PRINTED: 03/15/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495326	B. WING	Address of the second section of the second	C 03/08/2017	
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHC	ΣΔ 11	TREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901	1	initiality
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	DBE COMPLÉTIO	N
F 157	standard (complain 03/07/17 through 0 corrections are req CFR Part 483 Feder requirements. The investigated during The census in this 153 at the time of the consisted of 3 curres (Residents 1, 4, and reviews (Residents 483.10(g)(14) NOT (INJURY/DECLINE) (g)(14) Notification (i) A facility must improve the consistent with the responsistent with his consult with the responsistent with his consults in injury and physician intervention. (B) A significant charmental, or psychosodeterioration in head	Medicare/Medicaid Abbreviated at) survey was conducted 03/08/17. Significant quired for compliance with 42 eral Long Term Care are were three complaints at the survey. 180 certified bed facility was the survey. The survey sample ent Resident reviews at 5) and 2 closed record at 2 and 3). TIFY OF CHANGES E/ROOM, ETC) of Changes. Inmediately inform the resident; sident's physician; and notify, or her authority, the resident when there is- rolving the resident which at has the potential for requiring ion; ange in the resident's physical, ocial status (that is, a alth, mental, or psychosocial	F 000	1. Resident #2 was discharged from the facility on 02/17/17. 2. An audit was completed on 3/1 by the Unit Managers of the current residents' medical records for the 30 days to ensure the physician has been notified of changes in conditions. The licensed nurses were reeducated on 3/15/17 by the Staff	wille titute e ment tted nts om 14/17 ent e past as stion.	
	(C) A need to alter t a need to discontinu treatment due to ad	threatening conditions or ns); treatment significantly (that is, ue an existing form of dverse consequences, or to form of treatment); or	REC	Development Coordinator on the requirements of notification to the physician on changes in condition	e	
				All A		- 7

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

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.

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

TITLE

(X6) DATE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495326	B. WING		03	3/08/2017
	PROVIDER OR SUPPLIED	REHABILITATION AND HEALTHO	:A	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	resident from the §483.15(c)(1)(ii). (ii) When making (14)(i) of this sect all pertinent inform is available and prophysician. (iii) The facility more resident and the rewhen there issected in §4. (A) A change in resident as specified in §4. (B) A change in resident away or regulated to regulate the address phone number of This REQUIREMING. Based on staff in and facility documfailed to notify the change of conditions survey sample (Resident # 2; the	cransfer or discharge the facility as specified in notification under paragraph (g) ion, the facility must ensure that nation specified in §483.15(c)(2) rovided upon request to the ust also promptly notify the esident representative, if any, no or roommate assignment 83.10(e)(6); or esident rights under Federal or ations as specified in paragraph tion. Lust record and periodically and the resident representative(s). ENT is not met as evidenced terview, clinical record review nent review, the facility staff on for one of 5 residents in the resident #2), which resulted in all and mental status change for resident was sent to a regularly	F 1	4. The Director of Nursing or Managers will audit 5 current residents' medical records on the 3 units weekly for 4 week monthly for 2 months to ensu physician continues to be notichanges in condition. The Di Nursing will submit a report to Quality Assurance Committee monthly for 3 months. The Di of Nursing will be responsible monitoring and follow up. Completion Date: RECEIVED MAR 24 2017 VDH/OLC	each of s and re the fied of rector of the es	03/24/17
	scheduled infusion appointment esse	n appointment, arrived at the entially unresponsive, where life				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		495326	B. WING _		03/08/2017		
	PROVIDER OR SUPPLIE	E REHABILITATION AND HEALTHO	:A	STREET ADDRESS, CITY. STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIMED DEFICIENCY)	OBE COMPLETION		
F 157	resident was ther department and la (medical intensive subsequently exp Findings include: Resident # 2 was on 01/05/17, with on 02/02/17. Dia included, but were history of bleeding anemia, muscle wobesity, HTN (higmellitus) and Von bleeding disorder The most current was an admission This MDS assess score of "13", ind cognitively intact. The resident was extensive to total staff members for living). An admission MD was reviewed for assessed the res of "14", again ind cognitively intact. CAAS (care area	were implemented. The taken to the emergency ater admitted to the MICU e care unit); the resident ired two days later. admitted to the facility originally the most current readmission gnoses for Resident # 2 e not limited to: gastritis w/g, chronic kidney disease, weakness, hypothyroidism, h blood pressure), DM (diabetes Willebrand disease (a severe	F 15	RECEIVED MAR 24 2017 VDH/OLC			
	During a complai Resident # 2's clo	nt investigation on 03/07/17, osed clinical record was		ADLIIOFA			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495326	B. WING		03	C / 08/2017
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTH	CA	STREET ADDRESS, CITY, STATE, ZIP C 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901		700/2017
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	o1/05/17. The residence for anemia and relation and relat	nally admitted to the facility on dent was discharged from the d to the hospital on 01/25/17 tive hypotension.	F 15	RECEIVED		
	significant change in documented, no ass resident and no evid found in the clinical	n condition. No vital signs sessment information for the dence of notification were record.		MAR 24 2017 VDH/OLC		
		ician's orders were then ian's orders were found				

	(X2) MULTIPLE CONSTRUCTION (X3) DAT A. BUILDING		COMPLETED
495326	B. WING _		03/08/2017
	CA	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901	1 00/00/2017
ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
n page 4	F 15	7	
tal status change on the morning			,
sident expired at the hospital),per (name of long term care he lives, she went to bed last mal state of health. This morning he was found to be lethargic and ands, but doing so slowlySeptic andary to] GNR [gram-negative			
dent # 2 and her condition on # 3 stated that the resident had with the infusion center every other d an appointment that morning y 17, 2017). The LPN further had came in that morning and got night shift nurse (LPN # 5), the e told her (LPN # 3) that the low to respond and lethargic and # 3 to go assess the resident. It that she went to the room and resident and confirmed that the mental status change from her was slow to respond and LPN stated that the resident was any details or anything specific, or answers to questions, but was LPN stated that this was not usual self, because she could		RECEIVED MAR 24 2017 VDH/OLC	
The first serious for the first of the first	NTE REHABILITATION AND HEALTHOUS STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) In page 4 In page 4 In frame. One physician's progress I, dated 02/06/17. Ination regarding Resident # 2's tal status change on the morning all be found. In scharge summary dated 02/19/17 Instiguted the state of health. This morning she was found to be lethargic and hands, but doing so slowlySeptic ondary to] GNR [gram-negative al" It terviewed on 03/07/17 at 2:40 p.m. dent # 2 and her condition on # 3 stated that the resident had with the infusion center every other and an appointment that morning the state of the lethargic and lethargi	ATE REHABILITATION AND HEALTHCA Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) In page 4 In page 4 In page 4 In page 4 In page 5 In page 6 In page 6 In page 7 In page 7 In page 8 In page 9 In page	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901 Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) In page 4 If rame. One physician's progress I, dated 02/06/17. In attoin regarding Resident # 2's tall status change on the morning ald be found. Scharge summary dated 02/19/17 sident expired at the hospital),per (name of long term care she lives, she went to bed last smal state of health. This morning she was found to be lethargic and lands, but doing so slowlySeptic and ands, but doing so slowlySeptic and the full that the resident had with the infusion center every other did an appointment that morning y17, 2017). The LPN further had came in that morning and got night shift nurse (LPN # 5), the told her (LPN # 3) that the own to respond and lethargic and l.# 3 to go assess the resident. If that she went to the room and resident and confirmed that the mental status change from her lwas slow to respond and ELPN stated that the resident was any details or anything specific, to answers to questions, but was LPN stated that this was not usual self, because she could

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		E SURVEY MPLETED
		495326	B. WING		1	C /08/2017
	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTHC	A	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901	1 001	00/2017
(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 X (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 157	set of vital signs on "I didn't put them in The LPN was asked documented. The land that she probably jupiece of paper. The signs were normal of that she could not rasked if the night nu LPN # 3 stated that shift nurse assesse LPN #3 was asked The LPN stated than nurse had notified to there at the facility to k for her (resident) was early in the mothe NP was aware to got to the facility an assessed the reside that there is a 24 honot sure what was in	LPN was asked if she got a the resident. The LPN stated, my note, but I'm sure I did." d, where would those be LPN stated again that she did in her note. The LPN stated ast had them written down on a e LPN was asked if the vital or abnormal. LPN # 3 stated emember. LPN # 3 was urse assessed the resident. she did not know if the night	F 1	57		
	sent to the infusion emergency room wind The LPN stated that appointment that moderate (other) #2 at the infusion of condition, so they warrived. The LPN warme was. The LPN warme was. The LPN warme was.	asked why the resident was center and not to the thout physician notification. It the resident had an orning and that she called Ousion center and told O#2 to center of the resident's ould know when the resident was asked what O#2's last N did not know. The LPN was was the person a medical		RECEIVED MAR 2.4 2017 VDH/OLG		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
		495326	B. WING			03	C 3/ 08/2017
	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTHC	;A	1150	EET ADDRESS, CITY, STATE, ZIP CODE D NORTHWEST DRIVE ARLOTTESVILLE, VA 22901		700120
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y 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 157	she did not know, s the person's title.	operator. LPN # 3 stated that the did not get the last name or	F 1	57			
***************************************	resident to the infus emergency room. It me it was ok [for reappointment. The L was received for the did not know. The L wrote a note. The L not know. The LPN that told her to send center appointment as NP # 1. The LPN she speak with NP ididn't remember.	LPN was asked if an order at. The LPN stated that she LPN was asked if the NP LPN stated again that she did I was asked who was the NP I the resident to the infusion and the LPN identified the NP N was asked what time did #1. The LPN stated that she					
LPN # 3 was asked if the transp Resident # 2 to her appointment concerned in the resident's conc stated that they didn't seem con did they did not express that to h		appointment seemed sident's condition. The LPN n't seem concerned and if they					
	that morning she go center (individual wa (infusion center) had spoke with that mor O#2 and further stat	at approximately 11:00 a.m. of a call from the infusion as not identified) and they d asked who the LPN had rning and the LPN told them ted that she (woman at ed as though she did not know			RECEIVED		
	reading on Resident did not and stated th as a diabetic for us (d if she obtained a blood sugar t # 2. LPN # 3 stated that she hat the resident was not listed (the facility). The LPN was sident had a diagnosis of			VDH/CLC		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		E SURVEY MPLETED
		495326	B. WING		03	C / 08/2017
	ROVIDER OR SUPPLIER	REHABILITATION AND HEALTH	CA .	STREET ADDRESS, CITY, STATE, ZIP COL 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901		100/2017
(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 CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 157	Continued From pa	age 7	F 1	57		
	The NP stated that 2 or 3 times while se further stated twices February that the rethe NP. The NP st resident on 02/06/1 at that time. The Ne the resident on 02/1 already gone to the at the facility and he from the facility with # 2 at anytime. The made aware of any # 2, once he arrived The NP stated, "Not that I would have he I had a list of 15 pawasn't on the list, seek when the should have dealtered. The NP stated that notification that any or he would have seek assessment triaged The NP stated that needed, he (NP) with the NP was asked morning and told he send the resident to The NP stated, "I he would have remement that he was unaware the NP stated that the NP stated, "I he would have remement that he was unaware the NP stated, "I he would have remement that he was unaware the NP stated that the was unaware the NP stated, "I he would have remement that he was unaware the NP stated that the was unaware the NP stated, "I he would have remement that he was unaware the NP stated that the NP stated, "I he would have remement that he was unaware the NP stated that the NP stated, "I he would have remement that he was unaware the NP stated that the NP stated, "I he would have remement that he was unaware the NP stated that the NP stated, "I he would have remement that he was unaware the NP stated that the	wed on 03/08/17 at 8:20 a.m. The had only seen the resident she was here at the facility and a in January and once in resident was actually seen by ated that he last seen this 17 and wrote a progress note IP stated that he did not see 17/17, that the resident was a appointment when he arrived he had not received any calls he concerns regarding Resident e NP was asked if he was a concerns regarding Resident do at the facility that morning. The NP stated and a note if I had seen her and attents to see that day and she of I didn't see her, as far as I to her regular appointment as as. The NP stated there is a look if a resident has issues, ocumented that she was ated that he received now thing was wrong on the 17th reen her and based on that do with the physician if needed. The staff call me first and if ill call the physician. If had spoke with LPN # 3 that her (LPN # 3) to go ahead and to the infusion appointment. The NP stated re that any of this was going that it would have been		RECEIVED MAR 24 2017 VDH/OLG		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		E SURVEY MPLETED
					С
	495326	B. WING		03/	/08/2017
NAME OF PROVIDER OR SUPPLIER CHARLOTTESVILLE POINTE	REHABILITATION AND HEALTHO	CA	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901		
PRÉFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPENDEFICIENCY)	OULD BE	(X5) COMPLETION DATE
An attempt to conta 5) for interview was success. The infusion center 9:20 a.m. in an atter found to be an oper O#2 stated that all center and if immed physician is paged stated that he recall morning an informir lethargic and not he that LPN # 3 had ca and he entered the while on the phone information to the intitle as an access as professional. O#2 swhat the turn around how long it would ta email and that it couthere. O#2 could not the email was sent, approximately 8:35 The 24 hour report 103/08/17 at 12:50 pentry by LPN # 3 on documented the relethargic and slow to resident had an apponenter at 9:15 a.m. had been called and	f to notify me (NP) and further what I don't know." act the night shift nurse (LPN # made several times without was contacted on 03/08/17 at mpt to identify 0#2. 0#2 was rator for the infusion center. calls come through the call diate assistance is needed the for the person calling. 0#2 led LPN # 3 calling that ng him of the resident being er normal state. 0#2 stated alled approximately 8:30 a.m. information into an email, with LPN # 3 and sent that infusion center. 0#2 gave his sesociate, not a medical stated that he did not know d was on emails, as far as alke for someone to check that all dessentially still be sitting of provide an exact time when but estimated it to be at	F 1	RECEIVED MAR 24 2017 VDH/OLG		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495326	B. WING		0	C 3/08/2017
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	:A	STREET ADDRESS, CITY, STATE, ZIP CO 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	that the anyone with change in condition. The DON (director policy on physician (situation/backgronotify) form used to the presented and reversity maintain the residual change in condition in a timely manner occurs, the nurse document/report to information as new signsneurological consciousnessc statusonset, dur diagnosesbefore someone with an anursing staff will manurse will contact change in condition.	ner were marked to evidence as notified of Resident # 2's in. If of nursing) was asked for a notification and the SBAR und/appearance/review and by nurses on 03/08/17. If ange in Condition' was iewed and documented, "to ent's safety, a resident's in will be collected and reported rwhen a change in condition shall collect and the following baseline edd:vital al statuslevel of ognitive and emotional action, severityall active is contacting a physician about accute change of condition, the make pertinent observations and it or report to the physicianthe the physician about a significant in"	F 1	57		
	physician/NP/PA(phealth care profes Complete relevant below Check Vita heart rate, temper saturation, and fin Review record: R medications, other information availal remainder of the fo	ohysician's assistant)/other sional: Evaluate the resident: aspects of the SBAR form I Signs: BP, pulse and/or apical ature, respiratory rate, O2 ger stick glucose for diabetics; ecent progress notes, labs, r orders;have relevant ole when reporting" The form had areas for detailed illed in or checked off and		RECEIVED MAR 24 2817 VDH/OLC		

PRINTED: 03/15/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495326	B. WING		C 03/08/2017
	PROVIDER OR SUPPLIE		SA	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901	VVIVVIEW
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 309 SS=G	included, but was diagnoses, menta status, behavior seardiovascular staurinary, skin, pain type of form could 2. The DON and addithe serious concerchange of condition of the serious condition. The larger ding the phy evidence could be evidence that Resnotified and/or macondition, as a restorally unresponded and the serious were in subsequently expondical intensived. This is a complain 483.24, 483.25(k) FOR HIGHEST WAS 24 Quality of Quality of life is a applies to all care residents. Each refacility must provide services to attain practicable physic well-being, consis	s not limited to: symptoms, al status evaluation, functional status, respiratory status, atus, abdominal/GI evaluation, n, and neurological status. This d not be located for Resident # ministrator were made aware of erns regarding Resident # 2's on, without physician DON agreed with concerns vician not being notified. No elocated or presented to sident # 2's physician was ade aware of the resident's sult the resident was transported where the resident was found consive, where life saving nitiated, the resident pired two days later at the MICU elecare unit) at the hospital.	F 309	1. Resident #2 was discharged from the facility on 2/17/17. 2. An audit was completed on 3/15 by the Unit Managers of the curren residents' medical records to ensur residents with a change of condition within the past 30 days had assessments completed as required 3. The Licensed Nurses were reeducated on 3/15/17 by the Staff Development Coordinator on the requirements of completing and documenting assessment when their is a change in condition. 4. The Director of Nursing or the Undanager will audit 5 current residents' medical records on each	s/17 nt re on l. re Jnit of

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

Event ID: HOG411 _ _ _ Facility ID: VA0079

If continuation sheet Page 11 of 24





	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
		495326	B. WING		1	C / 08/2017
	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTHO	CA	STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	provided to resident consistent with profithe comprehensive and the residents' of the comprehensive and the residents' of the comprehensive and the residents who requiservices, consistent of practice, the comprehensive and the repreferences. This REQUIREMENT by: Based on staff intered and facility docume failed to complete a provide necessary of the highest practical residents in the survivinch resulted in harmonic thange in physical aregularly scheduler resident arrived essignificant change in physical and days later. Findings include: Resident # 2 was acon 01/05/17, with the	ent. Issure that pain management is the who require such services, ressional standards of practice, person-centered care plan, goals and preferences. It with professional standards aprehensive person-centered esidents' goals and It is not met as evidenced rview, clinical record review and review, the facility staff thorough assessment and care and services to maintain ble well being for one of 5 vey sample (Resident # 2),	F 30	RECEIVED MAR 24 2017 VDH/OLC		

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. BU		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495326	B. WING _		0:	C 3/08/2017	
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	SA	STREET ADDRESS, CITY, STATE, ZIP COI 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901		570072017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	history of bleeding anemia, muscle we obesity, HTN (high mellitus) and Von Volleding disorder). The most current f was an admission This MDS assesses score of "13", indictognitively intact for The resident was a extensive to total a staff members for living). An admission MDS was reviewed for coassessed the reside of "14", again indictognitively intact. CAAS (care area as of this MDS for, buurinary. During a complaint	not limited to: gastritis w/ , chronic kidney disease, eakness, hypothyroidism, blood pressure), DM (diabetes Willebrand disease (a severe	F 30	9			
	and discharged to anemia and relative The resident was reterm care facility or for the resident did antihypertensive m	eadmitted back to the long n 02/02/17. Admission orders		RECEIVED MAR 24 2017 VDH/OLC			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		495326	B. WING		03	C 5 /08/2017
	PROVIDER OR SUPPLIER DTTESVILLE POINTE	REHABILITATION AND HEALTH	CA	STREET ADDRESS, CITY, STATE, ZIP 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 2290	CODE	70072011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	treatment of diaber resident on this re A BIMS (brief interdated 02/02/17, do had a cognitive scresident was cogniskills.	tes had been ordered for the admission. view for mental status) form ocumented that the resident ore of "15", indicating the itively intact in decision making	F 3	09		
	dated 02/17/17 an "Resident noted to change. Resident Resident was able very slowly. This n person) [identified infusion center) in O#2 will make infu out of facility at 8:4	e reviewed. A nursing note d timed 8:45 a.m. documented, have an altered mental status slow to respond and lethargic. to follow some commands urse spoke with (name of as O (Other) # 2] at (initials of relation to resident condition. sion center aware. Resident to a.m. via priority in poor re of LPN [Licensed Practical				
	and/or in the clinica 3 had notified the p significant change could be located, r	s found in the nursing notes al record to indicate that LPN # ohysician of Resident # 2's in condition. No vital signs to assessment information for o evidence of notification to the located.				
	reviewed, no physi during this time fra note was found, da No other information	on regarding Resident # 2's status change on the morning		RECEIVED MAR 2.4 2017 VDH/OLG		

AND DUAN OF CORRECTION DENTIFICATION NUMBERS		(X2) MUL	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
	495326	B. WING		03/08/2017
NAME OF PROVIDER OR SUPPLIER CHARLOTTESVILLE POINTE	REHABILITATION AND HEALTH	ICA	STREET ADDRESS, CITY, STATE, ZIP C 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901	CODE
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMPLETION
this time. The ED (emergence reviewed. The ED timed 10:04 a.m. (a minutes after the redocumented, "Alt Hypoglycemia [low bleedDM who pre [treatment] from ca complaints of altered hypoglycemia. Per services], (name of center today for an lethargic, altered, a blood sugar of 16. [dextrose] EMS rep now 97 and she is a lethargic. The patien 98/70unable to persystems] mental staredleukocyte estemanyCT of head. abnormalitiesCT hemorrhageXR [x atelectasis and small effusioncould representation of the patients in the possible of patients treatment in the possible of patients treatment in the possible of patients treatment in the possible of the possible of patients treatment in the possible of the possible of the possible of the patients treatment in the possible of the	ere obtained and reviewed at any department) records were records dated 02/17/17 and approximately 1 hour and 25 esident left the facility) ered mental status blood sugar]history of Glesents to the ED via tx neer center (medic 5) with ed mental status and EMS [emergency medical resident) arrived at the cance infusion and was found nd semi-unresponsive, with a After receiving 1 amp of D50 erts that her blood sugar is more responsive but still ent's last blood pressure was erform ROS [review of atus changeurinalysiscolor erase largebacteriano acute intracranial of abdomenNo evidence of cray] chestbibasilar		£	
status, was hypoter acute respiratory fa care provided durin blood product admi	nsive, was hypoxic, was in ilure and was septic. The g this time included providing nistration, fluid administration, I pressor medication"		VDH/OLC	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
			, a Boile		··········	С
		495326	B. WING			03/08/2017
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	; A	STREET ADDRESS, CITY, S 1150 NORTHWEST DRIVI CHARLOTTESVILLE, V	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD ED TO THE APPROPF FICIENCY)	BE COMPLETION
F 309	Continued From pa	age 15	F 3	09		
	(the date the reside documented, "pe facility) where she night [02/16/17] in This morning [02/1 found to be letharg but doing so slowly to] GNR [gram-neg LPN # 3 was interv regarding Resident 02/17/17. LPN # 3 appointments with day and she had at (Friday February 1 stated that she had report from the nigh night shift nurse tol resident was slow thad asked LPN # 3 The LPN stated that checked on the resident had a mer normal self and walethargic. The LPN not able to give any basically yes no an very slow. The LPI Resident # 2's usua normally converse going on with her, sneeds known. The set of vital signs on "I didn't put them in The LPN was asked documented. The	arge summary dated 02/19/17 ent expired at the hospital), or (name of long term care lives, she went to bed last ther normal state of health. 7/17] on awakening she was ic and following commands, cSeptic shock 2/2 [secondary pative rod] bacteremia" iewed on 03/07/17 at 2:40 p.m. at #2 and her condition on stated that the resident had the infusion center every other in appointment that morning 7, 2017). The LPN further I came in that morning and got int shift nurse (LPN # 5), the did her (LPN # 3) that the corespond and lethargic and is to go assess the resident. The LPN that she went to the room and ident and confirmed that the intal status change from her is slow to respond and I stated that the resident was in details or anything specific, swers to questions, but was in the state of the thing was not all self, because she could and let you know what was she was able to make her in LPN was asked if she got a in the resident. The LPN stated, my note, but I'm sure I did." In the roote. The LPN stated in her note. The LPN stated in her note. The LPN stated		RECEIVE MAR 24 2017 VDH/OLC		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495326	B. WING		03	C 3/ 08/2017
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	:A	STREET ADDRESS, CITY, STATE, ZIP C 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	that she probably j piece of paper. The remembered whet or abnormal. LPN remember. LPN # nurse(LPN # 5) as did not know if the not. The LPN was asked The LPN stated that nurse had notified there at the facility ok for her (resident was early in the most the NP was aware got to the facility are had assessed the stated that there is was not sure what	ust had them written down on a le LPN was asked if she her the vital signs were normal #3 stated that she could not 3 was asked if the night sessed the resident. LPN #3 night shift nurse assessed or ed if she notified the physician. At she did not, the night shift the NP and that the NP was that day and the NP said it was that day and the NP said it was to to go to her appointment, it before she (LPN #3) had even and did not know if the nurse resident or not. The LPN a 24 hour report book and she was in the book for that day. ted that the night shift nurse	F 30			
	sent to the infusion emergency room where The LPN stated the appointment that mowers of the infusion center they would know where LPN was asked where LPN did not know. O#2's title, was he operator. LPN # 3 LPN # 3 was again resident to the infusion center they would know where we will be used to be used.	n asked why the resident was center and not to the vithout physician notification. At the resident had an norning and that she called center and told O#2 to inform of the resident's condition, so hen the resident arrived. The nat O#2's last name was. The The LPN was asked what was a medical professional or an stated that she did not know. asked why she sent the sion center instead of the LPN # 3 stated, "The NP told		RECEIVED MAR 24 2017 VDH/OLG		

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		03/08	03/08/2017	
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	;A	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE C	(X5) OMPLETION DATE	
F 309	appointment. The was received for the did not know. The wrote a note. The not know. The LF that told her to secenter appointment as NP # 1. The LI speak with NP #1 remember. LPN # 3 was asked Resident # 2 to he concerned. The LI concerned and if that to her. LPN # 3 stated that that morning she center and they (in the LPN had spok LPN told them O# (woman at infusion didn't know who of the LPN was ask reading on Resider.)	resident] to go to the LPN was asked if an order hat. The LPN stated that she LPN was asked if the NP LPN stated again that she did lend was asked who was the NP and the resident to the infusion and the LPN identified the NP lend the LPN stated that she didn't lend if the transporters taking ar appointment seemed lend they did not express lend at at approximately 11:00 a.m. got a call from the infusion lend asked who lend that morning and the lend asked who lend that morning and the lend asked who lend they did not express lend that she lend that the resident was not listed li	F 30	09			
	The NP stated that 2 or 3 times while further stated twice February. The NF resident on 02/06/at that time. The	ewed on 03/08/17 at 8:20 a.m. It he had only seen the resident she was here at the facility and e in January and once in P stated that he last seen this 17 and wrote a progress note NP stated that he did not see 1/17/17, that the resident was		RECEIVED MAR 24 2017 VDH/OLG			

PRINTED: 03/15/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	13 FOR WIEDICARE	A MEDICAID SERVICES	····		OIVID INC	<u>, บรงด-บงษา</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION		TE SURVEY MPLETED
		495326	B. WING		03/08/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				1150 NORTHWEST DRIVE	0002	
CHARLO	TTESVILLE POINTE	REHABILITATION AND HEALTH	1CA		.4	
				CHARLOTTESVILLE, VA 2290	/1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 309	Continued From pa	age 18	F 30	na		1
1 000	•	- ·	1	09		
		appointment when he arrived				
	. -	ad not received any calls from				1
		cerns regarding Resident # 2	m m,	l .		
		P was asked if he was made		1		:
		erns once he arrived at the				
		g. The NP stated, "No, I did				
		d that, I'd had a note if I had				
		a list of 15 patients to see tha				
		t on the list, so I didn't see her.		•		
		e is a communication book if a	1			Was a
	resident has issues			***		
		he was altered. The NP stated	1 ;			1
		notification that anything was				
		or he would have seen her and	1	41 1000		ļ
		ssment triaged with the				1 00000000
		I. The NP stated that the staff	į			
	call me first and if r	needed, he (NP) will call the		***		
	physician.		*	:		
		aware that there was little	i	•		
		I no assessment information		;		
		h as vital signs. The NP	ŧ	:		į
		ad vital signs that would have	1			
		IP further stated that an initial	1			
	set of vital signs de	termines what you do, they				27
	didn't have any. Th	ne NP stated that the resident's	3			÷
	blood sugars had b	een running normal and stated	1			
		checking them periodically.				
		od sugar checks could be				7
	located for Resider	nt # 2 for this admission	1			3 .
	(02/02/17) to the fa	cility.		Millionia Addressed		
	,	-		RECEIVED		
	The NP stated that	the resident's condition would		- The second of market statement is the second in the seco		
		n assessment. The NP was		MAR 24 2017		· delegation is a second of the second of th
		with LPN # 3 that morning	1	**************************************		:
		head and send the resident to		VDH/QLG		
		tment. The NP stated, "I have		VUNCUU		1
		nat, I would have remembered	}			

that." The NP stated that he was unaware that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495326	B. WING		0:	C 3/ 08/2017	
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	:A	STREET ADDRESS, CITY, STATE, ZIP C 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901		7.00,2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	any of this was goi would have been a (NP) and further st know." The infusion cente 9:20 a.m. in an atte found to be call cecenter. O#2 stated call center and if in the physician is pa O#2 stated that he morning an informilethargic and not h that LPN # 3 had cand he entered the while on the phone information to the i title as an access a professional. O#2 what the turn arour how long it would to there. O#2 could remail and that it could the email was sent approximately 8:35	ng on. The NP stated that it appropriate for staff to notify me ated, "I can't treat what I don't reated, "I can't treat what I don't ated, "I can't treat what I don't reated, "I can't treat what I don't reated, "I can't treat what I don't reated, "I can't treat what I don't reated to identify O#2. O#2 was not represent of the infusion of that all calls come through the neediate assistance is needed ged for the person calling. The recalled LPN # 3 calling that ng him of the resident being remailed approximately 8:30 a.m. information into an email, with LPN # 3 and sent that not not contain the infusion center. O#2 gave his associate, not a medical stated that he did not know he was on emails, as far as ake for someone to check that all dessentially still be sitting not provide an exact time when the but estimated it to be at	F 30				
	03/08/17 at 12:50 p entry by LPN # 3 or documented the re Mental Status), leth that the resident ha infusion center at 9 O # 2 had been cal the resident's cond had an area to che family were notified	c.m. The book documented and an 2/17/17 for 'dayshift', which esident was with AMS (Altered argic and slow to respond and an appointment at the 15 a.m. that morning and that led and given a message on 15 ition. The 24 hour report book ck if the physician and/or , neither were marked to 16 nyone was notified of Resident		RECEIVED MAR 24 2017 VDH/OLC			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495326	B. WING			C	
NAME OF I	PROVIDER OR SUPPLIER	493320	D. WING		EET ADDRESS, CITY, STATE, ZIP CODE	03/	08/2017
		REHABILITATION AND HEALTHC	;а	1150	NORTHWEST DRIVE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	5) for interview was success. CNA # 1 (certified in that worked the niginterviewed and staremember clearly, being sick or differed. The day shift CNA (02/16/17) was intedid not notice anythwas acting normal for the came to work with land noticed immed her normal self, clocoherent, and even would normally be considered to the night shift nurse as LPN # 4). The Company of the registering between 99-110 on stated that he left to	act the night shift nurse (LPN # s made several times without nursing assistant), the CNA ht before the 17th was ated that she could not put did not recall the resident ent. # 2 from the day before rviewed and stated that she ing unusual that the resident	F 3	309	RECEIVED MAR 24 237 VDH/CLC		
		ent and then he returned about apout mpt to work (therapy) with the			ANH/OTC	Acres to the second sec	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDII		С	
		495326	B. WING _		03/08/2017	
	PROVIDER OR SUPPLIER OTTESVILLE POINTE	REHABILITATION AND HEALTH	CA	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION	
F 309	resident again. The that same time trainersident up for her helped the transpostretcher, at that time in the room at the conversing back are resident should go to the appointment not know and did not assessment being notified or anything being obtained, he ox at approximatel with LPN # 4, short Resident # 2's CCF was reviewed and "Full codemy for my FULL CODE remain free from Urelated to incontine neededassist with as neededMonitor symptoms) UTI: purine, cloudiness, rolor, increased puffrequency, foul smeattered mental static change in eating particular to policy on physician (situation/backgroun notify) form that number of the policy or mental static change in eating particular to policy on physician (situation/backgroun notify) form that number of the policy or mental static change in eating particular to policy on physician (situation/backgroun notify) form that number of the policy or mental static change in eating particular to policy or physician (situation/backgroun notify) form that number of the policy or physician (situation/backgroun notify) form that number of the policy or physician (situation/backgroun notify) form that number of the policy or physician (situation/backgroun notify) form that number of the policy or physician (situation/backgroun notify) form that number of the policy or physician (situation/backgroun notify) form that number of the policy or physician (situation/backgroun notify) form that number of the policy or physician (situation/backgroun notify) form that number of the policy or physician (situation/backgroun notify) form that number of the policy or physician (situation/backgroun notify) form that number of the policy or physician (situation/backgroun notify) form that number of the policy or physician (situation/backgroun notify) form that number of the physician (situation/backgroun notify) form that number of the physician (situation/backgroun notify) form that number of the physician (situation notify) form that number of the physician (situation notify) for	re COTA stated that at about apport was coming to pick the infusion appointment and he refers get the patient onto the me LPN # 3 and LPN # 4 were same time and they were and forth about whether the to the emergency room or on. The COTA stated that he did to thear discussion of an done, of the physician being about any other vital signs knew for sure about the pulse of 7:35 because he was there by after 7:30 a.m. P (comprehensive care plan) documented the following, amily and staff are made aware statusthe resident will TI (urinary tract infection) anceassist with bed pan as an peri care personal hygiene or/document for s/sx (signs and periodic	F 30	RECEIVED		
	presented and revi	ewed and documented, "to nt's safety, a resident's		VDH/CLC		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495326	B. WING			C 03/08/2017	
	PROVIDER OR SUPPLIE	REHABILITATION AND HEALTHO	SA	STREET ADDRESS, CITY, STATE, Z 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 229		03/00/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 309	in a timely manne occurs, the nurse document/report to information as new signsneurological consciousness	on will be collected and reported rwhen a change in condition shall collect and he following baseline eded:vital al statuslevel of ognitive and emotional ation, severityall active e contacting a physician about acute change of condition, the nake pertinent observations and to report to the physicianthe the physician about a significant in" Documents, "Before calling the ohysician's assistant)/other sional: Evaluate the resident: aspects of the SBAR form I Signs: BP, pulse and/or apical ature, respiratory rate, O2 ger stick glucose for diabetics; ecent progress notes, labs, orders;have relevant ole when reporting" The form had areas for detailed illed in or checked off and not limited to: symptoms, status evaluation, functional atus, respiratory status, tus, abdominal/GI evaluation, and neurological status. This not be located for Resident #		RECEIVED WAR 2 2017 VDH/CLC			
		p.m. The DON and made aware of the serious		€		3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DA	TE SURVEY MPLETED
		495326	B. WING		03	C / 08/2017
	PROVIDER OR SUPPLIER	REHABILITATION AND HEALTHO	;A	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901	, 00	
(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 SHOUTH CORRECTIVE ACTION SHOUTH CORRECT TO THE APPROPRIES (EACH CORRECT)	ULD BE	(X5) COMPLETION DATE
F 309	condition and that the information for the inphysician was not in located or presente 2's physician was in the resident's conditionated to evidence completed on this resident was transposed the resident was found several life say the resident subsequence.	Resident # 2's change of here was not assessment resident, and the resident's notified. No evidence could be d to evidence that Resident # otified and/or made aware of tion, no evidence could be any type of assessment was esident, as a result the norted to a routine visit, where and essentially unresponsive ing measures were initiated, quently expired two days later al intensive care unit) at the	F3	RECEIVED MAR 2.4 2017 VDH/CLG		