STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495099	A. BUILDING _____ B. WING _____	C 04/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX REHABILITATION AND NURSING CENTER	10701 MAIN STREET FAIRFAX, VA 22030

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Standard Survey was conducted 4/18/17 through 4/19/17. One (1) complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements . The Life Safety Code survey/report will follow. The census in this 200 certified bed facility was 157 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Resident #1 through Resident #21) and 4 closed record reviews (Resident #21, #22, #23, #24 and #25).	F 000		
F 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide nail care services for 1 of 25 residents (Resident #14). The findings include: The facility staff failed to provide nail care services for Resident #14. Resident #14 was admitted to the facility on 4/18/16 with diagnoses of Parkinson's disease, dementia, coronary artery disease, left carotid	F 312	F 312 1.Resident #14 had no adverse effects, immediate corrective action was taken. 2.All residents have the potential to be effected. 3.Facility will conduct a house audit to identify like residents. Immediate corrective action will be taken. Initiate process for nail care to be assessed every shift, daily. Provide nail care immediately when need identified. Facility will implement new documentation tool in EMR for daily task monitoring and record.	6/2/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/05/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 312	Continued From page 1 artery stenosis, hip fracture, and hypertension. The current quarterly Minimum Data set (MDS) with a reference date of 1/20/17 assessed the resident with a cognitive score of "15" of "15". The resident was assessed requiring supervision of 1 person for bed mobility, transfers, ambulation, dressing, toileting and hygiene. The resident was assessed requiring total assistance of 1 person for bathing. A member of the survey team interviewed the resident on 4/18/17 and reported the resident had requested assistance for trimming of his toenails. The resident was seen by this surveyor on 4/19/17 at 10:30 a.m. accompanied by a safety certified nursing assistant (CNA#2). The nails were observed to be long and untrimmed , with second and third toe nails overlapping. The big toe nails were thick and long. The resident asked for assistance to "get on the list" to have his nails trimmed. He stated he had been asking and nothing had been done. The nurse assigned to the resident (LPN#3) along with the unit manager scheduled the resident to be seen by the podiatrist. They stated he had last been seen in December. The resident had been given a shower on 4/18/17. There was no documentation in the clinical record related to the resident's request for a nail trim and nothing documented on the skin check after his shower. The director of nursing and assistant director of nursing were informed of the findings on 4/19/17 at 1:00 p.m. The director of nursing provided the current physician orders that included an order for resident to be seen by the podiatrist as requested.	F 312	4.Facility will conduct random audits of 5 residents weekly for 4 weeks, then monthly for 4 months. Findings submitted to QAA for review and recommendations. 5.Corrective action complete by June 2, 2017	

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F 312	Continued From page 2 The administrator, director of nursing, and assistant director of nursing were informed of the findings during a meeting with the survey team on 4/19/17 at 1:50 p.m.	F 312		
F 356 SS=C	POSTED NURSE STAFFING INFORMATION CFR(s): 483.35(g)(1)-(4) 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows:	F 356		4/19/17

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F 356	Continued From page 3 (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to include the facility name on a daily basis on the daily nurse staffing form. The findings include: During the initial tour of the facility on 4/18/17 at 11:15 a.m., the surveyor observed the "Daily Nurse Staffing Form" dated 4/18/17 in the hallway near the main entrance to the nursing facility. The form did not include the name of the facility. The surveyor requested a copy of the form from the director of long term care services other #1 on 4/18/17 at 11:15 a.m. The director of long term care services was made aware the current daily nursing form did not include the name of the facility. Other #1 stated there was another form for staffing and he would provide a copy of that form to the surveyor.	F 356	F 356 1.Item was corrected April 19, 2017 2.No one else effected 3.Nurse Staffing Form will continue to be posted daily in locked display case by front lobby. It is now being printed on company letterhead stationary. 4.Scheduler has been instructed to print same form on company letterhead stationary only. Secretarial staff will audit for letterhead stationary usage. 5.Corrective action completed April 19, 2017	

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F 356	Continued From page 4 A second form was provided that read "Fairfax Nursing Center Sign-In Sheet". The form was dated 4/18/17; however, the form did not include the current census (157) or the staff hours. The census was listed as 164. The form contained a list for the shift, location, employee name, position, employee signature, and notes. The form did not contain the total and actual hours worked for registered nurses, licensed practical nurses and certified nursing assistants or was posted in a prominent place readily accessible to residents and visitors. The surveyor informed the administrator and the assisted living administrator (other #2) of the missing information from the daily nurse staffing form posted 4/18/17 on 4/18/17 at 11:30 a.m. Other #2 stated that would be easy to correct by placing the information on the facility letterhead. No other information was provided to the survey team prior to the exit conference on 4/19/17.	F 356		
F 469 SS=E	MAINTAINS EFFECTIVE PEST CONTROL PROGRAM CFR(s): 483.90(i)(4) (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and facility document review it was determined the facility staff failed to maintain a pest control program that effectively kept the resident's environment free of pests (rodents). Findings:	F 469	F 469 1.All effected resident rooms have been inspected by licensed pest control company. 2.Entire building, including exterior, has had comprehensive inspection by licensed	6/2/17

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F 469	Continued From page 5 The facility failed to maintain an effective pest control program to ensure a pest-free environment for this 200 bed facility. On 4/18/17 at 1:58 PM Resident # 11 was interviewed. She told the surveyor she had complained for several months about a mouse that ran through her room at night. The resident pointed out the mouse's nightly pathway and several traps placed around the room (two glueboards and two wooden mouse traps with out any visible bait). The traps were not placed in the pathway the resident described it taking during it's nightly run. She told the surveyor "it was smart enough to avoid those traps". On 4/19/17 at 9:05 AM the surveyor spoke to the MD (maintenance director) about the facility's pest control service. The MD told the surveyor the mice had been a problem in the facility for several months--since the start up of a construction site nearby. She said the pest control service came every two weeks, but he never saw any mice or any sign of mice at the facility. The MD stated, "He comes and places traps in the areas/rooms when staff or residents complain of seeing mice. When mice are caught in resident's rooms--we bag them up and discard them." The MD did not have any records to indicate where the mice were trapped and if the pest control service had been informed of the disposal of same. The MD said staff would note mouse sightings/issues on a special service record which	F 469	pest control company 3.Met with branch manager of pest control company. Process of exclusion and isolation initiated. Pest control program was re-evaluated, reassessed and new procedures implemented. Housekeeeping daily checklist now includes daily pest control documentation. department Head will follow new steps in communicating and follow through with pest control company. Staff have been educated on above. 4.Department Head will oversee pest control procedures. Supervisor will check log book daily. Service tickets will be reviewed by DH and Administrator. Building cleaniliness was never an issue. 5. Corrective action completed June 2, 2017	

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F 469	Continued From page 6	F 469		

she provided for the surveyor's review. She also said she would sometimes get reports from staff via her email and word of mouth and acknowledged the service records were not a comprehensive record of reported rodent activity.

The special service records included 19 complaints of rodent activity by staff, residents and family members since 2/10/17. The areas included were rooms 320, 324, 308, 321, 303, 307, 319, staff break rooms (multiple complaints--units unspecified), admissions office, reception area, dining room (unit unspecified).

The individual pest control service records were reviewed since 2/7/17 until the present time. The reports dated, 2/7/17, 2/9/17, 3/15/17,3/22/17, 3/24/17, 4/10/17, 4/13/17, 4/17/17 were examined individually for interventions to exterminate mice. On 2/7/17 & 4/17/17 inspections were performed and no signs of rodents were observed by the service tech, and no interventions were noted on the reports.

The service report on 4/17/17 documented the tech "inspected Rooms 428 - 420. Found no pest." No interventions (traps) were documented during this service. The surveyor observed a hand written note attached to this service call. It was dated 4/15/17 and was to housekeeping and maintenance from a family member of a resident residing in room 428. This family member complained of finding mouse droppings in her mother's room and was concerned because her mother kept candy and cookies in the room to eat.

The note was forwarded to the house-keeping department, with a note from house-keeping that

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F 469	Continued From page 7 they had cleaned the room. It was then forwarded to the MD, who attached it to the pest control service record. The review of the service records indicated the interventions (traps) were placed in the following areas: Rooms 305, 307, 309 118, 202, 320, office (unspecified), office, 4th floor (area unspecified). On 4/19/17 at approximately 9:30 AM the surveyor spoke to the pest control service tech via phone and asked why the traps did not have bait--as generally they were baited using peanut butter or cheese to attract the rodents to the appropriate area. The service tech said he was not allowed to put toxic substances out on the traps--but used what he termed a "mouse attractant" on the traps. This was a chemical named "PROVOKE" and was supposed to attract the mice to the trap. On 4/19/17, the MD informed the surveyor the service tech had placed mousetraps in room 428. These were later observed by a member of the survey team the same afternoon. This information was discussed with the administrator, and director of nursing on 4/19/17 at 2:00 PM. This program was discussed by the survey team during decision making. It was the group consensus that placement of mouse traps in the few rooms documented as serviced was inadequate to control an infestation that had increased, rather than diminished.	F 469		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		6/2/17

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F 514	Continued From page 8 LE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a	F 514	F 514	

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F 514	Continued From page 9 complete and accurate clinical record for 1 of 25 Residents, Resident #13. The findings included. The facility staff failed to document amount of sliding scale insulin that had been administered to Resident #13. The record review revealed that Resident #13 had been admitted to the facility on 1/18/14. Diagnoses included, but were not limited to, diabetes, dementia with behaviors, anemia and kidney disease. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/01/17 was coded 03 for his cognitive summary score. He had been assessed to understand and to be understood. Resident #13 physician had ordered insulin per sliding scale. For a BS (blood sugar) of 150--200 2 units, 201-250 3 units, 251-300 4 units, 301-350 5 units, and for a BS of 351 7 units and call MD (medical doctor) if greater than 350. A review of the Residents BS indicated that the Resident should have received sliding scale insulin on the following days/times. 04/1/17 at 11:30 a.m. for a BS of 282. 04/6/17 at 11:30 a.m. for a blood sugar of 195 Upon review of the Residents eMAR's (electronic medication administration records) the surveyor was unable to locate any documentation to indicate insulin had been given on 04/1/17 at 11:30 a.m. and on 04/6/17 at 11:30 a.m.	F 514	1.Resident #13 had no adverse effects, immediate corrective action was taken. 2. All resident have the potential to be effected. 3. Facility will conduct a house audit to identify like residents. Immediate corrective action will be taken. A review case will be submitted to EMR vendor, Point Click Care, as this was an EMR system error that allowed a sliding scale accucheck entry to be entered without automatic system entry of units given. Facility will initiate process in which nurse will double verify that EMR has imported the appropriate record and documentation of units given. 4. Facility will conduct random audits of 5 residents weekly for 4 weeks, then monthly for 4 months. Findings will be submitted to QAA for review and recommendations. 5. Corrective action completed by June 2, 2017	

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F 514	Continued From page 10 On 04/25/17 at approximately 4:35 p.m. the ADON was asked about the missing insulin documentation. The ADON (assistant director of nursing) provided the surveyor with a printed copy of the eMARs on 04/19/17 at 1:00 pm with the eMARS was the Location of Administration Record that showed that the insulin had been administered subcutaneously in the abdomen on both days. However, it did not show documentation of the amount of insulin given. The ADON said "it is unfortunate that it was not documented." The administrative staff were notified of the missing documentation regarding insulin administration during a meeting with the survey team on 04/19/17 at approximately 9:30 a.m. . . . No further information regarding this issue was provided to the survey team prior to the exit conference.	F 514		
F 518 SS=D	TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS CFR(s): 483.75(m)(2) The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to periodically review the fire safety procedures with existing staff and carry out unannounced fire/safety drills.	F 518	F 518 1.Review of Fire Drill Policies and Procedures was conducted	6/2/17

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F 518	Continued From page 11 The facility staff failed to conduct the July 2016 11-7 fire drill and conducted back to back 7-3 fire drills during the fourth quarter of 2016. The findings included: On 4/19/17 at 12:50 p.m., the surveyor, the director of environmental services (other #3), and the previous director of environmental services director (other #2) reviewed the fire drills for the past year. The surveyor noted that a fire drill was not done for July 2016 11-7 shift. The surveyor asked the director of environmental services other #3 why the fire drill was not done. The director of environmental services other #3 stated the 11-7 shift nurse was on vacation in July 2016 and didn't do the drill until she returned to work. The environmental services director other #3 stated the 11-7 staff told her they were "busy" and didn't have time to do it. A fire drill was noted to be done on 8/1/16 in the morning and a fire drill was done on 8/2/16 the 11-7 shift as well. The surveyor continued with the fire drill review and the fourth quarter reviewed identified a fire drill was done on 10/26/16 11-7 shift, 11/11/16 in the morning (day shift) and the next month the fire drill was done 12/28/16 in the morning (7-3 shift). The surveyor was unable to locate a fire drill completed on the 3-11 shift for the fourth quarter. The current director of environmental services other #3 was asked about the missing evening fire drill for the fourth quarter. The director of environmental services stated the facility was supposed to do each shift in each quarter but had no explanation as to why back to back 7-3 drills were completed. The surveyor asked both environmental services	F 518	2.All residents have the potential to be effected 3. Fire drill Policies and Procedures were reviewed with State Fire Marshall on 5-2-17. 4.Drills will continue to be held one per shift/per quarter. Drill records will be reviewed and filed in easily understood format. Department Head will review drill records monthly on the 20th and adjust schedule as needed for that quarter. 5.Corrective action completed June 2, 2017	

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F 518	Continued From page 12	F 518		

directors how often the fire drills were supposed to be conducted. The director of environmental services other #3 stated, "There should be one done every month and done on alternate shifts." The former environmental services director other #2 stated "One per shift per quarter."

The surveyor asked for the facility policy and procedure for fire drills/fire safety.

The surveyor informed the administrative staff on 4/19/17 at 1:55 p.m. that the facility staff failed to periodically review fire safety procedures and conduct a fire drill in July 2016 on the 11-7 shift and failed to conduct an evening fire drill in the fourth quarter in 2016.

On 4/19/17 at 2:15 p.m., the surveyor reviewed the facility policy for environmental services for fire drills 11-7 fire drills. The policy and procedure read in part: "Drills will be conducted quarterly by designated night supervisor. 5. The location of each fire should be rotated each quarter." The policy and procedure for environmental services for 7-3 and 3-11 fire drill procedure read "Policy The Safety Officer will initiate fire drills on each shift, every quarter. Purpose To train and test staff on the proper use of the fire alarm system, as well as response to the fire alarm. To evaluate the effectiveness of the fire plan and need for additional training."

No additional information was provided prior to exiting the facility on 4/19/17.