STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495178	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlottesville Health & Rehabilitation Center	505 West Rio Road Charlottesville, VA 22901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on staff interviews and facility document review, the facility failed to ensure resident preferences were met regarding showers for one of two units (unit one), which did not provide showers due to low weekend staffing. The findings include:Review of the facilities PBJ (Payroll Based Journal) indicated weekend staffing excessively low for the January through March 2025 quarter.Review of the as worked weekend scheduled for March 2025 revealed on March 8th and 9th (Saturday and Sunday) that there were two certified nursing assistants scheduled on unit one for 7 a.m. through 7 p.m. Review of the resident census log for these dates indicated a census of 59 residents on unit one.On 9/2/25 at 2:30 the director of nursing (DON) was interviewed regarding scheduling nursing staff. The DON verbalized not having a staff coordinator at the present time, but that typically there are four to five certified nurse assistants (CNA's) on unit one on both day/evening shift and evening/night shift. On 9/3/25 at 4:20 p.m. CNA #1 (aide that worked the weekend in question) was interviewed. CNA #1 verbalized that the unit should have four CNA's each shift. CNA #1 said that during that weekend the aides had thirty residents each and showers were not completed. CNA #1 said the other aide and herself helped each other and were able to provide hygiene and a shortened bed bath to residents, was able to feed residents with the help of other nursing staff and keep all the residents safe. CNA #1 said when a situation like that occurs that the staff prioritize what needs to be done and things like showers are not considered. On 9/4/25 at 9:00 a.m. license practical nurse (LPN #4-unit manager) was interviewed. LPN #4 the goal is to staff four CNAs on each twelve-hour shift, which does not always occur. LPN #4 verbalized when the unit is that short on help, the CNAs will do what is important for the resident. The above finding was presented to the DON and administrator on 9/3/25. No other information was presented prior to the exit conference on 9/4/25

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure that unnecessary psychotropic medications were not administered to one resident, Resident #5 (R5) out of a survey sample of six residents. The findings included:Staff completed the admission medication reconciliation using the resident's at-home medications rather than the physician-verified hospital discharge orders, resulting in the administration of two antipsychotic medications, Amitriptyline 10 mg at bedtime and Trazodone 100 mg at bedtime, that were not prescribed upon discharge. This failure placed R5 at risk for chemical restraint related to receiving unnecessary antipsychotic medications.Unable to conduct an interview with R5 due to R5 was no longer a resident at the facility.On 9/3/25 at 9:50 a.m., an interview was conducted with a licensed practical nurse, unit two manager, LPN#2 (LPN2). LPN2 stated that the discharge summary from the hospital was used for the admission orders. She stated the discharge medications on the summary was used and not the at home medications. She stated that if the orders were unclear that the hospital or the doctor was contacted for clarification. On 9-3-25 at 10:05 a.m., an interview was conducted with LPN#3 (LPN3). LPN3 stated that the facility follows the hospital's discharge summary for medication orders. He explained that if at-home medications were administered while the resident was in the hospital, they are entered into the facility's system; otherwise, the facility relies on the hospital discharge summary. LPN3 further stated that at-home medications may or may not be included in the discharge summary. On 9-3-25 at 10:28 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the facility follows the hospital discharge summary and the medications listed at the time of discharge. She stated that the at home medication list was not discharge medications. She explained that the pharmacy reviews new medications, and the nurse practitioner is notified if there is documentation in the chart related to starting new medications. On 9-3-25 at 11:45 AM, an interview was conducted with the DON and the Regional Director of Clinical Services. Both confirmed that when Resident #5 was admitted to the facility, staff entered medications from the at-home medication list rather than following the hospital discharge summary orders. They further confirmed that medications from the at-home list were entered into the record even though the resident was not discharged on those medications. The DON and Regional Director also acknowledged that the nurse practitioner documented in her progress notes that the resident's son had requested these medications be discontinued, and while her intent was to discontinue them, this was not completed.On 9-3-25 at 1:41 PM, an interview was conducted with the nurse practitioner. She stated that her intent was to discontinue the medications in response to the son's request. She explained that on 8-11-25 the resident was somewhat confused, and on 8-13-25 the resident was noted to be less confused, so the medications were continued after being placed on hold. The nurse practitioner stated that she did not feel the medications made a difference and confirmed that her intent was to discontinue the antipsychotic medications per the son's request, but this was not completedOn 9-3-25, a clinical record review was conducted. The hospital discharge summary was reviewed, and it was determined that staff used the at-home medication list for admission orders rather than following the discharge summary. The facility staff did not complete the admission process according physician's discharge orders. As a result, the resident received Amitriptyline 10 mg at bedtime and Trazodone 100 mg at bedtime from 8/4/25 to his discharge on [DATE]. R5 had delirium in the hospital due to hospital setting, medications, narcotics and a head strike when he fell. The discharge summary had R5's delirium had resolved but the facility was still monitoring delirium with each visit from the provider. During the clinical record review, the nurse practitioner's progress notes were reviewed. On 8-11-25, the nurse practitioner documented that the resident's son expressed concerns and requested that psychotropic medications be discontinued. On 8-13-25, the nurse practitioner again documented the son's request to discontinue the antipsychotic medications due to the resident experiencing increased confusion, agitation, and anxiety over the weekend. The nurse practitioner documented her intent to discontinue these medications; however, the medications were not discontinued.During the clinical record review, a progress note dated 8/9/25 by a nurse practitioner indicated that R5 exhibited an altered level of consciousness. The resident's son reported that R5 was experiencing confusion, and the nurse observed R5 asking if his son was inside the mirror he was looking at. On this date, the son requested that three medications, Amitriptyline, Trazodone and Seroquel to be discontinued due to concerns that they cause delirium. The medications were held for three days, and then restarted after the three-day hold, and lab work was obtained. Labs that were

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review, and facility document review, the facility failed to ensure an appropriate discharge for one of six residents, resident #6.The findings include:The facility did not set up home health therapy per discharge instructions for Resident #6 (R6).Diagnoses for R6 included spinal stenosis, diabetes, sepsis upon admission, scoliosis, status post spinal fusion. The most recent MDS (Minimum Data Set) was a 5-day assessment dated [DATE], R6 was assessed with a cognitive score was 10, indicating moderately cognitively impaired. Review of R6's clinical record indicated R6 was admitted to the facility due to status post-surgery for spinal fusion and was at the facility for skilled services requiring therapy.Review of R6's discharge instructions indicated R6 was scheduled to discharge home on 3/13/25 and receive home health services for therapy (physical and occupational). The record did not indicate that the facility initiated home health services. The discharge instructions evidenced that R6 signed the instructions on 3/13/25. On 9/2/25 at 3:00 p.m. the social worker (OS #5) was interviewed. OS #5 said typically she would talk with the resident or family and asked what their needs might be regarding equipment and home health is automatically set up unless the resident declines the service. OS #5 verbalized not remembering if she was working the week of R6's discharge but would review the discharge plan. On 9/2/25 at 3:30 p.m. OS #5 presented a progress note written by OS #5 dated 3/13/25 at time of discharge that read in part discharged on 3/13/2025 at 1:00 pm and was picked up by family to take home. Declined Home Health services. A progress note dated 3/13/25 preceding OS #5's discharge note read discharged home with health, DC summary and scripts reviewed. No concerns voiced. On 9/3/25 at 9:00 a.m. the therapy rehab. Director (other staff, OS #3) was interviewed. OS #3 verbalized that R6 was receiving therapy for strength training and self-transfers. Per insurance R6 would receive the therapy for six weeks and then be discharged . OS #3 reviewed the therapy notes and verbalized because R6 was not back to his baseline of functional abilities (prior to surgery) home health would be set up. OS #3 verbalized that according to therapy notes R6 needed partial assistance for transfers and home health would be working with R6 to achieve this. On 9/3/25 at 10:15 a.m. R6's emergency contact (EC) was interviewed by phone. EC verbalized that R6 did not come home on home health and R6's son was staying with R6 and helping R6 with his needs. The EC said that R6 did start receiving home health after going for a follow up appointment with R6's primary care provider.On 9/3/25 at 11:50 a.m. registered nurse (RN #2) was interviewed. RN #2 verbalized being the nurse that discharged R6 on 3/13/25. RN #2 verbalized going over all discharge instructions including home health care. RN #2 said that R6 agreed with all instructions, including home health, and signed the bottom of the discharge instructions. On 9/3/25 at 1:30 p.m. the facility nurse practitioner (OS #1) was interviewed. OS #1 said that if therapy felt like R6 needed more therapy after going home and R6 declined the therapy, then either the physician or OS #1 should have been notified to ensure a proper discharge. On 9/3/25 at 1:50 p.m. OS #5 and Nurse consultant (administrative staff, AS #3) were interviewed regarding discharge. The surveyor explained there was no documentation of the physician or OS #1 being notified of R6 declining therapy services from home health or that home health was contacted prior to discharge. AS #3 verbalized it's not typical that the physician is notified of a resident declining home health service, however if home health is needed and a resident declines it, then APS (Adult Protective Services) should be contacted to ensure the residents safety. OS #5 said that home health is typically contacted two days prior to discharge to ensure they know when the resident will be at home. The surveyor questioned, if home health is contacted two days prior to being discharged and R6 declined home health on the day of discharge there should be evidence that home health was set up. OS #5 said she could not recall all the details and was not sure what home health agency was contacted and was not sure about working the week R6 was discharged . On 9/3/25 at 4:50 p.m. AS #3 verbalized after calling home health agencies in the area where R6 resided, AS #3 was able to evidence that R6 started receiving home health care on 3/27/25 after being seen by R6's primary care physician and making the referral and not the facility. On 9/3/25 at 5:30 p.m. the above finding was presented to the administrator, director of nursing and nurse consultant.The facilities Discharge Instruction policy read in part Discharge planning will be initiated and coordinated by the social service department who will assist the patient/family to make arrangements for transportation, care equipment, Home Health Services, etc. (the social service department and/or therapy will take responsibility for completion of arrangements) No other information was provided prior to the exit conference on 9/4/25

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interview, clinical record review, and facility documentation review the facility staff failed to follow physician orders for one resident, Resident #5 (R5) out of a survey sample of six residents. The findings included:The facility staff did not follow the physician discharge orders for R5's admission to the facility.On 9/3/25 at 9:50 a.m., an interview was conducted with a licensed practical nurse, unit two manager, LPN#2 (LPN2). LPN2 stated that the discharge summary from the hospital was used for the admission orders. She stated the discharge medications on the summary was used and not the at home medications. She stated that if the orders were unclear that the hospital or the doctor was contacted for clarification. LPN3 stated that when pharmacy alerts come up with medication orders that it was discussed with the doctor. She said, I would hope the nurses would document the alerts.On 9-3-25 at 10:05 a.m., an interview was conducted with LPN#3 (LPN3). LPN3 stated that the facility follows the hospital's discharge summary for medication orders. He explained that if at-home medications were administered while the resident was in the hospital, they are entered into the facility's system; otherwise, the facility relies on the hospital discharge summary. LPN3 further stated that at-home medications may or may not be included in the discharge summary. He explained that when drug alerts appear, the pharmacy is contacted, and the pharmacy clears the alerts rather than the physician. He also stated that staff review the resident's medication history from the discharging hospital when admitting the resident.On 9-3-25 at 10:28 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the facility follows the hospital discharge summary and the medications listed at the time of discharge. She stated that the at home medication list was not discharge medications. She explained that the pharmacy reviews new medications, and the nurse practitioner is notified if there is documentation in the chart related to starting new medications. On 9-3-25 at 11:45 AM, an interview was conducted with the DON and the Regional Director of Clinical Services (RDCS). Both confirmed that when Resident #5 was admitted to the facility, staff entered medications from the at-home medication list rather than following the hospital discharge summary orders. They further confirmed that medications from the at-home list were entered into the record even though the resident was not discharged on those medications. The DON and Regional Director also acknowledged that the nurse practitioner documented in her progress notes that the resident's son had requested these medications be discontinued, and while her intent was to discontinue them, this was not completed. The RDCS said, the facility staff was not familiar with the discharge summary from this hospital and was different than what we are used to seeing. On 9-3-25, a clinical record review was conducted. The hospital discharge summary was reviewed, and it was determined that staff used the at-home medication list for admission orders and there were two medications (amitriptyline and trazodone) from the at home list that was not on the medication discharge orders. The facility staff did not complete the admission process according physician's discharge orders. The discharge summary medications were followed but the facility added the at home medications also.On 9-3-25, a facility documentation review was conducted. The policy titled, General Guidelines for Medication Administration, read in part, medications are to be administered only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to administer medications, and that medications must be administered in accordance with written orders of the prescriber.On 9/3/25 at 5:15 p.m., an end of day meeting was conducted. The administrator, DON and the regional director of clinical services were made aware of the above concerns.On 9/4/25 at 9:40 a.m., an interview with the nurse practitioner (NP) was conducted. The NP stated that the nursing staff completed the medications and the diagnosis on admission, and she signs off on the admission. She stated that she was not aware there were wrong entries for the medications and diagnosis. She stated her intent was to discontinue the three medications the son requested.On 9/4/25, a review of facility documentation was conducted. The policy titled, Physician Visits, read in part, that a discharging physician will provide patient information and orders to the facility at the time of admission. The patient's admission information is to be reviewed, and orders approved by the attending physician. The physician, nurse practitioner, or physician assistant is to review the patient's medical plan of care at each visit and provide documentation for the medical record'.No additional information was provided.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on staff interview, clinical record review, and facility documentation review the facility staff failed to ensure medication review was performed by physician services on admission for one resident, Resident #5 (R5) out of a survey sample of six residents. The findings included: On 9/3/25, a clinical record review of Resident #5 was conducted. The review showed the residents did not have a diagnosis of depression or delirium on the diagnosis list; however, amitriptyline was documented for depression without a corresponding diagnosis. A nurse practitioner's progress notes dated 8/11/25 and 8/13/25 documented the son's request for the antipsychotic medications (amitriptyline, trazodone and Seroquel) to be discontinued. The nurse practitioner stated it was her intent to discontinue the medications, but she did not complete the discontinuation. The medications were ordered on admission, 8/4/25 and continued until R5 was discharged on 8/15/25.On 9/4/25 at 9:00 a.m., an interview was conducted with the Minimum Data Set (MDS) Coordinator, LPN#1 (LPN1). LPN1 stated she reviewed Resident #5's diagnoses and was unable to find depression, or delirium. She stated the facility's nurse practitioner had assigned the diagnosis of depression, although there was no history of depression in the resident's hospital record. LPN1 further stated that delirium was noted in the nurse practitioner's progress notes, but the hospital discharge summary showed it had resolved; therefore, it was not placed on the diagnosis list. The MDS Regional Director, who participated by phone, stated the medication Amitriptyline was listed on the hospital record, but no diagnosis was documented with it.On 9/5/25 at 9:40 a.m., an interview was conducted with the nurse practitioner. The nurse practitioner stated the diagnosis of depression came from the hospital. She reported that when reviewing the history and physical and the hospital paperwork, she was unable to find the diagnosis of depression, but believed that was how she obtained it. When asked about the diagnosis of depression being linked to the antidepressant medication, she stated the nursing staff entered that diagnosis with the medication on admission, and she did not catch that the resident had no history of depression when she signed off on the paperwork.On 9/4/25, a review of facility documentation was conducted. The policy titled, Physician Visits, read in part, that a discharging physician will provide patient information and orders to the facility at the time of admission. The patient's admission information is to be reviewed, and orders approved by the attending physician. The physician, nurse practitioner, or physician assistant is to review the patient's medical plan of care at each visit and provide documentation for the medical record'.On 9/4/25 at 11:00 a.m., the administrator, director of nursing and the regional clinical care coordinator was made aware of the above concerns.No additional information was provided.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on staff interviews and facility document review, the facility failed to ensure sufficient staffing in accordance with the facility assessment on one of two units (unit one), which had excessively low weekend staff. The findings include: Review of the facilities PBJ (Payroll Based Journal) indicated weekend staffing excessively low for the January through March 2025 quarter. Review of the as worked weekend scheduled for March 2025 revealed on March 8th and 9th (Saturday and Sunday), there were two certified nursing assistants scheduled on unit one for 7 a.m. through 7 p.m. Review of the resident census log for these dates documented a census of 59 residents on unit one. On 9/2/25 at 2:30 the director of nursing (DON) was interviewed regarding scheduling adequate nursing staff. The DON verbalized not having a staff coordinator at the present time and was currently taking on that role, but typically there are four to five certified nurse assistants (CNA's) on unit one on both day/evening shift and evening/night shift (7:00 a.m. to 7:00 p.m. and 7:00p.m. to 7:00 a.m.). Review of current as worked schedules indicated no staffing concerns. On 9/3/25 at 4:20 p.m. CNA #1 (an aide that worked the weekend in question) was interviewed. CNA #1 verbalized that unit one should have four CNA's each shift. CNA #1 said during that weekend the aides had thirty residents each and showers were not completed. CNA #1 said the other aide and herself helped each other and were able to provide hygiene and a shortened bed bath to residents, was able to feed residents with the help of other nursing staff and keep all the residents safe. CNA #1 said when this occurred, the staff prioritized what needed to be done and showers are not considered. CNA #1 verbalized there were no incidents (such as falls or needs not being met) during this time period. CNA #1 verbalized this was an isolated incident and has been better since agency has been allowed to come into the facility. The above finding was presented to the DON and administrator on 9/3/25. The administrator verbalized that the facility has had a lot of turnovers in employment and call outs especially on weekends. The administrator said that recently the facility has started using agency staff to fill in vacancies when needed and is working towards hiring more staff.On 9/4/25 at 9:00 a.m. license practical nurse (LPN #4-unit manager) was interviewed. LPN #4 the goal is to staff four CNAs on each twelve-hour shift, which does not always occur. LPN #4 verbalized when the unit is that short on help, the CNAs will do what is important for the residents. On 9/4/25 the administrator presented the facility assessment and verbalized. Based on our census, acuity, and budget, the facility should be between four and five nursing assistants per shift.Review of incident logs, grievance logs, and resident council minutes did not evidence concerns regarding needs of residents or incident/accident concerns related to low staffing.The survey team conducted interviews regarding getting showers as scheduled with four residents in the survey sample, identified as R1, R2, R3, and R4. There were no concerns expressed except for R1(resident council president) who wanted to change shower schedule to be done early in the morning prior to breakfast, because of handing out daily menus to residents just after breakfast. This information was presented to LPN #4, LPN #4 verbalized being aware of the preference and had just gone into effect. No other information was presented prior to the exit conference.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and clinical record review, the facility failed to ensure a complete and accurate record for two of six residents. The findings include: 2. The facility staff failed to complete R5's admission medications correctly and had a diagnosis of depression and R5 had no history of depression. On 9/3/25 at 1:41 p.m., a phone interview was conducted with the nurse practitioner (NP). The NP stated she saw the resident on 8/11/25 with some confusion and again on 8/13/25 with less confusion. She reported that two other providers also noted improvement in his confusion. She stated she only heard the concern once about the son wanting the antipsychotic medications discontinued. She explained that it was her intent to discontinue the medication, but she did not do so. On 9/3/25, a clinical record review of Resident #5 was conducted. The review showed the residents did not have a diagnosis of depression or delirium on the diagnosis list; however, amitriptyline was documented for depression without a corresponding diagnosis. A nurse practitioner's progress notes dated 8/11/25 and 8/13/25 documented the son's request for the antipsychotic medications (amitriptyline, trazodone and Seroquel) to be discontinued. The nurse practitioner stated it was her intent to discontinue the medications, but she did not complete the discontinuation. On 9/4/25 at 9:00 a.m., an interview was conducted with the Minimum Data Set (MDS) Coordinator, LPN#1 (LPN1). LPN1 stated she reviewed Resident #5's diagnoses and was unable to find depression, or delirium. She stated the facility's nurse practitioner had assigned the diagnosis of depression, although there was no history of depression in the resident's hospital record. LPN1 further stated that delirium was noted in the nurse practitioner's progress notes, but the hospital discharge summary showed it had resolved; therefore, it was not placed on the diagnosis list. The MDS Regional Director, who participated by phone, stated the medication Amitriptyline was listed on the hospital record, but no diagnosis was documented with it. On 9/5/25 at 9:40 a.m., an interview was conducted with the nurse practitioner. The nurse practitioner stated the diagnosis of depression came from the hospital. She reported that when reviewing the history and physical and the hospital paperwork, she was unable to find the diagnosis of depression, but believed that was how she obtained it. When asked about the diagnosis of depression being linked to the amitriptyline medication, she stated the nursing staff entered that diagnosis with the medication on admission, and she did not catch that the resident had no history of depression when she signed off on the paperwork. On 9/4/25 at 11:00 a.m., the administrator, director of nursing and the regional clinical care coordinator was made aware of the above concerns. No additional information was provided. 1. Resident #6 (R6) progress notes and skin assessments failed to show documentation of a pressure ulcer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495178	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlottesville Health & Rehabilitation Center	505 West Rio Road Charlottesville, VA 22901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Diagnoses for R6 included spinal stenosis, diabetes, sepsis upon admission, scoliosis, status post spinal fusion. The most recent MDS (Minimum Data Set) was a 5-day assessment dated [DATE]. R6 was assessed with a cognitive score of 10, indicating moderately cognitively impaired. Review of R6's clinical record documented (via a skin assessment dated [DATE]) indicated that R6 had a stage three pressure ulcer upon admission. The clinical record documented treatments were put in place and a wound care company began to monitor and treat the wound. Further review of the daily skilled assessment progress notes dated 1/31/25 through 2/3/25 and weekly skin assessments dated 2/7/25 and 2/14/25 had inconsistent documentation of R6 having a pressure ulcer either by documenting No on the progress notes or no documentation regarding a stage three pressure ulcer on skin assessments. On 9/3/25 at 8:30 a.m. the director of nursing (DON) and nurse consultant (administrative staff, AS #3) were interviewed. AS #3 reviewed R6's clinical record and agreed there were discrepancies in the skin assessments and progress notes. A facility policy titled Wounds/Skin Impairments read in part, The Skin and Observation Tool will be completed by a licensed nurse [.], detailing any wounds/skin impairments. No other information was provided prior to the exit conference on 9/4/25.