESVILLE, VA 22901		
PREEIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
facility document ensure a sanitare a sanitare a sanitare The wall adjoining to have a black harboring fruit flow the findings incomplete the findings incomplete the findings incomplete the findicated that fruit for a sanitare the findicated that fruit freated in the kill frecommenced to cleaned from the this is considered in the building a concerning fruit for the finding for the finding fruit for finding fruit frui	rvation, staff interviews, and treview, the facility failed to y kitchen environment. Ing the dishwasher was observed substance, food debris and es.		71			

Facility ID: VA0079

dishwasher was black with what appeared to be mold. Also noted was food debris and fruit flies.

FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DA ⁻ COI	TE SURVEY MPLETED
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F 371	maintenance direct observe the wall. Overbalized that he of substance on the weither way the wall cleaned or replace On 9/11/17 at 10:2	rveyor requested that the tor (other staff, OS #10) also OS #10 observed the wall and did not know if the black vall was grease or mold, but needed to be completely	F;	371			
	kitchen staff had tr in the past, but the not continue. OS #	ied to pressure wash the wall wall just crumbled so they did #1 also verbalized that it had ne previous administrator and	1				
	brought to the atte	p.m. the above finding was ntion of the administrator and . No other information was exit on 9/11/17.					
F 386 SS=E	This is a complaint 483.30(b)(1)-(3) PI CARE/NOTES/OR	HYSICIAN VISITS - REVIEW	F	386			
	(b) Physician Visits The physician mus	s st		:			
	including medication	ident's total program of care, ons and treatments, at each aragraph (c) of this section;					
	(2) Write, sign, and visit; and	d date progress notes at each					
	influenza and pneu	all orders with the exception of umococcal vaccines, which may er physician-approved facility	/				

Facility ID: VA0079

FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CHARLOTTESVILLE POINTE	REHABILITATION AND HEALTHO	:A	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)

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F 386 Continued From page 103

policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review, the facility failed to review and sign physician orders for two of 24 residents in the survey sample. The physician had not reviewed and/or signed physician orders and/or progress notes for Resident #2 and Resident #18.

- 1. The physician failed to review the plan of care and sign verbal and telephone orders for Resident #2. No monthly physician order summary sheets or telephone orders for Resident #2 had been signed by a physician since 7/14/17.
- 2. Resident #18 who attended PACE (Program for All-inclusive Care of the Elderly) did not have signed physician orders in his clinical record, nor were there physician progress notes indicating the resident had been visited by his physician.

The findings include:

1. The physician failed to review the plan of care and sign verbal and telephone orders for Resident #2. No monthly physician order summary sheets or telephone orders for Resident #2 had been signed by a physician since 7/14/17.

Resident #2 was admitted to the facility on 7/13/17 with diagnoses that included bipolar disorder, hypernatremia (excess sodium in the blood), hyperkalemia (high potassium concentration in the blood), depression, diabetes, high blood pressure, anxiety, osteoporosis and dementia. The minimum data set (MDS) dated 7/26/17 assessed Resident #2 with severely impaired cognitive skills.

F 386

F386

- 1. Resident #2 and #18's physician orders statement and progress notes were completed and signed by the Medical Director.
- 2. An audit of residents' medical records who attend PACE for signed physician orders and progress notes was conducted by Nursing Administration.
- 3. Physicians and medical records were educated on timely physician visits and orders 9/8/2017.
- 4. Medical records or designee will conduct audits of 5 PACE residents' medical charts weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
- 5. Completion date 10/3/2017

Facility ID: VA0079

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		& MEDICAID SERVICES			C		/I APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTHO	CA		50 NORTHWEST DRIVE HARLOTTESVILLE, VA 22901		
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F 386	Continued From pa	ge 104	F3	886			
	Resident #2's clinic	al record documented					
		or medications, care and y the physician on 7/14/17. In					
	addition there were	three telephone orders for					
	Resident #2 dated physician on 7/14/1	7/14/17 signed by the 7.					
	Resident #2's clinic physician or any he #2's physician orde 7/31/17 and 8/29/1 physician. There w verbal orders docu 8/10/17. None of the by a physician. A fa medications from F care of the elderly) stating "Corrected of	were no other orders in sal record signed by the salth care provider. Resident or summary reports dated were 28 telephone and/or mented from 7/17/17 through nese orders had been signed exed list of physician orders for PACE (program for all inclusive was documented on 8/2/17 Orders for [Resident #2]." This had no physician signature c).					
	(DON) was intervied care and signing of routinely physicians verbal and/or telephysicians did not on ursing facility as their visits to the dapaperwork for revies supposed to be serieview and then reference and significant carefully as the control of the contro	p.m. the director of nursing wed about physician review of orders. The DON stated is reviewed and signed any hone orders during their e DON stated the PACE come to see residents at the ne residents were seen during ay facility. The DON stated the ew and signatures was not to the PACE physicians for turned to the facility to be filed nical record. The DON was					

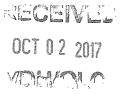
FORM CMS-2567(02-99) Previous Versions Obsolete

not sure who was responsible for sending the orders to the PACE physicians for signatures.

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Facility ID: VA0079

If continuation sheet Page 105 of 135



DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			ON	<u>18 NO. 093</u>	<u>8-0391</u>	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495326	B. WING			C 09/11/2017		
NAME OF PROVIDER OR SUPPLIER CHARLOTTESVILLE POINTE REHABILITATION AND HEALTH				STREET ADDRESS, CITY, S				
			CA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT) CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD E ED TO THE APPROPR FICIENCY)		(X5) MPLETION DATE	
F 386	Continued From pa	ae 105	F 38	86				
	These findings wer	e reviewed with the irector of nursing during a						
	for All-inclusive Car signed physician or were there physicia	no attended PACE (Program e of the Elderly) did not have ders in his clinical record, nor n progress notes indicating en visited by his physician.						
	03/10/2017. His dislimited to: Cerebro	admitted to the facility on agnoses included but were not vascular disease with ension, osteoporosis and						
	The initial MDS with an ARD (assessment reference date) of 03/17/2017. Resident #18 was assessed as having a cognitive summary score of "13", indicating he was cognitively intact.							
	Documentation from 03/10/2017 include physician electronic physician: "This is facility." There was his PACE physician progress note was practitioner on 04/2 additional progress	was reviewed on 09/07/2017. In the time of his admission on different the following history and cally written and signed by his a PACE patient seen at PACE also a handwritten note from a dated 03/10/2017. The next completed by a nurse 16/2017. There were no notes in the clinical record.						
	Review of the phys that none of the ord	ician order section revealed ders on the clinical record had						

been signed by a physician except for one order

DARTMENT OF HEALTH AND HUMAN SERVICES

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		& MEDICAID SERVICES					M APPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA	(X3) DATE SURVEY COMPLETED	
		495326	B. WING			0	C 9/11/2017	
	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTH	CA	1150	EET ADDRESS, CITY, STATE, ZIP CODE D NORTHWEST DRIVE ARLOTTESVILLE, VA 22901	-		
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F 386	knee immobilizer. During a meeting w 09/07/2017. He starecord for the PACI working at the PACI had assumed the residents at the fact would be reviewing residents. A meeting was held approximately 3:30 that there was no puthe clinical record for no physician visits administrator and to wee asked how the signed and when do resident. Both the administrator state with PACE and did suppose to be sign sister facility who wadministrator state physician sees the and the acting admilion look at the contract team. On 09/11/2017 at a sees the contract team.	with the medical director on ated that the physician of program was no longer E facility. He stated that he ole of provider for one of the ility the evening before and the records of the other PACE of on 09/07/2017 at p.m., concerns were voiced shysician oversight evident on or Resident #18. There were or signed orders. The acting he DON (director of nursing) e orders were suppose to be id the physician see the DON and the acting d that they were not familiar not know how the orders were ed. An administrator from a was there to help the acting d, "The assumption is that the m there at PACE." The DON inistrator stated they would and report back to the survey approximately 9:00 a.m., the		86				
	administrator and t training) came to the with the survey tea that multiple calls he PACE program and	he AIT (administrator in the conference room to speak the conference room to speak the conference room to stated the deen put through to the conference the facility had eventually orders progress notes, etc and						

Event ID: VWGC11

she would present them to the survey team.

FORM APPROVED
OMB NO 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTHO	:A	1150	EET ADDRESS, CITY, STATE, ZIP CODE) NORTHWEST DRIVE ARLOTTESVILLE, VA 22901		
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F 386	Continued From pa	ge 107	F3	86			
	PACE program was Progress notes wer July and August. T Resident #14 was s by the PACE physic orders presented. areas of PACE (occ therapy, social work AIT was asked if ar obtained from PACI #18's clinical record been signed. She seems to the seems of t	2:30 a.m., information from the spresented by the AIT represented for March, April, here was no evidence that seen during the month of June cian. There were no signed Multiple notes from other cupational therapy, physical ker, etc) were presented. The sy signed orders had been to be placed on Resident I since none of his orders had stated, "This is what we have."					
F 387 SS=E	exit conference on	on was obtained prior to the 09/11/2017. EQUENCY & TIMELINESS OF	F 3	87			
	least once every 30 admission, and at least once every 30 admission, and at least occurs not later that visit was required. This REQUIREMENT by: Based on staff intereview, the facility sphysician visit once days after admission survey sample. Revisit due in August 2	ust be seen by a physician at days for the first 90 days after east once every 60 thereafter. is considered timely if it in 10 days after the date the IT is not met as evidenced rview and clinical record taff failed to ensure a every 30 days for the first 90 in for two of 24 residents in the sident #2 missed a physician 2017 and Resident #18 visit due in May 2017.					

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

С

495326

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

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 387 Continued From page 108

The findings include:

1. Resident #2 missed a physician visit due in August 2017.

Resident #2 was admitted to the facility on 7/13/17 with diagnoses that included bipolar disorder, hypernatremia (excess sodium in the blood), hyperkalemia (high potassium concentration in the blood), depression, diabetes, high blood pressure, anxiety, osteoporosis and dementia. The minimum data set (MDS) dated 7/26/17 assessed Resident #2 with severely impaired cognitive skills.

Resident #2's clinical record documented the resident was admitted to the facility on 7/13/17. The physician documented a history and physical and admission orders on 7/14/17. As of 9/5/17 there was no evidence of a physician visit for Resident #2. The clinical record documented no physician progress notes since the admission physical.

On 9/7/17 at 7:50 a.m. the administrator was interviewed about any evidence of physician visits for Resident #2. The administrator stated there were no progress notes in the resident's clinical record but she would contact PACE (program for all inclusive care for the elderly) for the records. The administrator stated Resident #2 went to day programming at the PACE facility and was seen by a physician there.

On 9/7/17 at 12:00 p.m. the director of nursing (DON) was interviewed about physician visits for Resident #2. The DON stated Resident #2 was seen by the physician at PACE and was not a

F 387

F387

- 1. Resident #18 had planned discharge on 9/12/2017. Resident #2 was seen by the Medical Director on 9/7/2017 and #18 on 9/8/17.
- 2. An audit of residents' medical records who attend PACE for timely physician visits was conducted by Nursing Administration.
- 3. Physicians and medical records will be educated on timely physician visits and orders by 10/3/2017.
- 4. Medical records or designee will conduct audits of 5 PACE residents medical charts weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
- 5. Completion date 10/3/2017.

		AND HUMAN SERVICES					FORM	APPROVED
		& MEDICAID SERVICES	T.,,,,,,,,		V. F. O.O.V.O.T.D.V.O.T.O.V.	Or		<u>0938-0391</u>
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		495326	B. WING			-	l	_ 11/2017
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TWOIL OF T	TO VIDER OR OUT FILER				1150 NORTHWEST DRIVE	_, 000		
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTH	CA		CHARLOTTESVILLE, VA	22901		
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F 387	Continued From pa	ae 109	F 3	227	7			
1 007		ise physicians. The DON	I" C) (I				
		ysicians did not come to see						
		sing facility as the residents						
	were seen by during	g their visits to the day facility.						
		e paperwork for review and						
		posed to be sent to the PACE w and then returned to be filed						
		ical record. The DON stated						
		any physician visit notes for						
	Resident #2.							
	interviewed again a notes or evidence of #2. The administra were at the PACE for record. The admini	a.m. the administrator was bout any physician progress of a physician visit for Resident tor stated the progress notes acility and not in the clinical strator stated the assumption ld share their records with the						
	presented copies of facility for Resident progress note docu	a.m. the administrator all the notes from the PACE #2. There was no physician mented indicating the resident physician since 7/14/17.						
		e reviewed with the irector of nursing during at 4:45 p.m. and 9/7/17 at						
	for All-inclusive Care physician progress	no attended PACE (Program e of the Elderly) did not have notes indicating the resident his physician every thirty days ays after admission.						

FORM APPROVED

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB N	OMB NO. 0938-0391	
STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION . A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	CA	1150	EET ADDRESS, CITY, STATE, ZIP CODE) NORTHWEST DRIVE ARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 387	03/10/2017. His dia limited to: Cerebro hemiplegia, hyperte osteoarthritis. The initial MDS with reference date) of 0 assessed as having of "13", indicating homeof "14", indicating homeof "15", ind	admitted to the facility on agnoses included but were not vascular disease with ension, osteoporosis and an ARD (assessment 03/17/2017. Resident #18 was a cognitive summary score e was cognitively intact. was reviewed on 09/07/2017. In the time of his admission on d the following history and cally written and signed by his a PACE patient seen at PACE also a handwritten note from a dated 03/10/2017. The next completed by a nurse 6/2017. There were no notes in the clinical record. with the medical director on a ted that the physician of E program was no longer E facility. He stated that he ole of provider for one of the ility the evening before and the records of the other PACE	F 3	87			
	that there was no p the clinical record for	on 09/07/2017 at p.m., concerns were voiced hysician oversight evident on or Resident #18. There were or signed orders. The acting					

Event ID: VWGC11

administrator and the DON (director of nursing)

FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMR M	<u>0. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION		ATE SURVEY DMPLETED
		495326	B. WING			0	C 9/11/2017
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP C	ODE	
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTHO	CA		NORTHWEST DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 387	signed and when di resident. Both the administrator stated with PACE and did suppose to be signal sister facility who wadministrator stated physician sees ther and the acting adm	ge 111 e orders were suppose to be d the physician see the DON and the acting d that they were not familiar not know how the orders were ed. An administrator from a as there to help the acting d, "The assumption is that the n there at PACE." The DON inistrator stated they would and report back to the survey	F3	387			
	administrator and the training) came to the with the survey tear that multiple calls he PACE program and gone there to get of	pproximately 9:00 a.m., the ne AIT (administrator in e conference room to speak m. The administrator stated ad been put through to the the facility had eventually rders progress notes, etc and them to the survey team.					
	PACE program was Progress notes wer July and August. T	0:30 a.m., information from the presented by the AIT represented for March, April, there was no evidence that seen during the month of May bian.					
F 431 SS=D	exit conference on 483.45(b)(2)(3)(g)(f	on was obtained prior to the 09/11/2017. n) DRUG RECORDS, UGS & BIOLOGICALS	F۷	131			
	drugs and biologica	ovide routine and emergency als to its residents, or obtain eement described in					

Facility ID: VA0079

§483.70(g) of this part. The facility may permit

LIMITED, USTIGIZOTI FORM APPROVED

OCNITE	O EOD MEDICADE	MEDICAID SEDVICES				OMB NO	0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL		(X3) DA	TE SURVEY MPLETED		
AND PLAN U	FCORRECTION	IDENTIFICATION NOMBER.	A. BUILD	ING			C
		495326	B. WING		na	/11/2017	
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE				711/2017
				CHA	RLOTTESVILLE, VA 2290		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 431	law permits, but on supervision of a lice (a) Procedures. As pharmaceutical ser that assure the accidispensing, and ad biologicals) to mee (b) Service Consult employ or obtain the pharmacist who— (2) Establishes a sydisposition of all codetail to enable an (3) Determines that that an account of amaintained and permitted and permitted in accordar professional principal appropriate accessinstructions, and the applicable. (h) Storage of Drug (1) In accordance with facility must stolocked compartme	nel to administer drugs if State by under the general ensed nurse. Facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident. Lation. The facility must e services of a licensed Lystem of records of receipt and ntrolled drugs in sufficient accurate reconciliation; and the drugs in controlled drugs is riodically reconciled. Lystem of records are in order and all controlled drugs is riodically reconciled. Lystem of records are in order and all controlled drugs is riodically reconciled. Lystem of records are in order and all controlled drugs is riodically reconciled. Lystem of records of receipt and ntrolled drugs is riodically reconciled. Lystem of records of receipt and records are in order and all controlled drugs is riodically reconciled. Lystem of records of receipt and ntrolled drugs is riodically reconciled. Lystem of records of receipt and ntrolled drugs is riodically reconciled. Lystem of records of receipt and ntrolled drugs is riodically reconciled. Lystem of records of receipt and ntrolled drugs is riodically reconciled. Lystem of receiving, must be all controlled drugs is riodically reconciled. Lystem of receiving, must be all controlled drugs is riodically reconciled. Lystem of receiving, must be all controlled drugs is riodically reconciled. Lystem of receiving, must be all controlled drugs is riodically reconciled. Lystem of receiving, must be all controlled drugs is riodically reconciled. Lystem of receiving, must be all controlled drugs is riodically reconciled. Lystem of receiving, must be all controlled drugs is riodically reconciled.	F 4	131 F	1. The liquid loraze correct locked ar discovery by the 2. An audit of the f storage areas wa Registered nurse validate narcotic according to pro 3. Initiated License medication stora representative of Conduct 5 audits areas weekly fo for 2 months to a findings of these forwarded to the Committee for 3 up that may be respectively.	rea at the time of nurse on 9/7/2 facilities medicus conducted by e on 9/14/2017 as medications of ocol. The property of the	of 2017. ation to are stored ucated on cy gnee will storage monthly ance. The e

(2) The facility must provide separately locked,

FORM APPROVED
OMB NO 0938-0391

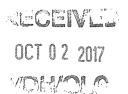
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	<u>). 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495326	B. WING		_ 09	C 9/11/2017
	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTHO	;A	STREET ADDRESS, CITY, STA 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA	ATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 431	controlled drugs list Comprehensive Dri Control Act of 1976 abuse, except when package drug distri quantity stored is mbe readily detected This REQUIREMEN by: Based on observation and staff interview, ensure a drug subject separate, permane compartment on or opened bottle of liquithe medications and not affixed locked box. The findings include On 9/7/17 at 7:45 a practical nurse (LPI room was inspected refrigerator in the medications was arbottle of liquid Loral marked as opened was stored on the min the mounted permavailable for use. Lime about the liquid the Lorazepam was affixed lock box ins stated she always permate locked box.	d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the minimal and a missing dose can . NT is not met as evidenced tion, facility document review the facility staff failed to ect to abuse was stored in a ntly affixed locked the of three nursing units. An uid Lorazepam was stored in gerator on unit two with other of in the available permanently	F 4	31		

Event ID: VWGC11

with other medicines.

FORM APPROVED OMB NO. 0938-0391

CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			C	IND INC). 0938-039 1
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED
		495326	B. WING _			09	C /11/2017
	ROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	:A	1150	EET ADDRESS, CITY, STATE, ZIP CODE NORTHWEST DRIVE ARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)) BE	(X5) COMPLETION DATE
F 431	Continued From pa	ge 114	F 43	31			:
	(DON) was intervied security of liquid Lot the liquid Lorazepa	.m. the director of nursing wed about the storage and razepam. The DON stated m should be stored in the x inside the refrigerator					
	of Medications, Bio (revised 1/1/13) sta Schedule II controll medications deemed abuse or diversion within the locked medical personnel receiving controlled inventory, Facility s V controlled substatinto a secured stora self-locked cabinet accordance with Approximation of the secured stora self-locked cabinet accordance with Approximation of the secured stora self-locked cabinet accordance with Approximations of the secured stora self-locked cabinet accordance with Approximations of the secured storage of the secured stora						
F 463 SS=D	administrator and omeeting on 9/7/17	DENT CALL SYSTEM -	F 4	63 [:]			
	(g) Resident Call S	ystem					
	residents to call for communication sys	e adequately equipped to allow staff assistance through a stem which relays the call ember or to a centralized staff					



If continuation sheet Page 115 of 135

		AND HUMAN SERVICES				FORM APPROVED OMB NO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495326	B. WING			C 09/11/2017
	PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP	
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTH	CA	CHAR	LOTTESVILLE, VA 2290)1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLÉTION HE APPROPRIATE DATE
F 463	Continued From pa	nge 115	F 4	63		
	work area -			F	463	
	by: Based on observa staff interview, facil working call light fo survey sample, Res Facility staff failed t system in room 118 Findings included: Resident #6 was as 07/29/2016 with dia limited to: Hyperte Diabetes, Multiple S	NT is not met as evidenced tion, resident interview, and ity staff failed to ensure a r one of 24 residents in the			 Resident #6 had Maintenance of 2. An audit of resicompleted by M. Staff were eductinoperable call Development / 10/3/2017. Maintenance of audits of 5 resign 4 weeks and to ensure compithese reports w. Quality Assurance of Maintenance of August 2007. 	idents' call bells was Maintenance on 9/10/17. Cated on reporting of bells by Staff designee by . It designee will conduct sidents call bells weekly d monthly for 2 months bliance. The findings of fill be forwarded to the nce Committee for 3
	an annual assessm reference date) of 0 assessed as cognitive score of 1 On 09/07/17 at app. Resident #6 was in of call lights being a Resident #6 stated outside the room.	DS (minimum data set) was nent with an ARD (assessment D7/28/17. Resident #6 was tively intact with a total 4 out of 15. Proximately 10:15 a.m., terviewed regarding timeliness answered by facility staff. To Well, my light doesn't work I don't know if it works at the nasn't worked for about two			months for any needed. 5. Completion dat	follow up that may be te 10/3/2017

the nurse's station."

weeks. I told one of the aides and someone at

At 10:20 a.m., this surveyor entered Resident #6's room and tried his call light. The light

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILL	DING		С	
		495326	B. WING			09/11/2017	
	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTH	CA	STREET ADDRESS, CITY, STATE, ZI 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 229			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD E THE APPROPRI	BE COMPLÉTION	
F 463	alarm at the nurse's	did not light up and it did not station. The call light for up outside of the room and	F	463			
	was interviewed reg Resident #6. LPN	#1 (licensed practical nurse) garding the call light for #1 stated, "I do not know call light not working."					
	#4-O#4) was interv system in room 118 now putting me in the system] to receive v pretty good about to	Maintenance Director (Other iewed regarding the call light I-B. O#4 stated, "They are just the TEL system [computer work requests. The staff are celling me about stuff. I will disee if I have written anything					
	room 118-B and test the wall lit up when pushed down, but v light outside of the replaced the call lig	and this surveyor entered sted the call light. The light on the red call light button was vent off when released. The room did not light up. O#4 ht cord. The new call light d worked the light outside of e nurse's station.					
	report that listed red August 15, 2017 ar with issues to "Call were listed on the regarding said repo	surveyor reviewed a TELS cent maintenance issues. Id August 21, 2017 were listed Cords." No specific rooms eport. O#4 was interviewed rt. O#4 stated, "I cannot get et, but someone from					
	RN #5 (registered r	urse)-Corporate Nurse					

Consultant was interviewed at 11:05 a.m.

DEPARTMENT OF HEALTH				FORM	APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
			V. F.		C
	495326	B. WING		09	/11/2017
NAME OF PROVIDER OR SUPPLIEF CHARLOTTESVILLE POINTE	REHABILITATION AND HEALTH	ICA	STREET ADDRESS, CITY, STATE, ZI 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 229		
PREELY (FACH DEFICIENCE	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
E 463 Continued From n	age 117	F 4	463		

F 463 Continued From page 117

regarding the above TELS report. RN #5 stated, "I cannot get into TELS, but I will find someone that can."

At approximately 11:30 a.m., this surveyor was informed that the call cord issues listed for August 15, 2017 and August 21, 2017 were for rooms 313 and 220, not 118.

The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 09/07/17. No further information was received prior to the exit conference on 09/11/17.

F 469 483.90(i)(4) MAINTAINS EFFECTIVE PEST SS=F CONTROL PROGRAM

> (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced bv:

Based on observation, staff interviews, and facility document review, the facility failed to ensure an effective pest control program throughout the facility.

The facility did not have pest control service from 2/16/17 through 6/12/17 due to non payment and fruit flies were observed throughout the facility.

The findings include:

Throughout the survey process conducted from 9/5/17 through 9/11/17 fruit flies were observed by the survey team on all units including resident rooms and common areas.

The facilities pest control invoices were reviewed

F 469

F469

- 1. Facility wide preventative pest control service was conducted on 9/22/2017 by Service Pro.
- 2. A facility wide audit was conducted by Service Pro on 9/22/2017.
- 3. Staff will be reeducated on preventative pest control and reporting by Administrator/designee by 10/3/2017.
- 4. Maintenance or designee will conduct audits of 5 residents call bells weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
- 5. Completion date 10/3/2017

24.31

		AND HUMAN SERVICES					M APPROVED D. 0938-0391
	S FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE C	CONSTRUCTION	(X3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '			co	MPLETED
		495326	B. WING _			00	C 9/11/2017
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		J, 11, 2011
CHABLO	TTERVILLE DOINTE	REHABILITATION AND HEALTHC	Δ.		NORTHWEST DRIVE		
CHARLO	TIESVILLE FOINTL	REHABIEHATION AND TEAETHO		CHA	ARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	· ·	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 469	Continued From pa	ige 118	F 4	69 i			
	on 9/7/17 and evide	enced that pest control was in					
	the facility on 2/16/	17. On 2/21/17 a letter to the					
	nest control technic	tor documented "The facilities can called this a.m. He					
	informed me that h	is office instructed him to					
	suspend service at invoices are paid."	the facility until outstanding					
	that the pest control pest control service	est control invoices indicated of resumed on 6/12/17. The ereports indicated that pest erformed at the facility 5 times gh 8/7/17.					
	observed and being resident rooms and that food debris and wall behind the disl	t indicated that fruit flies were g treated in the kitchen and deach report recommenced digrease be cleaned from the highwasher and plants be dent rooms as this is ding site.					
	in the building and concerning fruit flie #11) verbalized that problem throughout not doing a good e bathroom areas (as breeds fruit flies) a and urinals are not verbalized that fruit kitchen area arount moisture and food	a.m. pest control service was an interview was conducted as. Service technician (OS at fruit flies continue to be a at the facility because staff are nough job of cleaning around as areas close to moisture and plants (not deposed of), always cleaned. OS #11 at flies are especially bad in the d the dishwasher due to debris. OS #11 verbalized that is to the facility 14 times and solved.					

On 9/11/17 at 1:00 p.m. the above finding was brought to the attention of the administrator and

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING C B. WING 495326 09/11/2017

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)

TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 469 Continued From page 119 director of nursing. No other information was presented prior to exit on 9/11/17.

This is a complaint deficiency.

F 490 483.70 EFFECTIVE

NAME OF PROVIDER OR SUPPLIER

SS=D ADMINISTRATION/RESIDENT WELL-BEING

483.70 Administration.

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced

This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to ensure its resources were administered effectively and efficiently by not following its policy that cardiopulmonary resuscitation (CPR) certification be maintained for one employee.

1. The facility staff failed to ensure CPR (cardiopulmonary resuscitation) certification was obtained and valid for one nurse, who was a current employee of the facility.

Findings include:

On 9/6/17 at approximately 10:40 a.m., the DON (director of nursing) and AS (administrative staff) # 4 were asked for a current list of employees with evidence of CPR certification for nurses and CNA's. AS #4 stated that the nurses are the only ones in this facility who are required to have CPR certification and they are the only ones who can initiate CPR, this facility does not require CNA's

F 490

F 469

F490

1. Employee #1 has a valid Cardiopulmonary resuscitation (CPR) card at this time.

(X5) COMPLETION DATE

- 2. An audit was conducted by Assistant Administrator on 9/20/2017 ensuring current active Licensed Nurses have a valid CPR license.
- 3. Human Resources and Staff
 Development Coordinator were
 educated on ensuring compliance for
 maintaining valid CPR certifications for
 licensed nurses by Regional Nurse
 Consultant on 09/27/2017.
- 4. Staff Development Coordinator or designee will conduct audits of 5 employee records weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
- 5. Completion date 10/3/2017

1.11.

10 July 18

DEPARTMENT OF HEALTH CENTERS FOR MEDICAR				FOR	ED: 09/19/201 RM APPROVEI IO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		OATE SURVEY OMPLETED C
	495326	B. WING_		0	9/11/2017
NAME OF PROVIDER OR SUPPLIES CHARLOTTESVILLE POINTE	REHABILITATION AND HEALTH	ICA	STREET ADDRESS, CIT 1150 NORTHWEST D CHARLOTTESVILL	Y, STATE, ZIP CODE RIVE	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
allowed to do CPF present job descri The facility policy of Awareness" docur all residents witho advance directives perform CPR on redirective to do other can initiate CPR of once initiated is with do so by a physicial medical services is never a situation decision not to initiated. NEVER which a nurse can initiated. NEVER which a nurse can initiated. NEVER aware that as a number of the course, demonstration with responsibility and certification card I this card is on file. A list of current en book of CPR card certifications on 9 p.m., in addition to and CNA's. The responsibility.	fication and CNA's are not R. AS #4 was also asked to ptions for nurses and CNA's. on CPR titled, "CPR mented, "CPR is initiated on ut DNR (Do Not Resuscitate) or is identifiedNursing is to esidents who do not have a erwiseThe only time a nurse r can cease performing CPR hen you have been directed to an or when EMS [emergency arrives and takes overThere in which a nurse can make a late CPR on a full code !There is never a situation in order CPR to be stopped onceBy signing this form I am urse I am mandated to have form my duties: CPR cannot be this must be by return han instructormy until I can prove via CPR will not be able to work until	e	90		

CPR certification. The job description for CNA's documented that CNA's are to maintain CPR certification as mandated by state requirements.

The AA (assistant administrator) was asked on 9/6/17 at approximately 2:00 p.m., if all the



PRINTED: 09/19/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER WING NAME OF PROVIDER OR SUPPLIER CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA (X3) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL NUTSES in the facility were CPR certified. The AA stated that, 'most of nurses are CPR certified' and went on to say that they (the facility) use agency staff also. The AA was asked for a list of agency staff used and to present their CPR certification it was found that a current employee #1 did not have a copy of a CPR card and/or evidence of certification in the book presented by the facility. On 9/6/17 at 4:50 p.m., the survey team met with the AA, AS #4, and the DON. The staff were asked for assistance in locating evidence of Employee #1's on CPR certification. The staff were asked to provide the last day the	FORM AP	
AND PLAN OF CORRECTION A95326 B. WING	OMB NO. 09	<u> 938-0391</u>
NAME OF PROVIDER OR SUPPLIER CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 490 Continued From page 121 nurses in the facility were CPR certified. The AA stated that, 'most of nurses are CPR certified' and went on to say that they (the facility) use agency staff also. The AA was asked for a list of agency staff used and to present their CPR certification it was found that a current employee of the facility (not agency staff) an LPN (licensed practical nurse), also known as Employee # 1 did not have a copy of a CPR card and/or evidence of certification in the book presented by the facility. On 9/6/17 at 4:50 p.m., the survey team met with the AA, AS #4, and the DON. The staff were asked for assistance in locating evidence of Employee # 1's on CPR certification. The staff were asked to provide the last day the	N (X3) DATE SI COMPLE	
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 490 Continued From page 121 nurses in the facility were CPR certified. The AA stated that, 'most of nurses are CPR certified' and went on to say that they (the facility) use agency staff also. The AA was asked for a list of agency staff) an LPN (licensed practical nurse), also known as Employee # 1 did not have a copy of a CPR card and/or evidence of certification in the book presented by the facility. On 9/6/17 at 4:50 p.m., the survey team met with the AA, AS #4, and the DON. The staff were asked for assistance in locating evidence of Employee # 1's on CPR certification. The staff were asked to provide the last day the	C 09/11/	/2017
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 490 Continued From page 121 nurses in the facility were CPR certified. The AA stated that, 'most of nurses are CPR certified' and went on to say that they (the facility) use agency staff also. The AA was asked for a list of agency staff used and to present their CPR certifications, as well. During the review of the CPR certification it was found that a current employee of the facility (not agency staff) an LPN (licensed practical nurse), also known as Employee # 1 did not have a copy of a CPR card and/or evidence of certification in the book presented by the facility. On 9/6/17 at 4:50 p.m., the survey team met with the AA, AS #4, and the DON. The staff were asked for assistance in locating evidence of Employee # 1's on CPR certification. The staff were also asked to provide the last day the		
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FREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 490 Continued From page 121 F 490 nurses in the facility were CPR certified. The AA stated that, 'most of nurses are CPR certified' and went on to say that they (the facility) use agency staff also. The AA was asked for a list of agency staff used and to present their CPR certifications, as well. During the review of the CPR certification it was found that a current employee of the facility (not agency staff) an LPN (licensed practical nurse), also known as Employee # 1 did not have a copy of a CPR card and/or evidence of certification in the book presented by the facility. On 9/6/17 at 4:50 p.m., the survey team met with the AA, AS #4, and the DON. The staff were asked for assistance in locating evidence of Employee # 1's on CPR certification. The staff were also asked to provide the last day the	/ILLE, VA 22901	
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employee worked. On 09/11/17 at approximately 10:15 a.m., the AA was again asked for evidence of Employee # 1's CPR certification. The AA stated, 'she does not have an active CPR' The AA was asked where evidence was that the employee had a card. The AA stated that someone must have taken the card on file out of the book and there was no		
evidence as to when it expired. At approximately 10:45 a.m., LPN # 4 stated that Employee # 1 last worked on 8/25/17. On 9/1/17 at approximately 1:00 p.m., the administrator, AA and DON were made aware in a meeting with the survey team that this was part of a complaint investigation and it will be		

Event ID: VWGC11

information and/or documentation was presented

PRINTED: 09/19/2017 FORM APPROVED

OCNITCE	O FOR MEDICADE	O MEDICAID SERVICES				OMB NO. 0938-039
		& MEDICAID SERVICES	T (vo)	TIDLE 00 N	OTOLIOTION!	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CON	(X3) DATE SURVEY COMPLETED	
AND PLAN C	IF CORRECTION	DEIXTH TOXITION NO.	A. BUILDI	NG		
		405200	B. WING			C
		495326	B. WING			09/11/2017
NAME OF F	PROVIDER OR SUPPLIER				ADDRÉSS, CITY, STATE, ZIF	CODE
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTHO	CA		ORTHWEST DRIVE	0.4
UTARLO	TILOVILLE FORTE			CHARL	OTTESVILLE, VA 229	J1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 490	Continued From pa	nge 122	F 4	90 i		
1 430			, ,	00		
	•	ference on 9/11/17 at 2:45				
	p.m.					
	This is a complaint	deficiency.			i .	
F 514	483.70(i)(1)(5) RES		F 5	14		
SS=E		LETE/ACCURATE/ACCESSIB		T2 6 1 A	9. ° .	
00-L	LE			F514		
				1.	Resident #4's phys	
	(i) Medical records.				The state of the s	/2017. Resident # 2
	(1) In accordance v	with accepted professional			and 18's medical re	ecords from PACE
	standards and prac	ctices, the facility must			were placed on cha	art on 9/9/2017.
	maintain medical re	ecords on each resident that			Resident #3 medic	
	are-				corrected on 9/10/2	
	(:) Complete:				nurse.	2017 by neemsed
	(i) Complete;			2	An initial audit of	no ai dantal 1: 1
	(ii) Accurately docu	imented.		۷.		
	(11) Moduratory door	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				PACE and corrected.
	(iii) Readily access	ible; and				Medication Records
	, ,					ember was conducted
	(iv) Systematically	organized			by Director of Nur	
					10/03/17. All resid	ents that have enteral
	(5) The medical red	cord must contain-			feeding have poten	itial to be affected.
	(i) Cofficient inform	ation to identify the resident;		3.	Medical records we	ere educated on
	(I) Sumcient inform	ation to identify the resident,			maintaining record	
	(ii) A record of the	resident's assessments;				staff were reeducated
	(II) A record or the	, doi do			on documentation	
	(iii) The compreher	nsive plan of care and services			accurateness of Me	
	provided;	·				
					administration reco	
	(iv) The results of a	any preadmission screening			mouth (NPO) orde	rs.
	and resident review	v evaluations and		:		
	determinations cor	nducted by the State;				
	() 51	and other licensed				
	(v) Physician's, nur	rse's, and other licensed				
	professional's prog	ress notes, and			4.5	

Phys.

157

FORM APPROVED OMB NO. 0938-0391

TATEMENT OF D	DEFICIENCIES
ND PLAN OF CO	RRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	
A. BUILDING	

(X3) DATE SURVEY COMPLETED

C

495326

B. WING

09/11/2017

NAME OF PROVIDER OR SUPPLIER

CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA

STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE

CHARLOTTESVILLE, VA 22901

(X5) COMPLETION DATE CROSS-REFERENCED TO THE APPROPRIATE

(X4) ID **PREFIX** TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID **PREFIX** TAG

F 514 Continued From page 123

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:

Based on staff interview, and clinical record review, the facility failed to ensure a complete and accurate clinical record for four of 24 Residents, Resident's #4, #2, #18, #3.

- 1. Resident #4 (R 4's) physician orders indicated to give medications by mouth, however R 4 receives all medications via feeding tube.
- 2. Resident #2 clinical record did not include clinical documentation for care and services provided by "PACE." (Program for All inclusive Care for the Elderly).
- 3. Resident #18 did not have PACE notes in the clinical record.
- 4. Resident #3 had an inaccurate medication administration record.

The Findings Include:

1. R 4 was admitted to the facility on 2/11/17 with a readmission on 9/1/17 with diagnoses including tube feeding.

The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 5/26/17. R 4 was assessed as being severely cognitively impaired.

R 4's electronic record was reviewed on 9/5/17 and evidenced, via physician order set (POS) that R 4 received tube feedings 22 of 24 hours per day. The POS also gave instruction to give some

F 514

4. Medical records or designee will conduct audits of 5 PACE residents' medical charts weekly for 4 weeks and monthly for 2 months to ensure compliance. The Director of Nurses or designee will audit 5 resident charts weekly for 4 weeks and monthly for 2 months to ensure compliance with NPO orders and documentation on MARS. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

DEFICIENCY)

5. Completion date 10/3/2017

Facility ID: VA0079

		AND HUMAN SERVICES				FORM APPROV	
		& MEDICAID SERVICES	()(0) 1 11 11			OMB NO. 0938-03	91
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495326	B. WING			09/11/2017	
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	, , , , , , , , , , , , , , , , , , , ,	
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTHO	:A		NORTHWEST DRIVE ARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETI	NC
F 514	Magnesium-oxide)	ge 124 s Januvia, Levetiracetam and via feeding tube and some as Tylenol, Aspirin, and	F 5	14			
	facility staff, this sur medications orally a Registered nurse (F thought that R 4 did	.m. during a meeting with the rveyor asked if R 4 received and through a feeding tube. RN #2) verbalized that she I not receive anything orally given via feeding tube, but ke sure.					
	meeting, the admin takes all medication surveyor explained	.m. during a facility surveyor istrator verbalized that R 4 has via feeding tube. This that the orders in the POS has ons by mouth. The ed her head with					
	No other informatio conference on 9/11	n was presented prior to exit /17.					
	physician orders sir	nical record had no signed nce 7/14/17 and did not umentation for care and by PACE.					
	7/13/17 with diagnodisorder, hypernatroblood), hyperkalem concentration in the	dmitted to the facility on oses that included bipolar emia (excess sodium in the ia (high potassium e blood), depression, diabetes, e, anxiety, osteoporosis and					

dementia. The minimum data set (MDS) dated

FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY OMPLETED				
		495326	B. WING			0:	C 9/11/2017
	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTHO	CA	1150	EET ADDRESS, CITY, STATE, ZIP CO D NORTHWEST DRIVE ARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 514	Continued From pa 7/26/17 assessed F impaired cognitive s	Resident #2 with severely	F 5	14			
	admission orders for treatment signed by addition there were Resident #2 dated physician on 7/14/1 other orders in Ressigned by the physician provider. Resident reports dated 7/31/signed by a physician and/or verbal orders through 8/10/17. No reviewed or signed record documented therapy services the and occupational the of the resident's partherapy.	al record documented or medications, care and of the physician on 7/14/17. In three telephone orders for 7/14/17 signed by the 7. As of 9/5/17 there were not ident #2's clinical record cian or any health care #2's physician order summary 17 and 8/29/17 were not an. There were 28 telephone is documented from 7/17/17 one of these orders had been by a physician. The clinical the resident was prescribed at included speech, physical erapy. There were no records ticipation or progress with					
	(DON) was intervied documentation for In Resident #2 was treated therap facility. The DON is reviewed and signer orders during their instated the PACE pharesidents at the nurwere seen during the DON stated the signatures was sup	p.m. the director of nursing wed about clinical Resident #2. The DON stated eated by a PACE physician by services at the PACE tated routinely physicians d any verbal and/or telephone required visits. The DON sysicians did not come to see sing facility as the residents reir visits to the day facility. The paperwork for review and posed to be sent to the PACE w and then returned to be filed.					

Facility ID: VA0079

in the resident's clinical record. The DON was not sure who was responsible for sending the

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING C B. WING 495326 09/11/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1150 NORTHWEST DRIVE CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA CHARLOTTESVILLE, VA 22901 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLÉTION (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 514 Continued From page 126 F 514 orders to the PACE physicians for signature or for getting clinical documents from PACE. On 9/11/17 at 9:10 a.m. the administrator was interviewed about any physician progress notes or clinical documentation from PACE for Resident #2. The administrator stated the progress notes and other documentation were at the PACE facility and not in the clinical record. The administrator stated the assumption was that PACE would share their records with the facility. On 9/11/17 at 10:45 a.m. the administrator presented copies of all the notes and documentation retrieved from the PACE facility for Resident #2. The notes presented included therapy progress notes, nursing notes about medications administered at the facility, social worker notes and notes from the PACE registered dietitian. These notes had not been sent to the facility and had not been part of the resident's clinical record. These findings were reviewed with the administrator and director of nursing during meetings on 9/6/17 at 4:45 p.m. and 9/7/17 at 3:20 p.m.

3. Resident #18 who attended PACE (Program for All-inclusive Care of the Elderly) did not have progress notes or signed orders in his clinical record to reflect and coordinate the care received at PACE with the facility.

Findings were:

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	,, 03, 13,20 i 1 APPROVEI), 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495326	B. WING			. 09	C / 11/2017
NAME OF I	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP COD NORTHWEST DRIVE		
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTH	CA		ARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	ige 127	F 5	14			
	Resident #18 was a 03/10/2017. His dia limited to: Cerebro	admitted to the facility on agnoses included but were not vascular disease with ension, osteoporosis and					
	reference date) of 0 assessed as having	n an ARD (assessment 03/17/2017. Resident #18 was g a cognitive summary score e was cognitively intact.					
	Documentation from 03/10/2017 include physician electronic physician: "This is facility." There was his PACE physician progress note was practitioner on 04/2	was reviewed on 09/07/2017. In the time of his admission on d the following history and cally written and signed by his a PACE patient seen at PACE also a handwritten note from a dated 03/10/2017. The next completed by a nurse 16/2017. There were no notes in the clinical record.					
	that none of the ord been signed by a p	ician order section revealed ders on the clinical record had hysician except for one order iscontinue the use of his left					
	09/07/2017. He starecord for the PACE	with the medical director on ated that the physician of E program was no longer E facility. He stated that he					

A meeting was held on 09/07/2017 at

residents.

had assumed the role of provider for one of the residents at the facility the evening before and would be reviewing the records of the other PACE

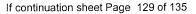
FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					O. 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) D.	(X3) DATE SURVEY COMPLETED		
		495326	B. WING			0	C 9/11/2017		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODI	=			
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTHO	A		0 NORTHWEST DRIVE ARLOTTESVILLE, VA 22901				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 514	the clinical record for no physician visits of clinical record. The DON (director of nu orders were suppose the physician see the and the acting administrator from a to help the acting assumption is that the at PACE." The DO	hysician oversight evident on or Resident #18. There were or signed orders present in the exacting administrator and the ursing) were asked how the se to be signed and when did not resident. Both the DON inistrator stated that they were CE and did not know how the se to be signed. An a sister facility who was there dministrator stated, "The the physician sees them there N and the acting administrator bok at the contract and report	F	514					
	administrator and the training) came to the with the survey tear that multiple calls he PACE program and gone there to get on she would present to PACE program was Progress notes were	pproximately 9:00 a.m., the ne AIT (administrator in e conference room to speak m. The administrator stated ad been put through to the the facility had eventually rders progress notes, etc and them to the survey team. 2:30 a.m., information from the presented by the AIT.							
	July and August. T Resident #14 was s by the PACE physic orders presented. areas of PACE (occ therapy, social work	here was no evidence that seen during the month of June sian. There were no signed Multiple notes from other cupational therapy, physical ker, etc) were presented. The my signed orders had been							



obtained from PACE to be placed on Resident #18's clinical record since none of his orders had been signed. She stated, "This is what we have."







FORM APPROVED OMB NO 0938-0391

CENTER	48 FOR MEDICARE	& MEDICAID SEKVICES			***************************************	<u> </u>	<u> </u>	0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		PLETED
		495326	B. WING					_ 11/2017
	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTH	CA	1150	REET ADDRESS, CITY, STATE, ZIP COD 0 NORTHWEST DRIVE ARLOTTESVILLE, VA 22901	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
NAME OF PROVIDE CHARLOTTESV (X4) ID PREFIX TAG RETAGENEED TAGENEED TAGENEE	should have been proceed facility. She stated	if the information presented part of the clinical record at the "Yes."	F	514				
	administration reco Resident #3 signed 8/3/17 at approxima return. The facility resident received m signed himself out of Resident #3 was or on 10/11/16, with a 08/07/17. Diagnosi but were not limited	himself out of the facility on ately 4:30 p.m. and did not staff documented that the nedications after the resident						
	amputation of the leweakness, difficulty cellulitis of the left lelymphedema and of the most current further most current further most current further with Commany) was a significant of the most current further most current further most current further further most current further	eft great toe, muscle walking, unsteadiness, ower limb, cough, steomyelitis. III MDS (minimum data set) AAS (care area assessment gnificant change assessment is MDS assessed the resident						
	resident had moder decision making sk assessed as requir one staff person for bathing. The reside	re score of '12', indicating rate impairment in daily ills. The resident was also ing limited assistance from transfers, ambulation and ent was assessed on this MDS infection and a surgical						

wound present. Additionally it was documented

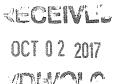
FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB M	J. 0936-039 I		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		495326	B. WING		0	C 9/ 11/2017		
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTHO	A	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC	ULD BE	(X5) COMPLETION DATE		
F 514	injections in the 7 d received IV ABX (in the 7 day look back cognition, ADL's (ar in the CAAS section A 14 day admission reviewed for compa MDS assessed the score of '13', indicat cognitively intact for resident was assess with setup for trans	sident received insuling ay look back period and also atravenous antibiotics) during at The resident triggered for activities of daily living) and falls an of this MDS. In MDS assessment was arison, dated 08/21/17. This resident to have a cognitive atting the resident was a decision making skills. The sed as requiring supervision fers and ambulation. The	F 5	514				
	and insulin during t	he 7 day look back. investigation on 9/5/17 sident #3's clinical record was						
	Resident #3 signed 8/3/17 at 4:30 p.m. resident was found (approximately 13.5 by EMS (emergency of consciousness.	I himself out of the facility on and did not return. The the next morning 8/4/17 hours later) under a bridge by medical services) with loss. The resident was taken to the ment and subsequently is.						
	specifically the resi	cal records were reviewed, dent's MARs (medication ords were reviewed for August						
	administered medi-	that Resident # 3 was cations at 5:00 p.m., when it nat the resident signed himself						

out of the facility at 4:30 p.m.

FORM APPROVED OMB NO. 0938-0391

OLIVILI	TO I ON MEDICANE	A MEDIONID OF MOLO				IVID IVO	. 0930-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495326	B. WING			1	C / 11/2017	
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	CA	115	REET ADDRESS, CITY, STATE, ZIP CODE NORTHWEST DRIVE ARLOTTESVILLE, VA 22901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 514	Continued From pa	ge 131	F5	14				
	administered medic	that Resident # 3 was cations at 6:00 p.m., when it lat the resident signed himself 4:30 p.m.						
	administered medicand the resident ha	that Resident #3 was rations on 8/4/17 at 9:00 p.m. d left the facility on 8/3/17 at admitted to the hospital at a.m. on 8/4/17.						
	(assistant administr nursing) were made were documenting a medications when t resident signed him 8/3/17 at 4:30 p.m. in at anytime after the	cimately 4:50 p.m., the AA ator) and DON (director of a aware of concerns that staff that the resident received here was evidence that the self out of the facility on and did not sign himself back that; the resident was admitted text morning on 8/4/17.						
F 500	presented prior to that 2:45 p.m.	on and/or documentation was ne exit conference on 9/11/17		200				
SS=D	483.75(g)(1)(i)-(iii)(2 COMMITTEE-MEM QUARTERLY/PLAN	BERS/MEET	F 5	20				
	(g) Quality assessm	ent and assurance.						
		aintain a quality assessment mittee consisting at a						
	(i) The director of no	ursing services;						
	(ii) The Medical Dire	ector or his/her designee;						



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		AND HUMAN SERVICES					ORM APPROVED		
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED		
		495326	B. WING				09/11/2017		
NAME OF F	PROVIDER OR SUPPLIER	Constitution of the Consti		STRI	EET ADDRESS, CITY, STATE, ZIP COD	E			
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTH	CA) NORTHWEST DRIVE ARLOTTESVILLE, VA 22901				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION E DATE		
F 520	Continued From pa	ge 132	F 5	20					
	staff, at least one of administrator, owner individual in a leader (g)(2) The quality as committee must: (i) Meet at least quality as coordinate and evalidentifying issues which assessment and as necessary; and (ii) Develop and impaction to correct ideal (h) Disclosure of inf Secretary may not records of such consuch disclosure is resuch committee with section. (ii) Sanctions. Good	er, a board member or other ership role; and essessment and assurance arterly and as needed to luate activities such as ith respect to which quality surance activities are entified quality deficiencies; formation. A State or the require disclosure of the nmittee except in so far as elated to the compliance of the requirements of this							
	committee to identification deficiencies will not sanctions. This REQUIREMENT by: Based on staff intereview, the facility s	Ty and correct quality be used as a basis for NT is not met as evidenced rview and facility document taff failed to meet the ty Assurance) committee							

The facility staff failed to ensure that the QA committee met quarterly and that the facility

medical director was present; the last

EODM ADDON/ED

		AND HOMAN SERVICES					TAPPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COV	TE SURVEY MPLETED
		495326	B. WING			1	C / 11/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
0114510		DELLA DILITATIONI AND LICAL THE	.	11	50 NORTHWEST DRIVE		
CHARLO	TITESVILLE POINTE	REHABILITATION AND HEALTHO	,A	CI	HARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From pa	ne 133	FS	520 ·			
1 020	•	-	1 0	,20			
		eeting was in April of 2017 with et, that showed the medical					
	director was not in	· ·					
	Findings include:						
	administrator) were allegation that the fameetings and that t						
	members of the factor administrator stated previous QA meeting documentation of the previous QA staff, with documentation includes that did not include	ility's QA committee. The I that she could not speak to ags, but did present he last meeting held by the which was April 20, 2017. The added an attendance sheet, the medical directors name as					
meetings and that there are a place to identify issues relate wounds, etc. The administrator was intervent members of the facility's QA administrator stated that she previous QA meetings, but did documentation of the last me previous QA staff, which was documentation included an attended that did not include the medic being present at this meeting documentation also had an awhich was blank. The administrator had a trecords regarding QA that controlled that QA committee would include	had an area called "agenda", The administrator stated that April was the most recent						
	QA committee would various department facility's Medical Dir facility's process for developing action p						

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No further information or documentation was provided to evidence that the facility staff were

Event ID: VWGC11

Facility ID: VA0079

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			OMB NO.	<u> 0938-0391</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495326	B. WING _			C 11/2017	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	· · · · · · · · · · · · · · · · · · ·		
			1150 NORTHWEST DRIVE				
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTHO	:A	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 (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)			
E 500		101					
F 520	Continued From page 134		F 52	20			
	having regular QA meetings or that the Medical Director was in attendance for last recorded			F520			
	quarterly QA meetings prior to the exit conference on 79/11/17 at 2:45 p.m. This is a complaint deficiency.			1. A Quality assurance	Meeting wa	S	
				established. 2. An audit was conducted Administrator of Quality Assessment Committee required attendees by Region on 9/14/2017. 4. Audits will be conducted Regional Nurse Conducted Conducted Audits Conducted Conduc	ith Department cal Director, and ses present and calendar anducted by f QA records on was educated on the nent and Assurance ired meetings and gional Nurse Consultant conducted through Consultant to assure h findings forwarded to for further review.		



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