STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	R-C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	**210 ELM STREET LOUISA, VA 23093**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid re-visit survey to the Standard survey conducted 08/09/2016 through 08/11/2016 was conducted on 09/29/2016. Corrections are required for the facility to be in compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Corrected deficiencies are identified on the CMS 2567-B. The census in this 90 certified bed facility was 83 at the time of the survey. The survey sample consisted of ten current Resident reviews (Residents #101 through #110).	{F 000}		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		10/11/16

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

Electronically Signed | 10/06/2016

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F 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to review and revise the comprehensive care plan (CCP) for one of 10 residents in the survey sample: Resident # 109. Resident # 109's CCP did not reflect interventions added after a fall. Findings include: Resident # 109 was admitted to the facility 9/1/16 with diagnoses to include, but not limited to: muscle weakness, difficulty walking, repeated falls, and dementia with behaviors. The most recent MDS (minimum data set) was the admission assessment dated 9/8/16. Resident # 109 was coded as having short term and long term memory problems, and severely impaired in daily decision making skills. The electronic medical record (EMR) was reviewed 9/29/16 at 1:30 p.m. A nurses' note dated 9/22/16 at 22:40 (10:40 p.m.) documented the following: " Situation: [Bold as documented in EMR] Patient left alone in day room after finishing her dinner. At about 7:45 pm a visitor who came by the room yelled out that someone was going to fall. By the Time (sic) I got there she was on the floor with the wheel chair leg laying on top of her left leg. Called for assistance with the help of one CNA (certified nursing assistant) & another nurse we got her back up in the chair. Background: Resident is a fall risk and was not	F 280	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F280 1. Resident #109 no longer resides at the facility. 2. Current residents that have sustained a fall since 9/29/16 were reviewed to ensure care plans were revised with post fall interventions as indicated. Corrections were made as necessary. 3. Licensed nursing staff were educated regarding updating care plans with interventions post fall. Residents that sustain a fall will be reviewed weekly X2 to ensure interventions have been added to the care plan. Any issues will be addressed at the time of identification. 4. Process will be reviewed in QA committee for one quarter.	

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suppose (sic) to be left in the room alone but in the sight of the Nurse (sic) station. Resident has to be reminded at times to sit up in the chair and not to stand up.

Assessment (RN) [registered nurse]/Appearance (LPN) [licensed practical nurse]: Where the leg was wedged under the leg of the wheel chair there were two indentions on the left leg below the left knee. The indentions were about 2 inches in length on above the other. No other signs of injury noted.

Recommendations: Do not leave Resident alone in room if she eats in the day room and when she is done bring her back out to the Nurse station so she can be monitored. Resident needs to be constantly monitored."

The CCP was then reviewed. Under "Focus" documented "She is at risk for falls r/t (related to) fall hx (history), dementia, failure to thrive, kidney cancer, CVA (stroke), behaviors, anxiety/hallucinations, impaired cardio (heart)/cerebro(brain)/vascular (blood vessel)/ medical health. Created on: 9/5/2016. Revision on: 9/9/2016." Under "Goals" was documented "She will not sustain serious injury through the review date. Created on: 9/5/2016. Revision on: 9/13/16. Target date: 9/20/2016." Under "Interventions" documented: "Monitor/report to the nurse onset s/sx (signs and symptoms) of delirium, hallucinations. Created on: 9/5/2016. Revision on 9/6/2016." Interventions listed were dated with the same dates as the focus and goals, and included "Anticipate and meet her needs..... Assistive Devices: assist bars, WC (wheel chair)..... Be sure call light within reach and encourage to use call light..... Ensure she is

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wearing appropriate footwear when ambulating or mobilizing in wheel chair..... Relocate to high-visible area."

During a meeting with facility staff 9/29/16 beginning at 2:10 p.m., the interim DON (director of nursing), regional nurse consultant, and interim unit manager were asked about the above documentation. The administrator was asked about any further information related to the fall, and any updated interventions to the CCP. The administrator stated there was a post fall note from the falls committee that met to discuss the fall. The administrator presented the note to this surveyor. Included in the note was documented "Are interventions effective Yes/No." "No" was checked. Under "Changes" was written "Maintain high visibility and encourage activity participation." The DON and administrator was then asked for any additional information of interventions added to the CCP.

On 9/29/16 at 3:30 the administrator the administrator stated "They [nursing staff] called me when this happened; I told them to put her on 1:1 observation for the rest of the shift, and we talked about getting her evaluated for a self-releasing seat belt." The administrator was informed no documentation could be located regarding the 1:1, or the seat belt evaluation. The administrator then stated "There's no way we can keep an eye on her 24/7, so there's no sense in putting that on the care plan. The seat belt is ordered, but not here yet, so that wasn't put on there [CCP] yet either. You're right; there are no new interventions added to the CCP."

No further information was presented prior to the exit conference.

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to ensure adequate supervision to prevent an accident for one of 10 residents in the survey sample: Resident # 109. Resident # 109 was left unsupervised in the day room and sustained a fall from her wheel chair. Findings include: Resident # 109 was admitted to the facility 9/1/16 with diagnoses tot include, but not limited to: muscle weakness, difficulty walking, repeated falls, and dementia with behaviors. The most recent MDS (minimum data set) was the admission assessment dated 9/8/16. Resident # 109 was coded as having short term and long term memory problems, and severely impaired in daily decision making skills. The electronic medical record (EMR) was reviewed 9/29/16 at 1:30 p.m. A nurses' note dated 9/22/16 at 22:40 (10:40 p.m.) documented the following:	F 323	F323 1. Resident #109 no longer resides at the facility. 2. Current residents that have sustained a fall since 9/29/16 were reviewed to ensure post fall assessment was completed and interventions were implemented as indicated. Corrections were made as necessary. 3. Licensed nursing staff were educated regarding post fall assessment completion and implementation of interventions. Residents that sustain a fall will be reviewed weekly X2 to ensure post fall assessment is complete and interventions have been implemented. Any issues will be addressed at the time of identification. 4. Process will be reviewed in QA committee for one quarter.	10/11/16

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" Situation: (Bold as documented in EMR) Patient left alone in day room after finishing her dinner. At about 7:45 pm a visitor who came by the room yelled out that someone was going to fall. By the Time (sic) I got there she was on the floor with the wheel chair leg laying on top of her left leg. Called for assistance with the help of one CNA (certified nursing assistant) & another nurse we got her back up in the chair.

Background: Resident is a fall risk and was not suppose (sic) to be left in the room alone but in the sight of the Nurse (sic) station. Resident has to be reminded at times to sit up in the chair and not to stand up.

Assessment (RN) [registered nurse]/Appearance (LPN) [licensed practical nurse]: Where the leg was wedged under the leg of the wheel chair there were two indentions on the left leg below the left knee. The indentions were about 2 inches in length on above the other. No other signs of injury noted.

Recommendations: Do not leave Resident alone in room if she eats in the day room and when she is done bring her back out to the Nurse station so she can be monitored. Resident needs to be constantly monitored."

The CCP was then reviewed. Under "Focus" documented "She is at risk for falls r/t (related to) fall hx (history), dementia, failure to thrive, kidney cancer, CVA (stroke), behaviors, anxiety/hallucinations, impaired cardio (heart)/cerebro(brain)/vascular (blood vessel)/ medical health. Created on: 9/5/2016. Revision on: 9/9/2016." Under "Goals" was documented "She will not sustain serious injury through the

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review date. Created on: 9/5/2016. Revision on: 9/13/16. Target date: 9/20/2016." Under "Interventions" documented: "Monitor/report to the nurse onset s/sx (signs and symptoms) of delirium, hallucinations. Created on: 9/5/2016. Revision on 9/6/2016." Interventions listed were dated with the same dates as the focus and goals, and included "Anticipate and meet her needs..... Assistive Devices: assist bars, WC (wheel chair)..... Be sure call light within reach and encourage to use call light..... Ensure she is wearing appropriate footwear when ambulating or mobilizing in wheel chair..... Relocate to high-visible area."

During a meeting with facility staff 9/29/16 beginning at 2:10 p.m., the interim DON (director of nursing), regional nurse consultant, and interim unit manager were asked about the above documentation. The administrator was asked about any further information related to the fall, including an investigation. The administrator was also asked what time dinner was served for the resident to still be in the day room. The administrator stated "Dinner is served around 5:00 p.m.; some residents who are easily distracted eat in the day room with fewer residents in there so they will eat better." The administrator stated she would get the requested information and get back to me.

On 9/29/16 at 3:20 p.m. the administrator brought documentation from a falls committee meeting held on 9/27/16 stating "They [nursing staff] called me when this happened; I told them to put her on 1:1 observation for the rest of the shift, and we talked about getting her evaluated for a self-releasing seat belt. These notes are the only documentation about the fall; we felt we knew

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what happened since the visitor saw her in the day room, so an investigation wasn't done. I asked therapy to look at her to see what could be done as far as anything needing to be done with the wheel chair, and maybe evaluating for a seat belt." The administrator was then asked what happened the day Resident # 109 fell. The administrator stated "We think she might have self-propelled to the day room after dinner, and the visitor saw her at 7:45 p.m. but we don't know how long she had been there." The survey team then informed the administrator that had an investigation been done, those assumptions would have been clearer. The administrator then presented this surveyor with the notes from a falls committee meeting indicating that was the only documentation from the incident. The administrator also presented a copy of the policy entitled "Falls Management Program" which included "Fall Occurrence: 2.A. A licensed nurse, using the Incident Report and the Post Fall Assessment will: Investigate the fall, and record findings surrounding the fall." The administrator was asked if therapy had evaluated the resident, and if there was documentation of the evaluation. The administrator stated she would get the therapist. (The nurse who documented the fall occurrence on 9/22/16 was not available for interview as she was a part-time, as needed employee who also worked other jobs).

On 9/29/16 at 3:30 p.m. the Rehab manager, identified as OS (other staff) # 1 was interviewed about the evaluation done for Resident # 109. OS # 1 stated "Well, she was already in the caseload, so we looked at her wheel chair; there were no seating issues. There are no separate notes about that since she's already followed in

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F 323	Continued From page 8 therapy. I did not do the seat belt evaluation; I think a nurse did that." No further information was presented prior to the exit conference.	F 323		