STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495420	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Albemarle Health & Rehabilitation Center	1540 Founders Place Charlottesville, VA 22902

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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide feeding assistance for 2 of 5 resident in the survey sample, Resident #4 (R4) and Resident #5 (R5). The findings included: 1. The facility staff failed to assist R4 with dentures and ensure they were put in place prior to feeding the resident. R4 was admitted to the facility on [DATE]. Diagnoses for R4 included but are not limited to dysphagia, oral phase. R4's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 6/22/24 coded R4 with moderate cognitive impairment. R4 was coded in section G with needing extensive feeding assistance of one person. On 7/26/24 at 8:15 a.m. an observation was made of the breakfast meal. R4' s breakfast meal was taken in her room and left within in her reach without facility staff remaining in the resident's room. Facility staff did not assist R4 with placing her dentures in her mouth prior to eating breakfast. The licensed practical nurse, LPN#3 was observed standing over the resident while assisting R4 with feeding. R4 did not have dentures in her mouth while being fed breakfast. On 7/26/24 at 9:32 a.m., an interview was conducted with a certified nursing assistant, CNA#2. CNA#2 stated that dentures should be cleaned and placed in the resident's mouth before they assist the resident with feeding. CNA #2 stated that they know which residents need feeding assistance from the report received from the nurse. On 7/26/24 at 9:35 a.m., an interview was conducted with CNA#3. CNA#3 stated that meals were not to be left in the room of residents that require feeding assistance, if staff is not in the room. On 7/26/24 at 9:40 a.m., an interview was conducted with a licensed practical nurse, LPN#3. When questioned about the dentures, LPN#3 stated, She had feed herself some and then I assisted her with breakfast, but I didn't put her teeth in, because she had begun eating. 2. The facility staff failed to provide feeding assistance to R5, who required assistance during breakfast. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495420	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2024
NAME OF PROVIDER OR SUPPLIER Albemarle Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1540 Founders Place Charlottesville, VA 22902	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5 was admitted to the facility on [DATE]. Diagnoses for R5 included but are not limited to dysphagia, oropharyngeal phase and muscle weakness. R5's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 6/8/24 coded R5 with severe cognitive impairment. R5 was coded in section G with needing extensive feeding assistance with one person. On 7/26/24 at 8:15 a.m., observation was made of the breakfast meal. R5 was being served breakfast in the dining room on unit 100. During the meal, R5 was observed drinking her maple syrup, dipping her french toast in the oatmeal, putting her oatmeal into her cup of coffee, and eating with her hands versus utensils. There were CNA's (certified nursing assistants) present in the dining room, who did not provide R5 any assistance with the meal. There were other residents in the dining area, one of whom yelled out that R5 needed help with her meal because she was drinking her syrup and putting the oatmeal in her coffee, but there was no staff response. Another resident yelled out that R5 needed assistance, but facility staff did not respond or provide any assistance to R5. It was observed that CNA #2 turned and looked at R5 but did not intervene. On 7/26/24 at 9:32 a.m., an interview was conducted with CNA#2. CNA #2 stated that we know which residents need feeding assistance from the report received from the nurse.When asked to identify the residents that required assistance with meals, CNA #2 identified R5 as requiring staff assistance with eating. On 7/26/24 at 9:35 a.m. an interview was conducted with CNA#3. When questioned about feeding guidelines, CNA#3 stated that meals were not to be left in the reach of a resident that needs feeding assistance. On 7/26/24 at 12:30 p.m. a facility documentation review was performed. The Mosby's Textbook for Long-Term Care Nursing Assistants, which was provided by the facility administration in lieu of a facility policy, it was reviewed and read in part in chapter 20 page 323, .position the person in a comfortable position for eating, get the tray and place on the overbed table, place a chair where you can sit comfortably, sit facing the person, encourage the person to eat as much as possible, remove the tray and assist with oral hygiene and hand washing. On 7/26/24, during a pre-exit meeting, the facility administration was made aware of the above findings. No additional information was provided.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 41449 Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide incontinence care to one resident (resident #2- R2), in a survey sample of five residents. The findings included: On 7/25/24 at 12:18 p.m., the daughter of R2 met with the surveyors. The family member reported that she visits daily and stays for long periods of time because she has concerns about the facility staff not providing care to her mother. On 7/25/24 at approximately 3:55 p.m., the surveyor went to visit with R2. R2 was lying in bed and did not communicate or answer questions. The daughter of R2 was at the bedside and reported that from the time she arrived a little after 12 noon, until 3pm, no staff had entered her mother's room to provide any care. At 3 p.m., the family member went into the hall and sought out a staff member to assist with incontinence care of R2. During care, it was noted that R2 had saturated not only her incontinence brief, but her pants were visibly wet with urine all the way to the knees. The family member showed the surveyor the pants which were visibly wet. On 7/25/24 at 4 p.m., an interview was conducted with the unit manager and director of nursing (DON). When asked about incontinence care, the DON said, The standard of incontinent care is every two hours, unless they wet where the diaper can't contain it. Then it needs to be more often. When asked what the process is for providing care if family is present in the room, the DON said, We will ask the family to step out but if they are the RP [responsible party], they can stay in the room. The DON further confirmed that it is the responsibility of the facility to continue to provide care even if family is present and that it is not the expectation that the family provide the needed care. Following the above interview with the unit manager and director of nursing, they accompanied the surveyor to R2's room, and were shown the pants that were saturated with urine. The DON said, That is very much a lack of care, adding that he would speak to the aide and would call the family. On 7/26/24 at approximately 9 a.m., during a clinical record review, it was noted that an entry was made into R2's nursing progress notes on 7/25/24 at 6:41 p.m., by the director of nursing that read, Spoke with [name of R2's daughter redacted], regarding care concerns that were brought to this writer's attention today. Addressed all concerns that [daughter's name redacted] had and provided assurance that these would be addressed upon completion of our conversation and that ongoing observations by the Unit Manager and the DON would ensure that the concerns do not continue. [daughter's name redacted] discussed that she had not brought this forward as she was concerned that retaliation may be an issue. Discussed strict No Retaliation policy and [daughter's name redacted] expressed her gratitude. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/26/24, during the clinical record review, it was noted that R2's most recent MDS (minimum data set) (an assessment tool) was conducted on 6/27/24. That assessment coded R2 as rarely/never being understood, having memory loss, and severely impaired in decision making. That same assessment coded R2 as requiring maximum assistance with all activities of daily living and being always incontinent of bowel and bladder. On 7/26/24, R2's care plan was reviewed. The care plan identified that R2 was at risk for pressure ulcers related to immobility and incontinence. One of the interventions for this area was noted to read, Keep skin clean and dry as possible. The care plan also identified a focus area that had been revised on 7/1/24, and read, The resident has bladder incontinence r/t [related to] dementia, decreased mobility and predisposing disease. Interventions included, but were not limited to, Clean per-area with each incontinence episode, monitor/document for s/sx [signs and symptoms] UTI [urinary tract infection] . On 7/26/24, the facility administration was asked to provide the survey team with a facility policy with regards to incontinence care and assistance with activities of daily living. The facility's director of nursing and corporate nurse consultant reported they had no policy but followed standards of practice as noted in the Ninth Edition, Mosby's Textbook for Long-Term Care Nursing Assistants, and provided the survey team with copies of the related pages. The page related to urinary incontinence was provided which explained the various types of incontinence, but the next page, page 347 was omitted. On 7/26/24, during an end of day/pre-exit meeting, the facility administrator was made aware of the above findings. No further information was provided.

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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 41449

Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for one resident (Resident #1- R1), in a survey sample of five residents.

The findings included:

For R1, the facility staff failed to maintain a complete clinical record with regards to the hospice services provided, including her death, which was pronounced by the hospice staff.

On [DATE], a closed record review was conducted of R1's chart. This review revealed that the resident was admitted to the facility on [DATE] and discharged on [DATE]. R1 was admitted from an acute care hospital with the diagnosis to include, but not limited to, traumatic subdural hemorrhage and subarachnoid hemorrhage.

According to the physician orders, on [DATE], an order was written for a hospice consult. On [DATE], another order was written, which noted a hospice company name.

Within the clinical record there were no notes or details regarding hospice care, treatment, or involvement when R1 expired at the facility. The only documents within R1's clinical record with regards to hospice was a hospice contract which was in the documents tab of R1's chart. The hospice contract was a 5-page document that was the enrollment of R1 into hospice services, and was dated [DATE].

Also under the documents tab, was a document titled, Record of Death. This document indicated that a nurse with hospice had pronounced R1's death.

On [DATE] at 3:35 p.m., an interview was conducted with the facility's director of nursing (DON). The DON stated that R1 was started on comfort care on the 14th and signed with hospice on the 16th. When asked if he would expect the hospice records to be a part of R1's clinical record at the facility, the DON indicated he would and would look to see if they had the records.

On [DATE] at 8:15 a.m., the DON reported, We had to call hospice for the notes, they had not made their binder yet, but should have gotten it to us long before now. When asked if he would have expected the hospice notes to have been available for review when the surveyor accessed R1's closed record on [DATE], the DON confirmed it should have been.

On [DATE] at 8:30 a.m., the DON provided the survey team with documentation that had been faxed to the facility on the afternoon of [DATE] from hospice regarding services provided for R1. Included in this hospice documentation were notes of a hospice nurse visit on [DATE] at 8:20 a.m. and another visit on [DATE] at 11:40 p.m., when the hospice nurse pronounced death. There was an extensive note included in the [DATE] charting, that explained that the medical examiner had been called and the reasoning.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], during an end of day/pre-exit meeting, the facility administrator was made aware of the above findings. No further information was provided.