State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	09/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND	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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection survey was conducted 09/13/2016 through 09/14/2016. Corrections are required for the facility to be in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated during the survey. The census in this 180 certified bed facility was 148 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Resident #1 through Resident #21) and 3 closed record reviews (Resident #22 through Resident #24).	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 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Regulations for the Licensure of Nursing Facilities: Cross Reference to F-Tag 280 12 VAC5-371-250 F Cross Reference to F-Tag 309 12 VAC 5-371-220 B	F 001	Cross Reference: F280 to 12VAC5-371-250 F F309 to 12VAC5-371-220 B	9/27/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 9-26-16

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

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 09/13/2016 through 09/14/2016. Corrections are required for the facility to be in compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 180 certified bed facility was 148 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Resident #1 through Resident #21) and 3 closed record reviews (Resident #22 through Resident #24).	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	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	solely pursuant to the requirements under state and federal laws **F 280** 1. Resident # 12's comprehensive care plan was reviewed and revised on 9/15/16 by the MDS coordinator to reflect current needs and condition including behaviors Resident #18's comprehensive care plan was reviewed and revised on 9/15/16 by the MDS Coordinator to reflect current needs and condition including behaviors.	

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

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F 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review revised the CCP (Comprehensive Care Plan) for three of 24 residents in the survey sample, Resident # 12, # 18, and # 14. 1. The facility staff failed to review and revise Resident # 12's CCP in the area of behaviors 2. The facility staff failed to review and revise the CCP for Resident # 18 in the area of behaviors. 3. The facility staff failed to review and revise the CCP for Resident # 16 regarding the use of a hoyer lift. Findings include: 1. The facility staff failed to review and revise Resident # 12's CCP in the area of behaviors. Resident # 12 was admitted to the facility on 10/20/14. Diagnoses for Resident # 12 included, but were not limited to: MS (multiple sclerosis-a disease in which the immune system eats away at the protective covering of nerves), anxiety disorder, manic depressive disorder, and schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms). The most recent MDS (minimum data set) was a quarterly assessment date 07/20/16, which assessed the resident with a cognitive score of	F 280	Resident #16's Comprehensive Care Plan was reviewed and revised on 9/15/16 by the MDS Coordinator to reflect current needs and condition including the use of a Hoyer lift. 2. The current residents' comprehensive care plans were reviewed and revised on 9/23/16 by the MDS Coordinators to ensure care plans reflect the residents' current needs and condition. 3. The licensed nurses and the interdisciplinary team were reeducated on 9/19/16 by the Director of Nursing related to the requirements of revising the care plan to reflect the residents' current condition and needs. 4. The MDS Coordinator will complete an audit weekly for 4 weeks and monthly for 2 months to ensure care plans continued to reviewed and revised to reflect the residents' current condition and needs. The Director of nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up.	9/27/16

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13, indicating the resident was cognitively intact for daily decision making skills.

An annual assessment was reviewed for comparison, dated 10/15/15. This MDS also assessed the resident with a cognitive score of 13. The resident also triggered in the CAAS (care area assessment summary) section of this MDS for psychosocial well-being.

Resident # 12's nursing notes were reviewed and documented the following in summary.

A nursing noted dated 06/07/16 documented that the resident left the facility (signed self out) on 06/07/16 and returned to the facility with the smell of ETOH (alcohol) on the resident and with slurred speech. It was determined by facility staff that the resident had consumed ETOH, while away from the facility and was intoxicated. The physician was notified and orders were given to hold the resident's medications for 24 hours and to do vital signs.

A nursing note dated 08/03/16 documented that the resident again, left the facility (signed self out) and went to the store; the resident returned with a bottle of liquor, the bottle had been opened and partially consumed by the resident, according to documentation. It was determined that the resident was not intoxicated and willingly surrendered the remaining bottle of liquor to facility staff.

A nursing note dated 08/12/16 documented that the resident again, left the facility (signed self out) at 7:35 p.m. and at 12:30 a.m. facility staff was notified that the resident was in the parking lot asleep in her wheel chair. The resident was

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F 280	Continued From page 3	F 280		

brought back into the facility and educated on the risk of falling.

Additionally, nursing notes documented that the Resident # 12 was non-compliant on multiple occasions, of not following the facility's smoking policy by smoking in undesignated areas, after being counseled repeatedly.

Resident # 12's CCP was reviewed and documented in the "Psychosocial well-being/behaviors/activities/social isolation" to, "...offer scheduled activities...initiate conversation...encourage resident to be out of room...offer interventions such as redirection, 1 on 1...encourage family and friends to visit as often as possible...resident has male friend she spends time with...." The CCP also had, hand-written updates, which included the incident on 06/07/16, where the resident came back to the facility "inebriated from alcohol" and on 09/13/16 the resident's CCP was updated regarding the incident on 08/12/16 where the resident was asleep in her wheel chair in the parking lot, with education provided. On 07/28/16 an intervention was added that Resident # 12 "May receive 1 alcoholic beverage." No other new and/or revised interventions were documented, as to what to do to deter Resident # 12 from this type of behavior and no interventions were in place to guide facility staff in responding to this type of behavior.

In the resident's "Smoking" care plan it was documented, "...Non compliant with smoking rules policies has obtained smoking paraphernalia supplies against our instruction...smoking allowed only in designated areas...patient education..." No interventions were listed to indicate what staff are to do if the

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F 280	Continued From page 4 resident is non-compliant with smoking. Resident # 12 was seen by psychiatry five times between December 2015 to July 2016. The five separate psychiatry notes were reviewed and did not address any of the above behaviors or concerns. Each note documented medications (changes/adjustments), but did not document or address any type of behavior interventions for Resident # 12 related to the above. On 09/14/16, the administrator, DON (director of nursing), ADON (assistant director of nursing) and the nurse consultant were made aware of concerns regarding Resident # 12's lack of interventions for behavioral issues, as documented in the resident's clinical record. The DON voiced, that the resident's CCP should be more individualized and focused for each person and agreed that more should be in place for Resident # 12. The DON stated that any nurse can update the CCP, that it should be updated and there is no specific person assigned to update the care plans. No further information or documentation was presented prior to the exit conference on 09/14/16 at 2:30 p.m., to evidence that Resident # 12's CCP was reviewed and/or appropriately revised to address the behavioral issues related to drinking alcohol and non-compliance with not following the facility's smoking policy. 2. The facility staff failed to review and revise the CCP for Resident # 18 in the area of behaviors. Resident # 18 was admitted to the facility on 08/25/14. Diagnoses for Resident # 18 included,	F 280		

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but were not limited to: anxiety disorder, delusional disorder, history of alcoholism, history of substance abuse, and cerebral palsy (a congenital disorder of movement, muscle tone, or posture).

The most recent MDS (minimum data set) was an annual assessment dated 07/16/16, which assessed the resident with a cognitive score of 15, indicating the resident was cognitively intact for daily decision making skills.

The resident also triggered in the CAAS (care area assessment summary) section of this MDS for psychosocial well-being.

Resident # 18's nursing notes were reviewed from June 2016 to present (September 2016) and documented the following in summary.

A nursing note dated 06/07/16 documented that the resident left the facility (signed self out) and returned to the facility with the smell of ETOH (alcohol) on the resident.

Several nursing notes from June to present (September 2016) documented that the resident was non-compliant with the facility's smoking policy, by not smoking in the areas designated for smoking. It was documented that the resident had been educated on numerous occasions and continued to engage in the same type of non-compliant behavior.

A nursing note dated 09/01/16 documented, "Seen smoking in parking lot. Cigarette butt and matches removed from resident's fanny pouch, reminded of smoking policy."

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F 280	Continued From page 6 Resident # 18's CCP was reviewed and documented in the "Psychosocial well-being/behaviors/activities/social isolation" to, "...educate patient on the importance of following rules and respecting rights of other residents...refer to psych services...treat resident with respect and explain all care prior to implementing..." In the resident's "Smoking" care plan it was documented, "...Non compliant with smoking areas and smoking in addition to taking nicotine gum consequences explained...provide a copy of facility smoking policy...smoking allowed only in designated smoking areas...while smoking will have direct supervision by staff or family member..." Resident # 18 was seen by psychiatry five times between February 2016 to July 2016. The five separate psychiatry notes were reviewed and did not address any of the above concerns or behavior. Each note documented medications (changes/adjustments), but did not document or address any type of behavior interventions for Resident # 18 regarding smoking in inappropriate areas. On 09/14/16, the administrator, DON (director of nursing), ADON (assistant director of nursing) and the nurse consultant were made aware of concerns regarding Resident # 18's lack of interventions for behavioral issues related to the above, as documented in the resident's clinical record. The DON voiced, that the resident's CCP should be more individualized and focused for each person and agreed that more should be in place for Resident # 18 regarding interventions. The DON stated that any nurse can update the	F 280		

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CCP, that it should be updated and there is no specific person assigned to update the care plans.

No further information or documentation was presented prior to the exit conference on 09/14/16 at 2:30 p.m., to evidence that Resident # 18's CCP was reviewed and revised with interventions to address the behavioral issues related to drinking alcohol and non-compliance with not following the facility's smoking policy.

3. The facility staff failed to review and revise the CCP (comprehensive care plan) for Resident #14 regarding interventions for the use of a Hoyer lift.

Resident #14 was admitted to the facility on 07/30/12 with a readmission on 4/13/16. Diagnoses for Resident #14 included, but were not limited to: Bilateral lower extremity edema, obesity, peripheral vascular disease, and difficulty walking.

The most current full MDS (minimum data set) was a quarterly assessment dated 07/20/16. Resident #14 was assessed as being cognitively intact.

On 9/13/16 Resident #14's clinical record review revealed an active care plan titled "Falls" related to "[...] generalized weakness, poor balance, difficulty walking, BLE [bilateral lower extremity] edema [...]" With interventions that included "Use Hoyer lift as needed."

Review of Resident #14's activity of daily living records (ADL's) for a period of July, August, and September 2016, indicated that Resident #14

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F 280	Continued From page 8 was transferred mostly (more than 50 % of the time) with the assist of one staff member and did not indicate through documentation that Resident #14 used a Hoyer lift to assist in transfers. On 9/13/16 at 3:30 p.m. Resident #14's physician was interviewed regarding the use of a Hoyer lift on an "as needed" basis without indicating when to use the Hoyer lift or in what circumstance should a Hoyer lift be used. Resident #14's physician verbalized that an as needed intervention (regarding a Hoyer lift) should not be on a care plan as there are no set parameters which allows the staff to use or not use the Hoyer lift and could cause an unsafe transfer. On 9/14/16 at 7:45 a.m. MDS coordinator, registered nurse (RN #1) was interviewed regarding the above finding. RN #1 verbalized that she does the initial care plan for the resident's and then it is updated by nursing staff. RN #1 verbalized, after reviewing Resident #14's care plan, RN #1 realized that a Hoyer lift used as needed did not set parameters and should not be on the care plan without knowing when to use the Hoyer lift. The DON (director of nursing) and administrator were made aware of the above finding in a meeting with the survey team on 09/14/16 at approximately 1:50 p.m. No further information or documentation was presented prior to the exit conference on 09/14/16.	F 280		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=D	Continued From page 9 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview, clinical record review, and facility document review the facility staff failed to follow physician orders for one of 24 residents in the survey sample: Resident # 16. Resident # 16 was not instructed to rinse his mouth after the use of an inhaler. Findings include: Resident # 16 was admitted to the facility 2/2/12 with a readmission date of 11/18/15. Resident # 16's diagnoses included, but were not limited to: chronic rhinitis (seasonal allergy symptoms) and Chronic obstructive pulmonary disease (COPD.) The most recent MDS (minimum data set) was a quarterly review dated 7/14/16. Resident # 16 was coded as being cognitively intact with a total summary score of 15 out of 15. On 9/14/16 beginning at 8:00 a.m. a medication pass and pour observation was conducted with LPN (licensed practical nurse) # 1. One medication "Breo Ellipta 100/25 mcg (micrograms)" instructed on the label "***RINSE	F 309	F 309 1. Resident #16 oral cavity was assessed by the licensed nurse on 9/14/16 with no change in condition noted. LPN #1 was reeducated on 9/19/16 by the Assistant Director of Nursing related to ensuring residents are instructed to rinse mouth after the use of steroid inhalers and physician orders are followed as required. 2. Medication pass audits were completed on 9/26/16 by the Unit Managers to ensure licensed staff are following physician orders as required. 3. The licensed nurses were reeducated on 9/19/16 by the Assistant Director of nursing related to inhaler administration and ensuring physician orders are followed as required. 4. The Unit Managers will complete med pass observations weekly for 4 weeks and monthly for 2 months to ensure physician orders continue to be followed as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director	

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F 309	Continued From page 10 MOUTH WELL AFTER USE OF STEROID INHALER***" (sic). The resident was to inhale one puff of the medication. LPN # 1 administered the residents medications, and after the resident took the one puff of the inhaler, LPN # 1 proceeded to then administer eye drops. LPN # 1 did not instruct the resident to rinse his mouth after using the inhaler. After leaving the resident's room, this surveyor asked LPN # 1 about the inhaler, and the omission of instructing the resident to rinse his mouth. LPN # 1 stated "I know that [he should rinse his mouth]; he had a cup of water there and I should have had him rinse his mouth out. I usually do; I was just....." LPN # 1's statement trailed off. On 9/14/16 at 8:45 the clinical record was reviewed for reconciliation of the medications administered to Resident # 16. The August 2016 POS (physician order summary) included an order carried forward from 1/12/16 for "Breo Ellipta 100/25 mcg dose inhaler Inhale 1 puff ***RINSE MOUTH WELL AFTER USE OF STEROID INHALER***" On 9/14/16 at 9:00 a.m. the DON (director of nursing) was asked for a policy for the administration of inhaled steroid medications. The DON gave this surveyor a copy of the facility policy "Orally Inhaled Medications" which included under "Procedure: #7. Gargling or rinsing mouth after spraying will reduce drug absorption from the oral mucosa. Rinsing the mouth is most commonly recommended with long term steroid use." The administrator, DON, ADON (assistant director of nursing), and the regional nurse consultant were informed of the above	F 309	of Nursing will be responsible for monitoring and follow up.	9/27/16

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(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 309	Continued From page 11 observation during a meeting with facility staff 9/14/16 beginning at 1:40 p.m. No further information was provided prior to the exit conference.	F 309		