

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Charlottesville Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 West Rio Road Charlottesville, VA 22901	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>21875</p> <p>Based on staff interview and clinical record review, the facility staff failed to notify the responsible party of changes in medications for one of ten residents in the survey sample (Resident #7).</p> <p>The findings include:</p> <p>Resident #7 (R7) had multiple medication changes with no notification to R7's family/responsible party.</p> <p>Resident #7 was admitted to the facility with diagnoses that included hip fracture, Alzheimer's, traumatic brain dysfunction, hypothyroidism, anemia, osteoporosis, anxiety, depression, seizures, and protein-calorie malnutrition. The minimum data set (MDS - assessment tool) dated 5/23/23 assessed R7 with severely impaired cognitive skills for daily decision making.</p> <p>R7's clinical record documented physician ordered medication and/or medication dose changes as follows:</p> <p>5/18/23 Celexa increased from 10 mg (milligrams) per day to 20 mg per day for treatment of depression.</p> <p>5/26/23 Celexa was discontinued and the antidepressant Zoloft 75 mg per day was started.</p> <p>6/03/23 Antibiotic cephalexin 500 mg every 12 hours for 7 days for treatment of a leg abrasion with cellulitis.</p> <p>6/05/23 Zoloft dose was increased to 100 mg per day.</p> <p>6/05/23 Namenda increased to 5 mg twice per day for treatment of dementia.</p> <p>6/05/23 Buspar 5 mg three times per day for treatment of anxiety.</p> <p>R7's clinical record, including nursing notes, documented no notification to R7's responsible party (RP) regarding the medication orders/changes.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/9/24 at 3:15 p.m., the director of nursing (DON) was interviewed about any notifications regarding R7's medication/treatment changes. The DON stated he reviewed the clinical record and did not find any notifications to the RP. The DON stated nurses were expected to notify families and responsible parties regarding changes in condition or treatment, including medication changes.</p> <p>On 4/10/24 at 8:45 a.m., the licensed practical nurse unit manager (LPN #2) was interviewed about any notifications regarding the above medication/dose changes for R7. LPN #2 stated that changes in medications and/or dosages should have been reported to R7's family/RP. LPN #2 stated that any notifications would have been documented in R7's clinical notes.</p> <p>This finding was reviewed with the administrator and DON during a meeting on 4/9/24 at 4:40 p.m.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>21875</p> <p>Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to follow posted menus for six of ten residents in the survey sample (Residents #1, #2, #3, #5, #6 and #10).</p> <p>The findings include:</p> <p>Residents #1, #2, #3, #5, #6 and #10 were not served food items as listed on the posted menu and/or meal tickets.</p> <p>On 4/8/24 at 2:20 p.m., the resident council president (Resident #5) was interviewed about meals/food service in the facility. The council president stated that foods served rarely matched the posted menus or meal tickets. The council president stated concerns with food had been discussed in council meetings for several months and dietary staff reported they were working to improve.</p> <p>The posted breakfast menu for 4/9/24 included scrambled eggs, bran muffin, oatmeal, whole milk, orange juice with alternates listed as hard-boiled eggs, wheat toast, and assorted cold cereals in addition to coffee or hot tea.</p> <p>On 4/9/24 at 8:30 a.m., meals served to Residents #1, #2, #3, #5, #6 and #10 were observed and compared to the meal ticket and posted menu with discrepancies noted as follows.</p> <p>Resident #1's tray had 1% milk and two sausage patties when the meal ticket listed whole milk. Sausage was not on ticket or menu.</p> <p>Residents #2 and #3 were served no bran muffin and 1% milk when their meal tickets listed bran muffin and whole milk.</p> <p>Resident #5's tray had 1% milk and no oatmeal when the ticket listed whole milk and oatmeal.</p> <p>Resident #6's tray had 1% milk when the meal ticket listed whole milk.</p> <p>Resident #10's tray had no oatmeal, 1% milk and sausage when the meal ticket listed whole milk, oatmeal. Sausage was not on the ticket or menu.</p> <p>On 4/9/24 at 8:40 a.m., Resident #10 was interviewed about foods provided. Resident #10 stated, We never get what's on the ticket.</p> <p>The steam table for lunch service was observed on 4/9/24 at 11:20 a.m. Posted menu items for the 4/9/24 lunch included mixed Italian vegetables and whole milk. There were no mixed Italian vegetables prepared or served to residents on 4/9/24 at lunch. Lunch trays were observed served to unit 1 residents starting on 4/9/24 at 12:15 p.m. Residents in rooms 24 through 33 were not served any milk with their meals.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/9/24 at 12:55 p.m., the dietary manager (other staff #2) was interviewed about the missing food items, 1% milk instead of whole milk, and food items not matching menus/tickets. The dietary manager stated the 1% milk was served because there had been an issue with the milk supplier not providing 2% and whole milk in small cartons. The dietary manager stated whole milk was available in the kitchen only in gallon jugs. Regarding the sausage served that was not on the menu/ticket, the dietary manager stated, We just know that some residents want meat. The dietary manager stated that she did not know why the muffins and oatmeal were not served as listed on the tickets. The dietary manager stated the mixed Italian vegetables did not come in so were not available to prepare/serve for lunch on 4/9/24. The dietary manager was not sure why milk was not served on the 4/9/24 lunch trays. The dietary manager stated foods served were supposed to match the tickets/menus.</p> <p>On 4/9/24 at 2:35 p.m., certified nurses' aide (CNA) #2 working on unit 1 was interviewed. CNA #2 stated drinks were provided from the kitchen and distributed by the unit staff during meals. CNA #2 stated that no milk was sent from the kitchen for lunch on 4/9/24.</p> <p>Clinical records for Residents #1, #2, #3, #5, #6, and #10 were reviewed. The meal tickets matched the prescribed therapeutic diets with consistencies (regular, mechanical soft, chopped, pureed) provided as ordered.</p> <p>The facility's policy titled Meal Distribution (October 2019) documented, It is the center policy that meals are transported to the dining locations in a manner that insures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner . The Dining Service Director will ensure that all meals are assembled in accordance with the individualized diet order, plan of care, and preferences .</p> <p>This finding was reviewed with the administrator and director of nursing during a meeting on 4/9/24 at 4:40 p. m.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>21875</p> <p>Based on observation, resident interview, staff interview, and facility document review, the facility staff failed to serve food at an appetizing temperature on one of two units (unit 1).</p> <p>The findings include:</p> <p>On 4/8/24 at 2:50 p.m., the resident council president, Resident #5 (R5), was interviewed about food/meals in the facility. R5 stated meals served to residents in rooms were usually cold. R5 stated issues with cold food and missing food items had been discussed multiple times in the council meetings and dietary staff reported they were working to improve.</p> <p>With the council president's permission, the resident council meeting minutes were reviewed from January, February and March (2024). Minutes documented residents expressed concerns that the overall appearance/taste of food needed improvement and foods were not served hot.</p> <p>The posted menu for 4/9/24 lunch included spaghetti with meatballs, Italian mixed vegetables, garlic bread, chocolate chip cookie, whole milk, coffee and tea. The alternate menu included grilled marinated chicken breast, whole kernel corn, mashed potatoes, and buttered pasta.</p> <p>On 4/9/24 at 11:20 a.m., the tray line lunch service was observed. Food temperatures (degrees F) on the steam table were as follows.</p> <p>Spaghetti with meatballs = 192</p> <p>Chicken breasts = 197</p> <p>Mashed potatoes = 191</p> <p>Buttered pasta = 185</p> <p>Whole kernel corn = 189</p> <p>On 4/9/24 at 12:06 p.m., a regular diet test tray was prepared and went with resident trays to unit 1 on 4/9/24 at 12:06 p.m. Three CNAs were observed delivering trays to residents on the hallway with rooms 24 to 33. The last resident was served from the unit 1 meal cart on 4/9/24 at 12:52 p.m. At this time, accompanied the dietary manager (other staff #2), the temperatures of the test tray food items were measured. The dietary manager measured the food temperatures as follows.</p> <p>Spaghetti with meatballs = 135 (loss of 57 degrees from steam table)</p> <p>Whole kernel corn = 133 (loss of 56 degrees from steam table)</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The test tray food items were then tasted. The spaghetti/meatballs and corn had good taste but were not hot and not considered palatable, due to the low temperature. The garlic bread was cold, chewy, and not palatable. The dietary manager tasted the same food items and stated that she agreed that the food was lukewarm and the bread was not tasty or warm. The dietary manager stated that it took too long for the food to get served after delivery to the floor.</p> <p>On 4/9/24 at 2:35 p.m., certified nurses' aide (CNA #2) assisting with meal delivery on unit 1 was interviewed. CNA #2 stated she experienced delay because the kitchen did not send enough beverages to the floor. CNA #2 stated that she ran out of tea and had to go to the kitchen to get additional tea for the remaining residents on the unit. CNA #2 stated the kitchen had sent no milk to the unit with the lunch trays.</p> <p>On 4/9/24 at 2:40 p.m., the licensed practical nurse unit manager (LPN #1) was interviewed about the lengthy meal service and cold food served during lunch. LPN #1 stated that the meal service normally did not take that long. LPN #1 stated that she and the other nurses usually helped to get meals served, in addition to the CNAs. LPN #1 stated beverages were provided from the kitchen. LPN #1 stated that all unit staff were expected to help with meal service.</p> <p>The facility's policy titled Meal Distribution (October 2019) documented, It is the center policy that meals are transported to the dining locations in a manner that insures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner .The nursing staff shall be responsible for verifying meal accuracy and timely delivery of meals to residents/patients .</p> <p>This finding was reviewed with the administrator and director of nursing during a meeting on 4/9/24 at 4:40 p. m.</p>		