State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
NH2625		B. WING		12/2	12/20/2021		
MARTHA JEFFERSON HOUSE 1600 GOR			DRESS, CITY, S RDON AVENI TESVILLE,		•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
F 000	An unannounced biennial State Licensure Inspection was conducted on 12/20/21. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 28 bed facility was 22 at the time of the survey. The survey sample consisted of three current resident reviews (Residents # 1 through 3).		F 000	F000 The facility sets fort following plan of co remain in compliant State and Federal rathe facility has take the following action plan of correction with facilities statem All statements of de have been or will be the dates indicated	rrection to ce with all ecommendation or will take is set forth in the which constitutes ent of compliant feciency sited a completed by here-in.		
F 001	The facility was out following state licer This RULE: is not The facility was not following Rules and of Nursing Facilities 12VAC5-371-250 (I and care planning Based on clinical reinterview, the facilit plan was reviewed residents in the sur Findings include: Resident #2 was as	met as evidenced by: in compliance with the d Regulations for the Licensure s. B. 3.) Resident assessment ecord review and staff y staff failed to ensure a care and revised for one of 3 vey sample, Resident #2.	F 001	F 001 Care Plan for Residen 12/21/24 with informa recent multi-disciplinar held September 28,20 representative and res requested no changes added a change in phy An in-house audit of al Carlyle unit was conduand reviewed by office Wilson. All deficiencies care plan scheduled for January in 2022. A Cabeen created for use be Assistant and DON to check for scheduling domonthly meeting on the every month. All care scheduled for 2022 an each month on the Cathe DON office and revery possible and revery possible and reversion will audit the point-click-care on a assure no gaps in care will be on-going, howe implementation will be 1/30/22.	t #2 was updated attion from the most ty care plan meeting 21, including family ident. Family in general plan but sician preferance. Il care plans for the toted by the DON assistant Annia found have had a found the month of the same of the month of the same of the month of the month of the month of the month of the same of the month of the m		
	06/11/18. Diagnoses for Resident #2 included, but were not limited to: high blood pressure, B12 deficiency, chronic pain, bell's palsy, cataracts, hypothyroidism and major depressive disorder. The facility's assessment tool documented the resident as alert and oriented to person and place					1/6/22	

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

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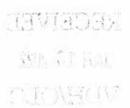
State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NH2625		B. WING		12/2	12/20/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADD MARTHA JEFFERSON HOUSE 1600 GOR			DRESS, CITY, S RDON AVENU			•
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 001	ADL's [activities of During the clinical r Resident #2's care current care plan in [electronic medical January of 2020. At approximately 2: nursing] was asked for Resident #2. The look for it. At approximately 3: presented a "care planted 06/28/21 and The DON stated the are completed, the be updated to reflect The documentation attendees and note well, no dislikes, probath but better with did not include any objectives and time needs for care and The DON stated the in her office, not the had not been added the DON was made care planted that she was No further informat.	ent upon staff for most all daily living]. ecord review on 12/20/21, plan was reviewed. The most in the resident's EMR record] was last updated in 00 PM, the DON [director of for the most current care plan in DON stated that she would 00 PM, the DON returned and plan meeting sign-in sheet" I stated this was all she had, at when care plan meetings care plan in the EMR should be the review and any changes. Included the names of es, which documented, "eating effers orange juice, dislikes shower bed" The care plan interventions or measurable estables to meet the resident's treatment. The care plan intervention was kept to resident's clinical record and do to the resident's care plan. The eaver that the resident's even updated in over a year, would make two years that the peen updated. The DON	F 001	DET TOLENGT		
		ne exit conference on ce that the resident's care plan				

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State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURV COMPLETEI	
				· · · · · · · · · · · · · · · · · · ·		
NH2625		B. WING		12/20/2021		
NAME OF I	PROVIDER OR SUPPLIER		100	STATE, ZIP CODE		
MARTHA	JEFFERSON HOUSE		DON AVENU TESVILLE, '			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETE	
F 001	Continued From pa	ge 2	F 001	12VAC-371-250 Resident assessment and care planning		
	had been reviewed and revised in a timely manner.			Care plan for resident #3 admitted on 3/2/2 updated on 1/6/22 using data gathered in previous quarters care plan meetings 3/5/2 8/10/21 and 11/19/21 and attended by resident processes and processes are plan to the processes of the processes are plant to the processes of the processes and processes are plant to the processes of the processes are plant to the processes of the processes are plant to the processes of the processes		
	care planning Based on staff inter	, H) Resident assessment and view, and clinical record		son and daughter-in-law. Resident add "care plan process" and "care plan log" monitoring by management and superv to insure continued compliance. Next comeeting pre-scheduled for 4/19/22. Systems of the state o	for isory team are plan stemic	1/6/22
	review, the facility for comprehensive can Resident #3.	ailed to develop a e plan for one of 3 residents,		change: all initial care plans will be docume in medical record within 24 hours of admiss after initial conference with family and resign This will be documented on the Care plan I review by team.		
;	The Findings Include:			•		
	Resident #3 was admitted to the facility on 3/2/21. Diagnoses for Resident #3 included; Hypertension, atrial fibrillation, hypothyroidism, and scoliosis. Resident #3 was assessed as being cognitively intact.					
	On 12/20/21 Resident #3's clinical record was reviewed. There was no evidence that a comprehensive care plan had been developed since admission. On 12/20/21 at 11:30 AM the director of nursing (DON) was interviewed. The DON said she may have Resident#3's care plan her her office and would go check.					
	On 12/20/21 at 12:30 PM the DON presented three care plan meetings sheets regarding Resident #3 and said that the care plans were not developed because of being behind in getting the care plans done "and that's on me."					
	The care plan meeting sheets were reviewed and indicated meetings were held on 3/5/21, 8/10/21, and 11/19/21 for Resident #3 and concerns were documented. However, concerns were not					

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State of Virginia (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ B. WING_ 12/20/2021 NH2625 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1600 GORDON AVENUE MARTHA JEFFERSON HOUSE CHARLOTTESVILLE, VA 22903** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 12VAC5-371-300 (I.) Pharmacy Services F 001 F 001 Continued From page 3 All Pharmacy Service recommendations for past 3 months will be reviewed by DON and Physician developed into care plans with problem, goals, Director to determine that all have had response and interventions. and are filed in medical records. This review will include all recommendations for all residents of the No other information was provided prior to exit Carlyle. A Pharmacy Recommendations Log is conference on 12/20/21. being developed to track incoming recommendations, distribution by date, and response follow-up. This log will be maintained by the DON and monitored by the Health and 12VAC5-371-300 (I.) Pharmacy Services 1/30/22 Wellness Coordinator on a monthly basis. The process will be maintained on an on-going basis Based on clinical record review and staff and the log will be complete and in place by interview, the facility staff failed to ensure pharmacy recommendations were completed for one of 3 residents in the survey sample, Resident #2. Findings include: Resident #2 was admitted to the facility on 06/11/18. Diagnoses for Resident #2 included, but were not limited to: high blood pressure, B12 deficiency, chronic pain, bell's palsy, cataracts, hypothyroidism and major depressive disorder. The facility's assessment tool documented the resident as alert and oriented to person and place and totally dependent upon staff for most all ADL's [activities of daily living]. During the resident's clinical record review, the resident's pharmacy recommendations were reviewed. Resident #2 had a pharmacy recommendation dated 10/15/21. The pharmacy recommendation documented, "...currently receiving...Haloperidol 0.5 milligrams (Began 11/30/20). Within first year...facility must attempt a GDR [gradual dose reduction]...unless clinically contraindicated...the physician has documented the clinical rationale...if appropriate, please consider a GDR at this time...please document

rationale...(prescriber's response...physician

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NH2625		B. WING		12/20/2021		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MARTH	A JEFFERSON HOUSI	-	IDON AVENU TESVILLE, 1			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
F 001	Continued From pa	age 4	F 001			
	signature)"					
	documented, "res receivingBuspiror 10/07/19)Citalopr mg]facility must a reduction]unless physician has docurationaleif appropat this timeplease (prescriber's responsate the resident's clinic reviewed and did not been attempted for medications listed abeen informed of the was no documental records regarding to the recommendations of [12/20/21], and not see the receiving the recommendations of [12/20/21], and not see the receiving the receiv	ne 15 mg (Began ram 10 ml [10 mg/5 ml=20 attempt a GDR [gradual dose clinically contraindicatedthe imented the clinical priate, please consider a GDR edocument rationale nsephysician signature)" cal records were further of evidence that a GDR had Resident #2 for any of the above or that the physician had ne recommendation. There tion in the resident's clinical				
	The DON [director of nursing] was interviewed at 3:00 PM on 12/20/21 regarding the location of completed pharmacy recommendations. The DON stated that they [pharmacy recommendations] are sent to her via computer, she in turn will then send to the appropriate physician or put in the "house" physician's box and after that, they are sent to medical records department to be put into the resident's chart. The DON was asked who was checking to make sure that the recommendations are actually seen by the physicians and followed up on. The DON stated, "I don't know, I haven't been checking them."					

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State of Virginia (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: __ B. WING 12/20/2021 NH2625 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1600 GORDON AVENUE MARTHA JEFFERSON HOUSE CHARLOTTESVILLE, VA 22903** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE 1D (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 12VAC5-371-360 (E.10.) Clinical Records F 001 F 001 Continued From page 5 Subsequent to the development of the Pharmacy Recommendations Log, a 2 The DON stated that she did not know if these copies will be recorded of all "follow-up" recommendations had been sent to the physician documents containing final determination or had been followed up on. A policy was of the physician(s) will be maintained- one requested from the DON on pharmacy services. copy will be submitted to pharmacy, the second will be kept in the log book The policy was presented and reviewed. The housed in the DON office, while the original will be submitted directly to the policy titled, "Pharmacy Consultant" documented, medical records office for filing. To ...engage the services of a licensed consulting ensure no missed recommendations, an pharmacist...provides consultation on all audit will be completed quarterly by the aspects...of pharmacy services...Reviews each nursing supervisor comparing log data medication of all residents in the and documents filed in medical records. The process will be on-going and the inital facility...contraindications...periodic reductions 1/15/2022 log set up completed bu 1/15/22. attempted...d. Reports any irregularities, issues or problems to the resident's physician and the director of nursing services. e. Ensures that these reports are acted upon...2. ...make sure: a. All recommendations are acted upon. b. All of the recommendations are reported to the residents' physicians. c. There is documentation in the residents' charts that notification and follow up occurred..." The DON stated that she could not explain why this wasn't done, but stated that she had not been checking to see if they were completed or acted upon by the physician. No further information or documentation was presented prior to the exit conference on 12/20/21 to evidence that pharmacy recommendations were acted upon and documented on in the resident's clinical record. 12VAC5-371-360 (E. 10.) Clinical records Based on clinical record review and staff interview, the facility staff failed to ensure a complete and accurate clinical record for one of 3

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residents in the survey sample, Resident #2.

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
NH2625			B. WING 12/2			0/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
MARTHA	JEFFERSON HOUSE		DON AVENU	•		
		CHARLOT	TESVILLE,	VA 22903		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
F 001	Continued From pa	ge 6	F 001			:
	Findings include:	A A A A A				
	Resident #2 was admitted to the facility on 06/11/18. Diagnoses for Resident #2 included, but were not limited to: high blood pressure, B12 deficiency, chronic pain, bell's palsy, cataracts, hypothyroidism and major depressive disorder.					
	The facility's assessment tool documented the resident as alert and oriented to person and place and totally dependent upon staff for most all ADL's [activities of daily living].					
	On 12/20/21, the resident's clinical record was reviewed for pharmacy medication reviews/recommendations. None were located in the resident's chart [EMR/electronic medical record or paper chart].					
i	At approximately 2:30 PM, the DON [director of nursing] was asked for the above information for Resident #2. The DON stated that they are supposed to be in the resident's paper chart under the "consults" tab. The DON was made aware that the resident's clinical records were reviewed and none were found. The DON stated that she would attempt to find the requested information.			·*		
	At approximately 3:10 PM, the DON returned with pharmacy reviews and recommendations. The DON stated that they are sent to her in the computer and she will print them off, give to the physician and then medical records will put them in the chart. The DON stated that these had not been part of the resident's clinical record. No further information and/or documentation was					
	No further information and/or documentation was presented to evidence that the resident's					

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PRINTED: 12/30/2021 FORM APPROVED State of Virginia (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING_ NH2625 12/20/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1600 GORDON AVENUE MARTHA JEFFERSON HOUSE CHARLOTTESVILLE, VA 22903** (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) F 001 F 001 Continued From page 7 pharmacy reviews and pharmacy recommendations were in the resident's clinical record.

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State of Virginia

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED						
NH2625		B. WING		R 02/01/2022						
			DRESS SITY S	TATE ZID CODE	02.0	7				
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CORPON AVENUE									
MARTHA	MARTHA JEFFERSON HOUSE 1600 GORDON AVENUE CHARLOTTESVILLE, VA 22903									
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	(X5) COMPLETE DATE					
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NATE					
(F 000)	Initial Comments		{F 000}							
	An offsite paper rev 1/30/22 for all previ 12/20/21. All deficie	visit survey was conducted on ous deficiencies cited on encies have been corrected. Inpliance with all regulations		E≡ #G						
:						*2				

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

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