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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	**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
E 000	Initial Comments An unannounced Emergency Prepardness survey was conducted 03/10/2020 through 03/12/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/10/2020 through 03/12/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code report will follow. The following three complaints were investigated during the survey: VA00047157: Substantiated without deficient practice VA00048135: Unsubstantiated VA00046590: Substantiated without deficient practice The census in this 180 certified bed facility was 140 at the time of the survey. The survey sample consisted of 28 current resident reviews and four closed record reviews.	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to accurately complete MDS (minimum data set) assessments for two of 32 residents, Resident # 35 and Resident #97. Resident #35 was not assessed	F 641	Completion of this plan of correction is per regulations to maintain compliance with state and federal guidelines. It does not validate the facility's agreement with or admission to the alleged deficient	3/25/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/20/2020

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.

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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	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 641	Continued From page 1 as edentulous on her annual MDS and Resident #97 was not assessed as having a lap buddy since it's implementation on 09/20/2018. Findings were: 1. Resident #35 was admitted to the facility on 06/20/2018. Her diagnoses included but were not limited to: cognitive impairment, dysphagia, Type 2 diabetes mellitus, and hypertension. The most recent MDS was a quarterly assessment with an ARD (assessment reference date) of 12/24/2019. She was assessed as moderately impaired in her cognitive status with a summary score of "09". During interviews Resident #35 was observed to be without any teeth (edentulous). Review of the clinical record contained information that Resident #35 had her remaining teeth pulled in November of 2018. Her annual MDS with an ARD of 04/26/2019 did not provide assessment information that Resident #35 was edentulous. 2. Resident #97 was admitted to the facility on 12/21/2012. Her diagnoses included but were not limited to: Unspecified dementia without behaviors, convulsions, depressive disorder, adult failure to thrive, hypertension and contractures. The most recent MDS was an annual assessment with an ARD of 02/06/2020. Resident #97 was assessed as having impairment with long and short term memory and severely impaired with daily decision making skills.	F 641	practices listed. The MDS Assessment for Resident #97 and Resident #35 were modified during the survey. MDS Coordinator/designee to audit most recent MDS for each resident to ensure that coding is accurate with focus on dental status and restraints/devices. DON re-educated the MDS staff on accurately coding resident dental(section L) and restraints(section P) in the MDS. DON/designee will complete a random audit of minimum of 5 Residents on MDS coding 2x per week for 4 weeks, then weekly for 4 weeks, then monthly for 1 month. Trends will be reported to the QAPI committee monthly for recommendations and additional corrective action as needed.	

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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	**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 641	Continued From page 2 During initial tour of the facility Resident #97 was observed in her room, sitting in a wheelchair. A lap buddy was across her lap. Resident #97 was asked if she could remove the device, she did not answer or attempt to remove it. The clinical record was reviewed. Resident #97 was assessed as needing the lap buddy due to forward leaning in her chair. Physician orders, device assessment and care plans were in place for the device. The physician orders for the use of the lap buddy were initiated on 09/28/2018. A total of seven MDS assessments were completed from the time of the implementation of the lap buddy to the survey. None of the assessments indicated that Resident #97 had a lap buddy. During a meeting with the DON (director of nursing) and the administrator on 03/11/2020 at approximately 11:15 a.m., the above information was discussed. On 03/11/2020 at approximately 2:30 p.m., the three MDS nurses, RN (registered nurse) #1, RN #2 and LPN (licensed practical nurse) #2 were interviewed regarding the discrepancies. RN #1 and RN #2 both stated, "It was a mistake, we are fixing it." No further information was obtained prior to the exit conference on 03/12/2020.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		3/25/20

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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	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 657	Continued From page 3 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to review and revise a comprehensive care plan (CCP) for one of 32 in the survey sample. Resident #121's CCP was not revised for impaired mobility and transfer assistance. Resident #121 was originally admitted on 01/30/19 and readmitted on 02/11/20 with diagnoses that included hemiplegia and hemiparesis following a cerebral infarction (stroke) affecting the left side, bilateral	F 657	The care plan for Resident #121 was revised during the survey. MDS coordinator/designee audited 100% of resident care plans to resident mobile and made corrections as needed. The DON re-educated MDS staff on the importance of completing and revising care plans accurately. The DON/designee to audit a minimum of	

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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	**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 657	Continued From page 4 osteoarthritis of the knee, chronic kidney disease - stage 2, congestive heart failure, bipolar disorder, and muscle weakness. The most recent minimum data set (MDS) dated 02/19/2020 which was a significant change, assessed Resident #121 as cognitively intact for daily decision making with a score of 14 out of 15. Under Section G - Functional Status, the MDS assessed the resident as extensive assistance, requiring one person physical assistance for bed mobility, dressing and eating; total dependent, requiring two person physical assistance for transfers; and total dependent, requiring one person physical assistance for hygiene, bathing, and locomotion off the unit. Locomotion on the unit and ambulation on/off the unit did not occur during the look back period on the MDS. On 3/11/20, Resident #121 was interviewed during the initial tour regarding the quality of life and quality of care at the facility. Resident #121 was interviewed regarding her need for assistance with her activities of daily living (ADLs). Resident #121 stated she had a stroke last month and required staff to assist her with most of her ADLs. Resident #121 stated she was not walking because she was weak and she was dependent on staff to help transport her on and off unit. On 03/11/2020, Resident #121's clinical record was reviewed. Observed on the care plan were the following focus areas: "I have impaired functional mobility. Goal: I will maintain highest functional level through the review period. Interventions: Ambulation: I am independent with ambulation .... I am	F 657	5 care plans to ensure accuracy with focus on mobility 2x per week for 4 weeks, then weekly for 4 weeks, then monthly x1. Trends will be reported to the QAPI committee monthly for review and further recommendations as needed.	

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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	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 657	Continued From page 5	F 657		

independent for locomotion. Date Initiated: 03/05/2018. Revision on : 02/25/2020. Target Date 05/20/2020."

"I have self-care deficit h/o (history of) CVA (cerebral infarction accident - stroke). Goal: I will have my ADLs (activities of daily living) met through this period. Date Initiated: 03/05/2018. Revision on: 03/25/2020. Target Date: 05/20/2020."

The mobility care plan documented that Resident #121 had impaired functional mobility and was independent with ambulation and locomotion. The self-care care plan included inventions for bathing, shower, dressing, bed mobility, eating, personal hygiene and toilet use. No interventions for transfer assistance was observed on the care plan."

On 03/11/2020 at 9:35 a.m., the licensed practical nurse (LPN, #3) who routinely provided care for Resident #121 was interviewed regarding the resident's ADLs and mobility. LPN #3 stated Resident #121 did not ambulate and required a hoyer lift for transfers and was dependent on staff for ADL assistance and locomotion.

On 03/11/2020 at 1:45 p.m., the MDS coordinator (RN #1) who was responsible for the care plans was interviewed. RN #1 reviewed the mobility care plan and stated "this is an old care plan." RN #1 continued and stated "this needs to be resolved. I will review and revise the care plan to show her [Resident #121] is not ambulating."

On 03/11/2020 at 4:10 p.m., RN #1 was interviewed regarding if Resident #121's transfer ability should have been included on the care

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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	**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 657	Continued From page 6 plan. RN #3 reviewed the care plan and stated, "does she [Resident #121] require a hoyer lift each time?" The second MDS coordinator (LPN #2) was present during the interview and stated "we should have included the transfer and hoyer lift on the care plans because she [Resident #121] does require transfer assistance since she returned from the hospital." RN #3 then continued and stated, "I will include the transfer needs on the care plan." The above findings were reviewed with the administrator, ADON, and corporate nurse during a meeting on 03/11/2020 at 11:00 a.m. No additional information was received by the survey team prior to exit on 03/12/2020 at 9:00 a.m.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview, and facility document review, the facility staff failed to administer medications per manufacturer's recommendations during medication administration on the third floor. LPN (licensed practical nurse) #1 crushed an extended release tablet of Isosorbide (a heart medication) prior to administration. The facility	F 684	The weight for Resident #41 was obtained during the survey. The third floor LPN to received 1:1 re-education on the "do not crush" list. Resident #51 was assessed for potential adverse reaction and notification made to the physician and MD during the survey.	3/25/20

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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	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 684

Continued From page 7

also failed to obtain weekly weights on 1 of 32 residents, Resident #41.

Findings were:

1. A medication pass and pour observation was conducted on 03/11/2020 at approximately 8:20 a.m. on the third floor of the facility. LPN #1 was observed preparing medications for administration to Resident #51. After placing all the medications in a pill cup, he stated, "She takes hers crushed in applesauce." He proceeded to place the pills in a plastic bag and crushed them, then mixed them with applesauce. He took them to Resident #51's room and administered them.

After administration of the medications, LPN #1 was asked to look at the medication card for the Isosorbide. The pharmacy instructions typed on the medication label in the top right hand corner included the following: "Do NOT CHEW or CRUSH". LPN #1 stated, "Yes, I see I crushed them."

The facility policy regarding medication administration was reviewed and contained the following:
"Facility staff should crush oral medications only in accordance with pharmacy guidelines as set forth in Appendix 16: Common Oral Dosage Forms that Should Not Be Crushed and/or facility policy." The referenced appendix was reviewed. The medication Isosorbide extended release was listed.

The DON (director of nursing) and the administrator were notified during a meeting on 03/11/2020 of the above medication error,

F 684

All residents with oral medication orders could be at risk. All residents with weekly weight orders were reviewed during the survey by the RDCS with no additional issues identified.

All nurses to have re-education by the DON/designee on following MD orders and utilization of the "do not crush" list along with reviewing medication label instructions. Unit managers educated on the correct process for entering weekly weight orders into the electronic medical record.

Nursing administration to complete medication competencies on minimum of 3 nurses 2x/week for 4 weeks, then weekly for 4 weeks, then monthly x1. Weights will be audited by nursing administration during their weekly clinical meeting x3 months to ensure that all residents will weekly weight orders have been obtained and documented per MD order.

Any identified trends will be reported at the monthly QAPI for further recommendations.

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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	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 684	Continued From page 8	F 684		

resulting in a medication error rate of 2.78%.

No further information was obtained prior to the exit conference.
2. Resident #41 was admitted to the facility on 03/27/15. Diagnoses for Resident #41 included; Contractures, hemiplegia, aphasia, tube feeding and diabetes. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/5/20. Resident #41 was assessed with long and short-term memory impairment with severe cognitive impairment.

On 3/11/20 Resident #41's clinical record was reviewed. A physician's order dated 2/3/20 read "weekly weights."

Review of the weight summary report indicated that Resident #41's last documented weight was on 2/3/20.

On 03/11/20 at 9:15 AM, the director of nursing (DON) was interviewed and sated that sometimes all weights are not entered into the system, and restorative was responsible for getting weights.

On 03/11/20 at 9:39 AM, certified nursing assistant (CNA #1, restorative aide) was asked to show documentation of Resident #41 getting weighed weekly. CNA #1 retrieved a Resident weight book. Documentation showed Resident had been weighed on 2/3/20 and 3/2/20 and showed blank spaces for 2/10/20, 2/17/20, and 2/24/20.

CNA #1 stated that sometimes she gets pulled to the floor and weights might not get done timely and sometimes the nurses tell the CNAs when 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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	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 684	Continued From page 9 get weights, and she does not have a good way of keeping up with all the weights that need to be done because it is not written down. CNA #1 was unable to provide documentation that Resident #41's weight was completed weekly. Resident #41's care plan initiated 1/3/19 documented a care problem with nutrition and hydration in which Resident #41 uses a feeding tube to supplement poor nutritional intake. Review of an order dated 7/11/19 indicated Resident #41 was to receive 250 millimeters (ML) of IsoSource 1.5 two times daily. This order was in affect from 7/1/19 and discontinued on 2/3/20. On 2/3/20 a new order was written for IsoSource 1.5 at 60 ML's/hour twice daily. This coincided with the weekly weight order written on 2/3/20. On 3/11/20 at 4:15 PM the above information was presented to the administrator and director of nursing (DON). On 3/12/20 at 7:45 AM the DON showed evidence that Resident #41 had not been losing weight and felt the weekly weight order was put in the system in error. No other information was provided prior to exit conference on 3/12/20.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		3/27/20

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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	**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 686	Continued From page 10 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility failed to provide care and services to promote healing and prevent infection of a pressure ulcer for one of 32 Residents. Resident #128's pressure ulcer was left uncovered. The Findings Include: Resident #128 was admitted to the facility on 07/29/16 with a current readmission on 2/15/20. Diagnoses for Resident #128 included: Sepsis, Urinary tract infection, and stage 3 pressure ulcer to left buttock. The most current MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 2/21/20. Resident #128 was assessed with a score of 13 indicating cognitively intact. On 03/11/20 at 11:00 AM, license practical nurse (LPN #4) was observed performing a dressing change to Resident #128's left buttock pressure ulcer. LPN #4 was assisted in turning Resident #128. Upon exposing Resident #128's buttock, it was observed that Resident #128 did not have a dressing intact. Resident #128 was laying on a protective pad where food crumbs and pieces of snuff (tobacco product) were observed. LPN #4	F 686	The dressing for Resident #128 was replaced by the wound care nurse during the survey. The wound care nurse reviewed all residents with current dressing orders during the survey to ensure that dressings were intact, with no additional issues identified. DON/designee to re-educate nursing staff on reporting/replacing of any dressing that becomes dislodged or soiled during ADL care. MD order for PRN dressing changes obtained for all residents with current dressing orders. Residents with history of identified non-compliance and/or removal of dressings had an order added to the TAR for checking of placement Q Shift. Wound care Nurse/designee to audit 5 random dressing per week x 4 weeks, then 3 random dressings per week x 8 weeks with findings reported to the QAPI committee monthly for trending and further corrective action if needed.	

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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	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 686	Continued From page 11	F 686		

was asked if the dressing had been removed by her prior to the procedure. LPN #4 answered "No."

On 03/11/20 at 11:25 AM, LPN #4 was interviewed regarding the wound not having a dressing applied prior to the observation of a dressing change. LPN #4 stated that she was surprised that a dressing was not intact and stated that Resident #128 may have been cleaned up during the night and didn't allow the staff to redress the wound as Resident #128 is non-compliant with allowing the nurses to apply a dressing.

On 03/11/20 at 1:00 PM, Resident #128 was interviewed regarding the above finding. Resident #128 stated when the nurses come in to clean him up at night they don't always put another dressing back on. Resident #128 was asked if he refused to have the dressing reapplied after getting cleaned up last night (3/10/20-3/11/20). Resident #128 said he did not refuse to have the dressing replaced and again stated this happens often.

On 3/11/20 Resident #128's clinical record was reviewed. A physician's order dated 2/18/20 read "Cleanse left buttock with wound cleanser. Apply Silverdine and cover with dry dressing QD [every day]."

Resident #128's current care plan titled "Alteration In Behavior" documented a care problem area that was initated on 4/26/2017 regarding refusing wound care.

Documentation on Resident #128's TAR (Treatment Administration Record) indicated

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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	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 686	Continued From page 12 Resident #128 received a dressing change on 3/10/20 (the day prior to observation). The remainder of the TAR for the month of March 2020 did not evidence that Resident #128 refused a dressing change. Resident #128's daily skilled nursing notes were also reviewed for the month of March 2020 and did not evidence that Resident #128 had refused dressing changes. On 03/11/20 at 02:36 PM, the above information was presented to the director of nursing (DON). The DON stated Resident #128 does have a history of of refusing care but would expect the staff to document if Resident #128 had refused to allow the staff to reapply the dressing. The DON also stated unawareness that there is a specific policy regarding this but the expectation would be to replace the dressing. No other information was presented prior to exit conference on 3/12/20.	F 686		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		3/25/20

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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	**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 880	Continued From page 13	F 880		

a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	**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 880	Continued From page 14 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview, and facility document review, LPN (licensed practical nurse) #1 failed to follow infection control practices during the administration of medications on the third floor. LPN #1 was observed preparing and administering medications to two residents. He did not wash his hands with soap and water or use hand sanitizer during the observation. Findings were: A medication pass and pour observation was conducted on 03/11/2020 beginning at approximately 8:20 a.m. on the third floor of the facility. LPN #1 was observed preparing medications for administration to Resident #29 and Resident #51. LPN #1 did not wash his hands or use hand sanitizer before beginning the medication preparation for Resident #29. He entered Resident #29's room, gave the medications, and returned to the cart. He then began preparing medications for Resident #51. He did not wash his hands or use hand sanitizer	F 880	LPN #1 re-educated on hand washing during medication pass by the DON/designee. Resident #29 and Resident #51 had no adverse reactions related to this practice. Any resident could have potential risk from this practice. Licensed nurses to be re-educated on proper hand washing during medication administration by the DON/designee. Nursing administration to complete medication competencies to include observation of hand washing on a minimum of 3 nurses 2x/week for 4 weeks, then weekly for 4 weeks and then monthly x1. Any identified trends will be reported to the QAPI committee monthly for recommendations and further action if required.	

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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	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 880 Continued From page 15 — F 880

between giving medications to Resident #51 and preparing medications for Resident #29. He entered Resident #29's room and administered her medications. He then returned to the medication cart. He did not wash his hands with soap and water or use hand sanitizer prior to beginning medication preparation for the next resident.

During the observation LPN #1 used his bare hand to touch the medication cart, the medication cards in the drawers, the stock medications, the pill cups, the water pitcher, the pill crusher, the plastic bags used to crush the medications, the computer, spoons to administer crushed medications, a container of applesauce, and the door to each resident's room. There was a bottle of hand sanitizer on the medication cart that he did not use.

LPN #1 was interviewed regarding the lack of hand washing at approximately 9:00 a.m. He stated, "Yes, I forgot to wash my hands."

The facility policy regarding medication administration was reviewed and contained the following:
"Prior to preparing or administering medications,...facility staff should follow facility's infection control policy (e.g. handwashing)."

The facility policy on handwashing was reviewed and contained the following: "Perform hand hygiene: Wash hands with either plain or antimicrobial soap and water or rub hands with an alcohol-based formulation before handling medication..."

The DON (director of nursing) and 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 ______	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	**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 880	Continued From page 16 administrator were notified during a meeting on 03/11/2020 of the above observation. No further information was obtained prior to the exit conference on 03/12/2020.	F 880		