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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 10/25/2017

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

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{F 000}	INITIAL COMMENTS	{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 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY	F241	1. Resident #106's drainage bag was placed in a privacy cover. 2. An audit was completed by Nursing Management on 10/27/2017for residents with foley catheters. 3. Nursing Staff were re-educated on maintaining dignity and privacy with catheter bags by Director of Nurses / designee beginning 10/28/17. 4. A Nursing Manager or designee will conduct audits of 5 residents with a catheter for presence of dignity covers weekly for 4 weeks then monthly for 2 months to ensure presence of privacy bags on catheters. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed or further recommendations. 5. Completion date 11/4/17.	

An unannounced Medicare/Medicaid revisit to the standard survey conducted 9/5/17 through 9/11/17, was conducted on 10/24/17 through 10/25/17. One complaint was investigated on this survey. Uncorrected deficiencies are identified within this report. The facility was not in compliance with 42 CFR Part 483, the Federal Long Term Care requirements.

The census in this 180 certified bed facility was 153 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents # 101 through 114).

(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.
This REQUIREMENT is not met as evidenced by:
Based on observation, and staff interview, facility staff failed to ensure a urinary drainage bag was in a privacy bag for one of 14 residents in the survey sample, Resident #106.

Resident #106's suprapubic urinary drainage bag was a clear bag, not in a privacy bag.

Findings included:

Resident #106 was originally admitted to the facility on 07/29/16 and recently readmitted on 10/06/17 with diagnoses including, but not limited

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheryl R Martin | TITLE: Administrator | (X6) DATE: 11/3/17

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

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F 241	Continued From page 1	F 241		

to: Multiple Sclerosis, Neurogenic Bladder, Suprapubic Catheter, Pneumonia, Respiratory Failure, Depression, and a Stage 4 Decubitus Ulcer.

The most recent MDS (minimum data set) was a 5-day assessment with an ARD (assessment reference date) of 10/13/17. Resident #106 was assessed as cognitively intact with a total cognitive score of 14 out of 15.

Resident #106 was observed lying in his bed on 10/24/17 at 2:10 p.m. A clear urinary drainage bag was hanging from the side of his bed and contained clear, yellow urine.
Resident #106 was observed again on 10/25/17 at 9:30 a.m. lying in his bed. A clear urinary drainage bag was hanging from the side of his bed and contained clear, yellow urine.

At approximately 9:35 a.m. this surveyor approached LPN #1 (licensed practical nurse) and asked if she was caring for Resident #106. LPN #1 stated, "Yes." LPN #1 and this surveyor walked to Resident #106's room to observe his urinary drainage bag. LPN #1 stated, "I don't believe that's one of our bags." Written on the back of the drainage bag in black marker was, "Changed 10/13/17 at 0100 [1:00 a.m.]." LPN #1 stated, "I doubt the hospital changed it." At approximately 9:41 a.m., LPN #1 went to the supply room and retrieved another catheter bag with a privacy cover. LPN #1 showed this surveyor the new drainage bag and stated, "I have no idea what happened to the other. I am taking care of it now."

The Administrator and DON (director of nursing) were informed of the above during a meeting with

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F 241	Continued From page 2	F 241		

the survey team on 10/25/17 at 10:30 a.m. No further information was received prior to the exit conference on 10/25/17.

{F 281} SS=D 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

(b)(3) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observations, and staff interview, the facility staff failed for one of 14 residents in the survey sample (Resident # 105), to verify the transcription of medication orders to the Electronic Medication Administration Record. Upon readmission to the facility, duplicate medications were entered on Resident # 105's Electronic Medication Administration Record.

The findings were:

Resident # 105 in the survey sample, a 57 year-old male, was admitted to the facility on 8/18/17, and most recently readmitted on 10/23/17 with diagnoses that included cirrhosis, depression, chronic obstructive pulmonary disease, melena, generalized muscle weakness, chronic pain, history of falling, and sleep apnea. According to an Admission Minimum Data Set, with an Assessment Reference Date of 8/24/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact,

{F 281} F281

1. Resident #105's medication administration record was corrected by the licensed nurse on 10/25/2017 and suffered no negative outcome.
2. An audit of newly admitted residents was conducted by Director of Nurses / designee beginning 11/3/2017 to validate there are no duplicate orders are present. Any negative findings will be corrected at that time.
3. Licensed Nurses were re-educated on the readmission process with emphasis on prevention of duplicate orders by Director of Nurses / designee on 11/3/17.
4. The Director of Nurses or designee will conduct audits of 5 newly admitted residents medication administration records weekly for 4 weeks and monthly for 2 months to ensure no duplicate orders are present. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed or further recommendations.
5. Completion date 11/4/17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 281}	Continued From page 3	{F 281}		

with a Summary Score of 14 out of 15.

Resident # 105's hard copy (paper) clinical record included Discharge Summary Notes, dated 10/23/17, the date of his discharge from the hospital. A part of the Discharge Summary was a "Current Discharge Medication List" that included the following notation, "CONTINUE these medications which have NOT CHANGED." The medications included the following:

Folic Acid 1 mg - Take 1 mg by mouth once a day.
Gabapentin 300 mg - Take 300 mg by mouth every night at bedtime.
Lidocaine 5% - Apply one patch as directed every 24 hours.
Therapeutic multivitamin-minerals - Take one tablet by mouth once a day.
Sertraline 25 mg - Take 25 mg by mouth once a day.

Review of the October 2017 Electronic Medication Administration Record (E-MAR) in Resident # 105's electronic clinical record revealed that the five of the medications on the Discharge Medication List were entered on the E-MAR with an order date of 10/23/17.

The October 2017 E-MAR also included the following medications and the dates ordered:

8/18/17 - Folic Acid 1 mg - Give 1 mg by mouth one time a day.
8/18/17 - Gabapentin 300 mg - Give 300 mg by mouth at bedtime.
8/18/17 - Lidocaine 5% - Apply to lower back topically one time a day.
8/18/17 - Therapeutic multivitamin-minerals -

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	495326	A. BUILDING _____ B. WING _____	R-C 10/25/2017

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{F 281}	Continued From page 4	{F 281}		

Give one tablet by mouth one time a day.
9/24/17 - Sertraline 25 mg - Give 25 mg by mouth one time a day.

Further review of the October 2017 E-MAR indicated that both orders of Gabapentin were signed off as being administered on 10/23/17, and that both orders of Folic Acid, Lidocaine, Therapeutic Multivitamin, and Sertraline were signed off as being administered on 10/24/17.

At 2:15 p.m. on 10/24/17, RN # 1 (Registered Nurse), whose initials appeared on the E-MAR as having administered some of the medications, was asked how many Lidocaine patches were applied to Resident # 105. RN # 1 replied, "He gets one." The surveyor then asked RN # 1 to review the E-MAR for Resident # 105 and explain why the E-MAR indicated two patches were applied. After reviewing the Discharge Medication List and then the E-MAR, RN # 1 said the E-MAR was not correct. "Someone must have entered the medication (Discharge Medication List) orders on the E-MAR without checking the current orders." RN # 1 went on to say that the resident was receiving only one of each medication listed.

The surveyor then asked to see the medications for Resident # 105 in the medication cart. RN # 1 retrieved the medications for Resident # 105 from the medication cart. There were no duplicate medications in the medication cart for Resident # 105.

Potter-Perry notes the following about the transcription of medication orders, "A registered nurse compares the list of medications on the MAR against the original orders for accuracy and

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{F 281}	Continued From page 5 thoroughness. If an order seems incorrect or inappropriate, the nurse consults the prescriber." (Ref. Potter-Perry Fundamentals of Nursing, 7th Edition, Chapter 35, page 713.) The duplicate medication orders were discussed during a meeting at 10:30 a.m. on 10/25/17 that included the Administrator, Director of Nursing, and the survey team.	{F 281}		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	F 309	F309 1. Resident #110 is receiving medications according to physician's order. 2. An initial audit of current PACE resident's medical records was conducted to ensure compliance with initiating physician orders by Director of Nurses / designee by 11/3/2017. 3. Licensed nurses will be re-educated on initiation of physician orders by Director of Nurses, Staff Development Coordinator/designee by 11/3/2017. 4. The Director of Nurses or designee will conduct audits of 5 PACE 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 11/4/2017.	

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F 309	Continued From page 6	F 309		

and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to promptly initiate a physician's order for one of 14 residents in the survey sample. Resident #110's physician's order for Premarin cream for treatment of atrophic vaginitis was not started until five days after it was ordered.

The findings include:

Resident #110 was admitted to the facility on 3/31/17 with a re-admission on 6/15/17. Diagnoses for Resident #110 included heart failure, high blood pressure, urinary tract infection, vaginitis, diabetes and spinal stenosis. The minimum data set (MDS) dated 8/28/17 assessed Resident #110 with moderately impaired cognitive skills.

Resident #110's clinical record documented a physician's order dated 10/12/17 for Premarin cream to be administered every other day for treatment of atrophic vaginitis. The resident's treatment administration record (TAR) for October 2017 documented the cream application was not started until five days later on 10/17/17. The clinical record including nursing notes documented no reason for the delay in treatment.

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F 309	Continued From page 7	F 309		

On 10/15/17 at 8:30 a.m. the medical director was interviewed about Resident #110's order for Premarin cream. The medical director stated the nurse practitioner from PACE (program for the all inclusive care for the elderly) wrote the order for the Premarin cream. The medical director stated he did not know for sure what prompted the order for the Premarin.

On 10/25/17 at 12:10 p.m. the director of nursing (DON) was interviewed about the delay in starting the Premarin cream for Resident #110. After researching, the DON stated the medical director reviewed all orders from the PACE providers. The DON stated the medical director reported the facility nurses called him about the Premarin order and he gave verbal approval to start the medication. The DON stated there was no documentation in the record about this call or when the call took place. The DON stated she did not have an explanation for the five-day delay in starting the Premarin cream for Resident #110.

The Nursing 2017 Drug Handbook on page 577 described Premarin as an estrogen cream used to treat vulvar/vaginal atrophy in addition to symptoms of menopause. (1)

These findings were reviewed with the administrator and DON during a meeting on 10/25/17 at 10:30 a.m.

(1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.

{F 325} SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	{F 325}	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 325}	Continued From page 8 (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- (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 by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure that a physician ordered therapeutic diet was followed for one of 14 residents, Resident #107. Resident #107, did not receive physician ordered nectar thick liquids during a medication pass and pour observation, and did not have her diet changed to include fortified foods as recommended by the RD (registered dietitian) and ordered by the physician on 10/20/2017. Findings were: Resident #107 was originally admitted to the facility on 04/04/2015 and was most recently readmitted on 09/25/2017. Her diagnoses included, but were not limited to: Hypertension, cerebrovascular disease, ,diabetes mellitus,	{F 325}	F325 1. Resident #107 is receiving diet and liquids according to physicians order. 2. Nurse Consultant conducted an audit of the nutritional therapy recommendations from time frame 9/29/17 through 10/26/17 to validate recommendations were carried thru as indicated on 10/31/2017. Any negative findings were corrected at that time. Director of Nursing/designees conducted a baseline audit of all diet order for current residents to validate current diet order is being served according to physicians order on 10/31/2017. 3. Nursing staff were re-educated on protocols to ensure physician ordered therapeutic diet orders are initiated by Director of Nurses / Designee by 11/3/2017. Director of Nursing was re-educated by the nurse consultant on 10/31/17 regarding protocol of completing nutritional recommendations. 4. The Director of Nurses or designee will conduct audits of 5 residents therapeutic diet orders 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 or further recommendations. 5. Completion date 11/4/2017	

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{F 325}	Continued From page 9	{F 325}		

altered mental status, and Hallervorden-Spatz Disease.

The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 10/06/2017. Resident #107 was assessed as having a cognitive summary score of "06", indicating severe impairment with her cognitive status.

The clinical record for Resident #107 was reviewed on 10/24/2017 at approximately 3:30 p.m. The orders section of the electronic record included the following diet order: "Regular diet Pureed texture, Nectar thickened consistency."

A medication pass and pour observation was conducted on 10/25/2017 beginning at approximately 8:00 a.m. LPN (licensed practical nurse) #1 was observed preparing the morning medications for Resident #107. Included in the morning medications was "Miralax 17 gram (sic) by mouth one time a day...mixed in liquid PO Q am [by mouth every morning]. LPN #1 measured the Miralax and poured it into a cup and added water from a pitcher on the medication cart. She stated, "It takes some time to give her [Resident #107] her medications, we go slow with her because she gets choked easily." LPN #1 finished preparing the medications. She crushed the medications in pill/tablet form and added them to applesauce, stating this would help Resident #107 swallow them. LPN #1 also measured out 120 mls of Ready Care 2.0, a physician ordered supplement. This surveyor accompanied LPN #1 to Resident #107's room. Resident #107 swallowed the pills mixed in the applesauce without difficulty. LPN #1 then administered the Miralax. She held the cup and

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{F 325}	Continued From page 10	{F 325}		

placed small amounts of the liquid in Resident #107's mouth. Resident #107 became strangled with coughing periodically during the administration of the Miralax. At approximately 8:30 a.m., Resident #107 finished the Miralax. LPN #107 then administered the supplement in the same manner to Resident #107, by placing small amounts in her mouth. Resident #107 did not become strangled during the administration of the supplement. This surveyor asked LPN #1 if she thought that Resident #107 handled the supplement and the applesauce better because it was thicker. She nodded her head and stated, "Probably so." Observed on the wall in Resident #107's room was a typed piece of paper with the resident's name on it, titled "Safe feeding/intake strategies". The strategies were: "1. Mechanical Soft/Ground Consistency Diet; 2. Thin liquids in Provale cup only if Independent-cup rim if fed by staff; 3. PO intake when out of bed/in chair only; 4. Alternate Bites/sips; 5. Verbal cue to clear oral residue prior to next bite; 6. Stop pt [patient] from self-feeding if coughing noted; 7. Wait 5 minutes after coughing episode to restart feeding." There was phone number listed for staff to call if there were any questions and the name of a SLP listed at the bottom of the page. The paper was not dated or signed. LPN #1 was asked about the paper on the wall. She went over to the paper and removed it from the wall. She stated, "That is from PACE...we don't take orders from them, [name of medical director] writes our orders."

After the medication pass and pour observation was completed, this surveyor again reviewed the clinical record to determine the diet and liquid consistency ordered for Resident #107. The order in the clinical record was for puree diet with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 10/25/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 325}	Continued From page 11	{F 325}		

nectar thick liquids, not the posted diet on the paper in Resident #107's room. This surveyor returned to LPN #1 and asked her what type of liquid was in the pitcher on the cart. She stated, "Just water." This surveyor asked if it was thickened. She stated, "No." This surveyor then asked LPN #1 what type of diet and liquids Resident #107 was ordered to receive. LPN #1 looked a the screen used to give medications and stated that she did not see the orders there. She then went to a different screen, (the physician order screen) and stated, ""There it is, puree diet with nectar thick liquids...that doesn't show up on the screen we use to give the medicines...I didn't know that was what she was getting but I should have known that." LPN #1 was asked how she would know the type of diet for her residents. She stated, "I would have to go to the order screen for each one and look." LPN #1 was asked if residents at the facility ever had the nectar thick liquids placed in coolers in their rooms. She stated, "Yes, they do...she doesn't have one of those."

This surveyor then went to the kitchen to speak with the dietary manager. He was asked what type of diet Resident #107 was receiving. He stated he would bring the orders to the conference room. At approximately 9:30 a.m., he brought a "Diet Requisition Form" to this surveyor. The form was marked with the following information: Diet Change; Texture: Puree; Thickened Liquids: Nectar. The form was dated 10/11/2017. He stated, "This is the most recent diet order that we have." The dietary manager was asked if nectar thickened liquids were placed in a residents room in a cooler if they had orders for nectar thick liquids. He stated, "Yes, most of the time, but she goes to PACE so

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 10/25/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 325}	Continued From page 12	{F 325}		

we don't do that with her...her liquids on her tray for breakfast and dinner are nectar thick, but since she is gone all day to PACE we don't put any in her room." The DON came to the conference room at that time and she was asked how a nurse giving medications was suppose to know the type of diet a resident was receiving. She stated, "It should be on her shift report."

This surveyor went back to LPN #1 and asked to see her shift report. No notations were made on the shift report regarding diet orders for any of the residents. The DON came down the hall and spoke with LPN #1. She instructed her to click on an area on the screen of the computer. When LPN #1 did so, the information field expanded revealing additional information including diet orders. LPN #1 stated, "I didn't know about that." The DON was asked by this surveyor how she knew to do that. The DON stated, "Another nurse just told me."

Further review of the clinical record was conducted. The progress notes were reviewed. A Nutrition/dietary note dated 10/19/2017 was observed and contained the following information: "Weight 10/9 = 116.4 # [pounds] - significant weight loss 13..39 % X [times] 1 mo [month], sig wt loss 14.03% X 3 mo, sig wt loss 16.74% X 6 mo. 10/11/17: diet downgraded to Pureed with nectar-thick liquids by SLP [speech language pathologist]. Intakes variable, with overall decreased noted. Large portions at meals. Plate guard now d/c [discontinued] d/t [due to] need for resident to be fed. 2.0 supplement in place for increased kcal and protein intake; 120 ml BID [twice a day] Monday -Friday (480 kcal, 20 gm pro [protein]) and 120 ml TID [three times a day] on weekends 9720 kcal, 30 gm pro), Out to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 10/25/2017

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

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{F 325}	Continued From page 13	{F 325}		

hospital overnight 9/24 to 9/25 s/p [status post] fall from bed. Currently receiving antibiotics for UTI [urinary tract infection]. Decreased appetite could be r/t [related to] acute episodes, antibiotics. Recommend addition of fortified foods to all meals." A note written by the DON (director of nursing) on 10/20/2017 contained the following: "MD reviewed RD recommendations, new order received for fortified foods with meals and weekly weights..."

The physician order section was again reviewed on both the electronic and paper clinical record. No orders were observed for the fortified foods. On 10/25/2017 at approximately 10:30 a.m., a meeting was held with the DON and the administrator. The DON stated that she had written the note regarding the fortified foods and weekly weights but had not written the verbal orders for the fortified foods. She stated, "That was on Friday, we have a PAR [patient at risk] meeting every Wednesday...we would have caught that today in our meeting....we go over weight loss and we would have reviewed the notes and made sure orders were in place." This surveyor clarified that Resident #107 had gone an additional five days without fortified foods because a verbal order had not been written and communicated to the dietary department. She stated, "Yes, but we would have caught it today. We would have written the order and made sure it was care planned."

At 11:10 a.m., the SLP from PACE was contacted via telephone to discuss the safe feeding strategies posted in Resident #107's room. He stated, "I brought the information to the facility for the nursing staff and the CNAs (Certified nursing assistants) to use...I think I took about four

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 10/25/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 325}	Continued From page 14	{F 325}		

copies...I don't know how they do their training over there so I told the nurse, and I don't know who it was, to place them wherever they were needed...I didn't tell her to put them on her wall." He was asked if the strategies he had given to the facility were physician ordered. He stated, "No, they are not orders...They are recommendations...We don't need a physician to sign off on our recommendations." The SLP was asked what type of diet Resident #107 was currently on. He stated, "There was some kind of incident over there so they had their speech therapist look at her...that's when the diet got downgraded to puree with nectar thick liquids." He was asked if he had updated the recommendations he gave the facility regarding the intake strategies due to the diet change. He stated, "No, I did not."

At approximately 11:30 a.m., the medical director came in to speak with this surveyor regarding the Resident #107's diet orders for fortified foods. Resident #107's 22.2 pound weight loss (16.5%) in one month was also discussed. The medical director stated that yes he had agreed to the fortified foods being added. He also stated that the facility staff had become concerned regarding Resident #107's ability to swallow and eat safely without choking. He stated that the facility speech therapist had evaluated her and subsequently the diet was downgraded to puree with nectar thickened liquids.

The speech therapist at the facility spoke with this surveyor at approximately 11:45 a.m. and stated that she had worked with Resident #107 and nursing staff on downgrading the diet to puree with nectar thickened liquids and safe eating strategies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 10/25/2017

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

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{F 325}	Continued From page 15	{F 325}		

ST notes were reviewed. The Speech Therapy Plan of Care (10/11/2017 -10/13/2017) included the following information: "Reason for Referral: Pt is a LTC resident at this facility who receives ST through PACE. Pt was referred per MD for skilled ST services for swallowing evaluation to determine the safest diet for pt. Staff has become very concerned about feeding pt her current mech soft with thin liquids via flow cup diet. Pt exhibits frequent coughing during meals even with the use of PACE recommended safe swallowing strategies. Therapy Necessity: Patient presents with severe oropharyngeal dysphagia influencing their ability to safely and efficiently consume current mech soft solids with thin liquids diet w/o [without] s/s [signs/symptoms] of dysphagia or aspiration/penetration. Skilled intervention is necessary for swallowing assessment, diet texture analysis, and pt/caregiver training in use of safe swallowing strategies. Without therapy, patient is at risk for further weight loss, aspiration, choking and decline in functioning....Initial Assessment: Prior Level Functional Deficits: Swallowing, Swallow Status Mild impairment (25-50% impairment; risk of aspiration on liquids; mild oral residue and may need meats ground or chopped; .... Swallowing, Diet Level: Mechanical soft/ground Swallowing, Liquid Level: thin liquids." "Current Level Functional Deficits: Swallowing, Swallow Status Severe impairment (75-90% impairment...high risk of aspiration; requires supervision with oral intake due to aspiration risk and/or significant weight loss...Swallowing, Diet Level: Pureed Swallowing, Liquid Level: Nectar Thick Liquids..."

No further information was received prior to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 10/25/2017

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

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{F 325}	Continued From page 16 exit conference on 10/25/2017.	{F 325}		
{F 386} SS=D	483.30(b)(1)-(3) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS	F386		

(b) Physician Visits
The physician must--

(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;

(2) Write, sign, and date progress notes at each visit; and

(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure a progress note was written after provider visit for one of 14 residents in the survey sample. Resident #110, who attended PACE (Program for All-inclusive Care of the Elderly), did not a progress note documented and/or signed regarding a visit with the PACE nurse practitioner (NP).

The findings include:

Resident #110 was admitted to the facility on 3/31/17 with a re-admission on 6/15/17. Diagnoses for Resident #110 included heart failure, high blood pressure, urinary tract infection, vaginitis, diabetes and spinal stenosis. The minimum data set (MDS) dated 8/28/17

1. Resident #110's progress notes were completed and signed by the Nurse Practitioner of PACE (Program for All-inclusive Care of the Elderly) and Medical Director.
2. An audit of residents' medical records who attend PACE for progress notes was conducted by Nursing Administration / designee by 11/3/17.
3. PACE Physicians and medical records were educated on signing of progress notes on 11/3/2017 by Administrator / designee.
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 11/4/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 10/25/2017

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

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{F 386}	Continued From page 17	{F 386}		

assessed Resident #110 with moderately impaired cognitive skills.

Resident #110's clinical record documented a physician's order dated 10/12/17 for Premarin cream to be administered every other day for vaginitis. The order was written by a nurse practitioner providing care to Resident #110 at PACE. There were no nursing notes and/or mention of resident complaints in the clinical record indicating what prompted the order for the Premarin.

On 10/25/17 at 8:30 a.m. the director of nursing (DON) was interviewed about the assessment that prompted the order for the Premarin cream. The DON stated she did not see anything in the clinical record but she would check with PACE personnel for information about the Premarin.

The DON presented documentation from PACE that included a nursing note dated 10/6/17 stating Resident #110 was "seen in clinic for burning on urination, urine specimens sent for C&S [culture and sensitivity]. FU [follow up] next week..." The DON also presented a NP note dated 10/10/17 stating, "... [Resident #110] comes to clinic today for re-evaluation of dysuria. She was seen on 10/6 [2017], diagnosed with UTI [urinary tract infection] ..."

The clinical record documented no progress note for Resident #110's visit with the PACE nurse practitioner on 10/6/17.

On 10/25/17 at 11:45 a.m. the DON was interviewed about a progress note for the 10/6/17 visit. The DON stated there was no progress note from the NP for the 10/6/17 visit. The DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 10/25/2017

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

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{F 386}	Continued From page 18 stated the nursing note was the only documentation from PACE on 10/6/17. The DON stated the PACE providers were supposed to document progress notes for each resident assessment/visit and send the notes to the facility for inclusion in their clinical record. These findings were reviewed with the administrator and DON during a meeting on 10/25/17 at 10:30 a.m.	{F 386}		
{F 514} SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F514	1. Resident #110's progress notes were completed and signed by the Nurse Practitioner of PACE (Program for All-inclusive Care of the Elderly) and Medical Director. Resident# 107 has the correct resuscitation status in medical record according to physician order as of 10/31/17. 2. An initial audit of residents' medical records who attend PACE was conducted by Medical records and corrected by 11/3/2017 to validate recent progress notes are available on the medical record. An initial audit was conducted by Social Services to validate each residents medical record contains the correct advanced directive by 11/3/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 10/25/2017

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

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{F 514}	Continued From page 19	{F 514}		

and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(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 staff failed to ensure a complete and accurate clinical record for two of 14 residents in the survey sample. Resident #110's record was missing a progress note written by the PACE (program for the all inclusive care of the elderly) nurse practitioner regarding diagnosis and treatment of a urinary tract infection. Resident #107's clinical record documented conflicting resuscitation status for the resident.

The findings include:

1. Resident #110's record was missing a progress note written by a PACE nurse practitioner.

Resident #110 was admitted to the facility on 3/31/17 with a re-admission on 6/15/17. Diagnoses for Resident #110 included heart failure, high blood pressure, urinary tract infection, vaginitis, diabetes and spinal stenosis. The minimum data set (MDS) dated 8/28/17 assessed Resident #110 with moderately impaired cognitive skills.

Resident #110's clinical record documented the resident went to the PACE facility each week day and received ongoing care/treatment by PACE

3. Medical records and PACE providers were educated on maintaining records of the PACE residents 11/3/2017 by Administrator/ designee. Social services, medical records, and licensed nurses will be educated on maintaining the correct resuscitation status in the medical record by Director of Nursing / designee beginning 11/3/17.
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 with progress notes and advanced directive status.
   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 11/4/2017.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 10/25/2017

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

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{F 514}	Continued From page 20	{F 514}		

providers. Resident #110's clinical record documented a note from the medical director dated 10/24/17 indicating the resident was seen by a nurse practitioner (NP) on 10/12/17. The clinical record included no progress note from the NP on or around 10/12/17.

On 10/25/17 at 8:30 a.m. the medical director was interviewed about the reference to the NP visit in his note dated 10/24/17. The medical director stated he reviewed a medication order sent from the PACE nurse practitioner dated 10/12/17 but he was not sure if this was a verbal order or if the resident was seen by the NP while at the PACE facility.

On 10/25/17 at 9:10 a.m. the DON was interviewed about a progress note regarding a PACE provider visit related to the medication order dated 10/12/17. After reviewing the DON stated the resident was seen by a NP while at the PACE facility. The DON presented a NP progress note dated 10/10/17. When asked why the progress note was not in the resident's clinical record, the DON stated PACE had the progress note and it had not been sent to the facility. The DON stated the PACE providers were supposed to document any clinic visits with the resident and send the progress notes to the facility so they could be included in their clinical record.

These findings were reviewed with the administrator and DON during a meeting on 10/25/17 at 10:30 a.m.

2. Resident #107, had conflicting resuscitation orders in her paper record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	R-C 10/25/2017

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

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{F 514}	Continued From page 21	{F 514}		

Resident #107 was originally admitted to the facility on 04/04/2015 and was most recently readmitted on 09/25/2017. Her diagnoses included, but were not limited to: Hypertension, cerebrovascular disease, diabetes mellitus, altered mental status, and Hallervorden-Spatz Disease.

The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 10/06/2017. Resident #107 was assessed as having a cognitive summary score of "06", indicating severe impairment with her cognitive status.

The clinical record for Resident #107 was reviewed on 10/24/2017 at approximately 3:30 p.m. The electronic medical records contained a physician order for Resident #107 to be a "DNR" (do not resuscitate). Review of the paper chart on 10/25/2017 revealed a green piece of paper in the front of the clinical record with the word "FULL" typed on it. Behind the green paper was a Durable Do Not Resuscitate Order for Resident #107.

During a meeting with the DON (director of nursing) and the administrator on 10/25/2017, the DON was asked how it was determined if a resident was a full code or a DNR. She stated, we go by the physician orders. The green "FULL" was shown to the DON. She stated, "The orders are for her to be a DNR, that is what we would go by."

No further information was received prior to the exit conference on 10/25/2017.