FAUQUIER HEALTH
Rehabilitation & Nursing Center

FACSIMILE TRANSMITTAL SHEET

TO: Wietske Weigel-Delano
FROM: M. A. Crocker

DATE: 9/1/17

COMPANY: VDH

TOTAL NO. OF PAGES INCLUDING COVER: 10

FAX NUMBER: 804-367-2100

SENDER'S REFERENCE NUMBER:

PHONE NUMBER: 804 367-2100

YOUR REFERENCE NUMBER:

RE: POC Revision

☐ URGENT ☒ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

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Rehabilitation & Nursing Center
360 Hospital Drive ■ Warrenton, VA 20186-3027 ■ 540-316-5500 P ■ 540-316-5389 F ■ fauquierhealth.org

August 31, 2017

Ms. Wietske Weigel-Delano
LTC Supervisor
Division of Long Term Care Services
Office of Licensure and Certification
9960 Mayland Drive Suite 401
Richmond, Va. 23233

Dear Ms. Weigel-Delano:

Enclosed please find the Plan of Correction for the revisit survey which was conducted on August 16, 2017 at Fauquier Health Rehabilitation & Nursing Center. If you require any further information, I may be reached at (540) 316-5471.

Respectfully yours,

Mary Ann Crocker, LNHA, JD
Interim Administrator

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495233	A. BUILDING ______ B. WING ______	R 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAUQUIER HEALTH REHABILITATION & NURSING CENTER	360 HOSPITAL DRIVE WARRENTON, VA 20186

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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 6/27/17 through 6/29/17, was conducted 8/15/17 through 8/16/17. One complaint was investigated during the survey process. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567 - B. The census in this 113 bed certified facility was 90 at the time of the survey,. The survey sample consisted of twelve current resident reviews (Residents #101 through # 111 and #113) and one closed record review, Resident #112.	{F 000}	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by the provision of Federal and State regulations.	
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a call bell was within reach for one of 13 residents in the survey sample, Resident #110. Resident #110 was observed on separate occasions in bed with her call bell positioned	F 246	On 8/29/17, location of call bell discussed with resident#110. Resident stated preference to have call bell in nightstand drawer. Care plan updated to specify resident preference. When Resident is in bed, call bell will be within reach. An audit of call bell placement will be conducted. Cognizant residents' preference will be accommodated and care plans updated, if necessary. Residents not capable of determining their call bell placement will have the call bell placed within their reach and care plans updated, if necessary.	9/8/17

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] LNHA, Esq
TITLE
(X6) DATE: 8.31.17

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.

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F 246	Continued From page 1 either in the nightstand drawer, or on top of the nightstand, out of her reach. The findings include: Resident #110 was admitted to the facility on 3/14/16 with a readmission on 6/15/17, with diagnoses, that included but were not limited to: high blood pressure, dementia, atrial fibrillation (a condition characterized by rapid and random contractions of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (1)), and history of falls. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 7/7/17, coded the resident as usually understanding others and usually making herself understood. The resident was coded as having both short and long term memory problems and was coded as being moderately impaired to make daily cognitive decisions. The resident was coded as having no difficulties with her range of motion in either her upper or lower extremities. Resident #110 was coded as requiring extensive assistance for moving in the bed and transfers. Observation was made of Resident #110 on 8/15/17 at 3:00 p.m. The resident was in her room, in bed. She was facing the window on her right side. The call bell was in the night stand drawer on the resident's left side. There was a fall mat approximately two feet in width, observed on the floor between the bed and night stand. The call bell was not accessible to Resident #110. A second observation was made of Resident	F 246	Daily manager rounds are being done. Care managers for each unit will regularly check room for correct call bell placement. Nursing staff will make observations when in rooms. Staff are being reeducated regarding care planning process. Monitoring of compliance will be done by managers, care managers and nursing staff. Audits will be used to document locations checks and given to DON/designee. Results will be reviewed and addressed by the QUAPI committee for guidance and further instruction.	

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F 246		F 246		

F 246 Continued From page 2

#110 on 8/16/17 at 8:45 a.m. The resident was in her bed on her back. Her head was turned toward the window, towards her right side. A fall mat was in place on the left side of the bed on the floor, between the bed and the night stand. The call bell was observed sitting on top of the night stand, and was not accessible to Resident #110.

The comprehensive care plan dated, 4/22/16 and revised on 7/6/17, documented in part, "Focus: (Resident #110) is at risk for falls characterized by history of falls, multiple risk factors related to: unstable health condition." The "Interventions/Tasks" documented in part, "Call light within reach at all times when (Resident #110) is in her room."

An interview was conducted with CNA (certified nursing assistant) #1 on 8/16/17 at 1:58 p.m. CNA #1 was asked where call bells should be positioned when residents are in bed. CNA #1 stated, "Right next to the resident, in front of them, anywhere that is easy access for them." When asked if the call bell should be positioned on top of the nightstand or in the night stand drawer, CNA #1 stated, "No." When asked if Resident #110 could use the call bell, CNA #1 stated, "She used to use it but has declined." When asked if Resident #110 can still activate the call bell, CNA #1 stated, "Yes, she doesn't use it as much as she used to, but still can use it."

An interview was conducted with LPN (licensed practical nurse) #1, on 8/16/17 at 2:02 p.m. When asked where call bells should be positioned when residents are in bed, LPN #1 stated, "Within reach." LPN #1 was asked if it is acceptable to have the call bell positioned on top of a nightstand or in the night stand drawer, when

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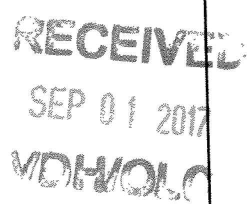
F 246	Continued From page 3 there is a fall mat on the floor, between the bed and the night stand. LPN #1 stated, "It should be in the bed, within reach of the resident." When asked if Resident #110 could use the call bell, LPN #1 stated, "She's relatively new to me but she can use the call bell. She has no physical issues with her arms." The administrative staff member (ASM) #1, the administrator, ASM # 2, the director of nursing, and ASM #3, the chief administrative officer, were made aware of the above findings on 8/16/17 at approximately 2:45 p.m. A copy of the facility policy on call bells was requested. The facility policy, "Call Light" documented in part, "Make sure call light is placed within reach of resident when leaving resident unattended." No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 246		
{F 282} SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	{F 282}	On 8/29/17, location of call bell discussed with resident#110. Resident stated preference to have call bell in nightstand drawer. Care plan updated to specify resident preference. When Resident is in bed, call bell will be within reach.	9/8/17



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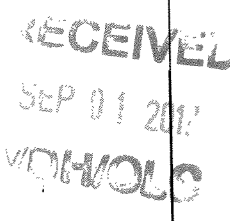
{F 282}	Continued From page 4 document review, and clinical record review, it was determined that the facility staff failed to follow the comprehensive plan of care for one of 13 residents in the survey sample, Resident #110. The facility staff failed to ensure Resident #110's call bell was positioned within reach per the comprehensive care plan. Resident #110 was observed on separate occasions in bed with her call bell positioned either in the nightstand drawer, or on top of the nightstand, out of her reach. The findings include: Resident #110 was admitted to the facility on 3/14/16 with a readmission on 5/16/17, with diagnoses, that included but were not limited to: high blood pressure, dementia, atrial fibrillation (a condition characterized by rapid and random contractions of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (1)), and history of falls. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/7/17, coded the resident as usually understanding others and usually making herself understood. The resident was coded as having both short and long term memory problems and was coded as being moderately impaired to make daily cognitive decisions. The resident was coded as having no difficulties with her range of motion in either her upper or lower extremities. Resident #110 was coded as requiring extensive assistance for moving in the bed and transfers.	{F 282}	An audit of call bell placement will be conducted. Cognizant residents' preference will be accommodated and care plans updated, if necessary. Residents not capable of determining their call bell placement will have the call bell placed within their reach and care plans updated, if necessary. A review of the care plans is being done to ensure call bell usage is reflective of residents' need/preference. Daily manager rounds are being done. Care managers for each unit will regularly check room for correct call bell placement. Nursing staff will make observations when in rooms. Staff are being reeducated regarding care planning process. Care plans regarding call bells are reviewed and updated as needed per residents' preference.	



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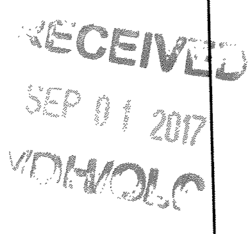
{F 282}	Continued From page 5 The comprehensive care plan dated, 4/22/16 and revised on 7/6/17, documented in part, "Focus: (Resident #110) is at risk for falls characterized by history of falls, multiple risk factors related to: unstable health condition." The "Interventions/Tasks" documented in part, "Call light within reach at all times when (Resident #110) is in her room." Observation was made of Resident #110 on 8/15/17 at 3:00 p.m. The resident was in her room, in bed. She was facing the window on her right side. The call bell was in the night stand drawer on the resident's left side. There was a fall mat approximately two feet in width, observed on the floor between the bed and night stand. The call bell was not accessible to Resident #110. A second observation was made of Resident #110 on 8/16/17 at 8:45 a.m. The resident was in her bed on her back. Her head was turned toward the window, towards her right side. A fall mat was in place on the left side of the bed on the floor, between the bed and the night stand. The call bell was observed sitting on top of the night stand, and was not accessible to Resident #110. An interview was conducted with CNA (certified nursing assistant) #1 on 8/16/17 at 1:58 p.m. When asked the purpose of a resident's care plan, CNA #1 stated, "That's how we provide care to the residents." An interview was conducted with LPN (licensed practical nurse) #1, on 8/16/17 at 2:02 p.m. When asked the purpose of the resident's care plan, LPN #1 stated, "It's a guide to the care we are to provide to each resident." When asked where call bells should be positioned when residents are in	{F 282}	Monitoring of compliance will be done by managers, care managers and nursing staff. Audits will be used to document location checks and given to DON/designee. Results will be reviewed and addressed by the QUAPI committee for guidance and further instruction.	



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{F 282}	Continued From page 6	{F 282}		

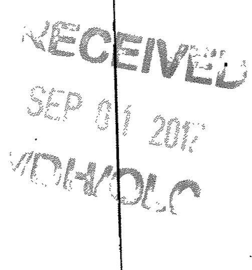
bed, LPN #1 stated, "Within reach." LPN #1 was asked if it is acceptable to have the call bell positioned on top of a nightstand or in the night stand drawer, when there is a fall mat on the floor, between the bed and the night stand. LPN #1 stated, "It should be in the bed, within reach of the resident." When asked if Resident #110 could use the call bell, LPN #1 stated, "She's relatively new to me but she can use the call bell. She has no physical issues with her arms."

The administrative staff member (ASM) #1, the administrator, ASM # 2, the director of nursing, and ASM #3, the chief administrative officer, were made aware of the above findings on 8/16/17 at approximately 2:45 p.m., ASM #3 stated, "I saw that on the care plan when I copied it." When asked if the care plan should be followed, ASM #1, the administrator stated that it should have been followed. A copy of the facility policy on call bells was requested.

The facility policy titled, "Assessment and Care of Patient/Resident Through the Plan of Care," documents in part, the following: "All patients/residents hereafter referred to as resident admitted to (Name of Facility) are required to have an assessment of care needs made by each discipline. The goal of the assessment of residents function is to determine what kind of care is required to meet a patient/resident's initial needs, as well as the needs as they change in response to care..."

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.



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