

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495326	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/30/2024
NAME OF PROVIDER OR SUPPLIER  Monroe Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1150 Northwest Drive 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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>28106</p> <p>Based on staff interview, and clinical record review, the facility staff failed to complete an assessment after a fall for one of 3 residents.</p> <p>Resident #1 (R1) did not have documented assessment after a fall.</p> <p>The findings included:</p> <p>Diagnoses for R1 included Dementia, manic depression, and fractures secondary to falls. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/3/24. R1 was assessed with a cognitive score of 00 indicating severely cognitively impaired.</p> <p>R1's clinical record was reviewed regarding a falls leading to R1 being sent to the hospital and diagnosed with two rib fractures and lacerated spleen on 12/9/23. Progress notes dated 12/9/23 documented a fall had occurred at 4:16 AM while R1 was in the hallway taking off clothing. A full assessment was completed and did not show any abnormalities or injuries. R1 was assisted back to bed.</p> <p>Another progress note dated 12/9/23 at 12:15 PM indicated R1 had become confused, lethargic, restless, with an unsteady gait, and was hypotensive. R1 was transferred to the hospital due to change in condition and was found to have fractures of two ribs and a lacerated spleen. This progress note was prompted due to a fall occurring near the elevator at this time and R1 was observed unsteady on feet.</p> <p>Further review of R1's progress notes dated 12/22/23 as a late entry for 12/9/23 indicated R1 had a fall on 12/9/23 around 8:00 AM and was found partially under the bed, was assessed for injuries and noted a bruise to the right side of R1's head.</p> <p>Review of the clinical record did not evidence any assessments were completed at the time of the fall (8:00 AM). There was evidence that a Neuro check form had been initiated but not until 12:00 PM after the third fall.</p> <p>The nurse involved in the 8:00 AM fall was unable to be interviewed due to no longer working at the facility.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/30/24 at 10:00 AM the director of nursing (DON) was interviewed concerning the above finding. The DON verbalized R1's injuries were investigated by the facility and during the investigation it was evident that the staff knew about the falls occurring on 12/9/24 but two nurses that were involved during R1's falls did not document on the falls at that time and one of the nurses did not document any assessments after the fall. The DON said when it was evident that the nurses did not document at the time of the falls both nurses were inserviced and then all nursing staff were inserviced. The DON verbalized a plan of correction for this was completed at the time of the findings.</p> <p>The DON provided the following plan of correction:</p> <ol style="list-style-type: none"> <li>1. On 12/21/23, one on one education was provided to newly hired nurse on change of condition and the process that are expected.</li> <li>2. To identify like residents that have the potential to be affected the DON/designee reviewed all residents that had change in condition to ensure proper documentation. Completed on 12/21/23.</li> <li>3. To prevent this from happening again the DON/designee will educate licensed nurses on assessment and notification of change in condition.</li> <li>4. DON and or unit manager to monitor for ongoing compliance with documentation will be completed in morning meetings for three months to ensure SBARs and change in condition is assessed and documented. An audit sheet will evidence monitoring was completed. Results will also be discussed in QAPI monthly for 3 months.</li> <li>5. Date of correction 12/22/23.</li> </ol> <p>All inservice records were reviewed along with all forms used to monitor the plan of correction. At the time of the survey there were no current concerns regarding change in condition assessment implementation. The survey team accepted the deficiency as past non-compliance.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>28106</p> <p>Based on staff interview, and clinical record review, the facility staff failed to maintain an accurate clinical record for one resident (Resident #1, R1) in a survey sample of 3 residents.</p> <p>The findings included:</p> <p>The facility staff failed to maintain accurate documentation with regards to falls.</p> <p>Diagnoses for R1 included Dementia, manic depression, and fractures secondary to falls. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/3/24. R1 was assessed with a cognitive score of 00 indicating severely cognitively impaired.</p> <p>R1's clinical record was reviewed regarding a falls leading to R1 being sent to the hospital and diagnosed with two rib fractures and lacerated spleen on 12/9/23. Progress notes dated 12/9/23 documented a fall had occurred at 4:16 AM while R1 was in the hallway taking off clothing. A full assessment was completed and did not show any abnormalities or injuries. R1 was assisted back to bed.</p> <p>Another progress note dated 12/9/23 at 12:15 PM indicated R1 had become confused, lethargic, restless, with an unsteady gait, and was hypotensive. R1 was transferred to the hospital due to change in condition and was found to have fractures of two ribs and a lacerated spleen.</p> <p>Further review of R1's progress notes dated 12/22/23 as a late entry for 12/9/23 indicated R1 had a fall on 12/9/23 around 8:00 AM and was found partially under the bed, was assessed for injuries and noted a bruise to the right side of R1's head.</p> <p>Another progress note dated 12/22/23 and timed 12:18 PM as a late entry for 12/9/23 indicated R1 was observed with unsteady gait and having trouble holding a cup of water was at the elevator and began to fall a certified nursing assistant (CNA) and nurse tried to prevent the fall but R1's knee touched the floor. R1 was assessed and due to change in condition was sent to the hospital.</p> <p>On 7/30/24 at 9:45 AM license practical nurse (LPN #6) was interviewed. LPN #6 verbalized being the nurse near the elevator when R1 lost balance and tried to help the CNA prevent a fall. LPN #6 was asked about not documenting the fall on 12/9/23. LPN #6 verbalized not being assigned to R1 that day and thought that the assigned nurse to R1 would document the fall.</p> <p>On 7/30/24 at 10:00 AM the director of nursing (DON) was interviewed concerning the above finding. The DON verbalized R1's injuries were investigated by the facility and during the investigation it was evident that the staff knew about the falls occurring on 12/9/24 but two nurses that were involved during R1's falls did not document on the falls at that time. The DON said when it was evident that the nurses did not document at the time of the falls both nurses were inserviced and then all nursing staff were inserviced. The DON verbalized a plan of correction for this was completed at the time of the findings.</p> <p>The DON provided the following plan of correction:</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. On 12/21/23 All nursing staff educated on fall huddle and risk management documentation. one on one education was provided both nurses involved in fall documentation.</p> <p>2. To identify like residents that have the potential to be affected the DON/designee reviewed all residents that ambulate without assist devices with high fall risk to ensure fall interventions are in place and reflected on the care plans.</p> <p>3. To prevent this from happening again the DON/designee will educate CNA's and licensed staff on when residents has a fall that the fall is documented and interventions to prevent further falls are in place after every fall.</p> <p>4. DON and or unit manager to monitor for ongoing compliance with documentation will be completed in morning meetings when discussing falls for three months to ensure that falls are documented in risk management and fall huddle form is completed and brought to morning meetings to ensure thorough investigation of fall and intervention was placed. An audit sheet will evidence monitoring was completed. Results will also be discussed in QAPI monthly for 3 months.</p> <p>5. Date of correction 12/22/23.</p> <p>All inservice records were reviewed along with all forms used to monitor the plan of correction. At the time of the survey there were no current concerns regarding inaccurate records. The survey team accepted the deficiency as past non-compliance.</p>		