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

PRINTED: 12/03/2019
FORM APPROVED
OMB NO. 0938-0391

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 10/25/2019

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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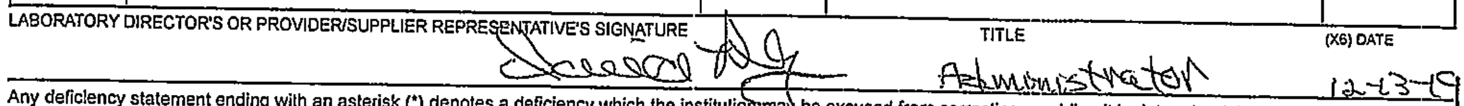
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/22/19 through 10/25/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. The census in this 200 certified bed facility was 174 at the time of the survey. The survey sample consisted of 34 current Resident reviews and 6 closed record reviews .	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/22/19 through 10/25/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Complaints were investigated during this survey. The census in this 200 certified bed facility was 174 at the time of the survey. The survey sample consisted of 34 current Resident review and 7 closed record reviews.	F 000	RECEIVED DEC 17 2019 VDH/OLC	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578	1. Resident #11 and 35 had no adverse effects. Immediate corrective actions were taken. Both DDNR's for the affected residents were immediately corrected.	12-30-2019



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	12-13-19

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 578	Continued From page 1 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review, and staff interview, the facility staff failed to provide written information to concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive by ensuring an accurate durable do not resuscitate (DDNR) form for two of 42 residents in the survey sample, Resident # 11 and Resident	F 578	2. The facility will conduct a house wide audit to identify like residents while auditing the accuracy of all DDNR forms. Immediate corrective actions will be taken. 3. The facility will initiate a daily quality assurance auditing process that involves daily monitoring of new code status changes, completions of DDNR forms, and collection of advanced directives if applicable. 4. In order to ensure ongoing compliance, the facility will conduct random audits of 5 residents weekly x4 weeks, then monthly x 4 months. All findings will be submitted to the QAA for review and recommendations. 5. The corrective action will be completed December 30, 2019	12-30-2019

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F 578	Continued From page 2 # 35. The findings include 1. The facility staff failed to ensure that the DDNR form for Resident # 11 was filled out correctly. The DDNR form for Resident # 11 reflected that Resident # 11 had an advanced directive when she did not have an advanced directive in place. Diagnoses included but were not limited to, dementia with behavioral disturbance and type 2 diabetes mellitus. On 10/22/19 at 2:39 pm, the surveyor reviewed the DDNR form for Resident # 11. The surveyor observed a handwritten "x" next to the statement "While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required)" The surveyor reviewed the clinical record for Resident # 11 further and did not locate an advanced directive. The surveyor asked the unit secretary to locate an advanced directive for Resident # 11. On 10/24/19 at 3:33 pm, the director of nursing provided the surveyor with a new DDNR form dated 10/24/19. The surveyor observed a handwritten "x" documented next to, "The patient has not executed a written advanced directive (living will or durable power of attorney for health care) (Signature of "Person Authorized to Consent on the Patient's Behalf is required)." The surveyor asked the director of nursing if the	F 578		

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F 578	Continued From page 3 facility had made an error on the DDNR for Resident # 11. The director of nursing stated, "Yes," and informed the surveyor that the facility had amended the DDNR form for Resident # 11. On 10/25/19 at 11:00 am, the administrator, director of nursing, and assistant director of nursing were made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 10/25/19. 2. The facility staff failed to ensure an accurate DDNR form for Resident # 35. The DDNR reflected that Resident # 35 had an advanced directive, when in fact Resident # 35 did not have an advanced directive. Diagnoses included but were not limited to, heart failure and dementia with behavioral disturbances. On 10/23/19 at 9:04 am, the surveyor reviewed the DDNR form for Resident # 35. The surveyor observed a handwritten "x" next to the statement "While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required)" The surveyor reviewed the clinical record for Resident # 35 further and did not locate an advanced directive. The surveyor asked the unit secretary to locate an advanced directive for Resident # 35.	F 578		

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F 578	Continued From page 4 On 10/24/19 at 9:30 am, the unit secretary informed the surveyor that Resident # 35 did not have an advanced directive, and that the facility had contacted Resident # 35's responsible party to get the DDNR form for Resident # 35 corrected. On 10/25/19 at 11:00 am, the administrator, director of nursing, and assistant director of nursing were made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 10/25/19.	F 578		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657	1. Resident #87 had no adverse effects. A Review and assessment of the resident was completed with a complete review of 'progress notes. An accurate and equivalent care plan was in place. Resident #360 had no adverse effects. This resident was a discharged resident-no corrective action could be taken.	12-30-2019

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F 657	Continued From page 5 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. 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 for 2 of 42 residents, Resident #87 and Resident #360. The findings included: 1. For Resident #87 the facility staff failed to review and revise the care plan for behaviors. Resident #87's face sheet listed an admission date of 08/20/14 and a readmission date of 05/10/17. The resident's diagnosis list indicated diagnoses, which included but not limited to Parkinson's disease, dementia without behavioral disturbance, depression, atrial fibrillation, hyperlipidemia, anxiety, and hypertension. Resident #87's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 09/12/19 assigned the Resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns, indicating the resident is cognitively intact. Section E, behavior, coded the resident as not having any indicators of psychosis, nor any behavioral symptoms. Subsection E0800 coded the resident as not exhibiting any rejection of care. Resident #87's previous quarterly MDS, with an ARD of 07/02/19	F 657	2. The facility will conduct a house Wide audit to identify residents with behavioral disturbances. Immediate corrective actions will be taken to include a review of accurate diagnosis, supporting progress notes and documentation from IDT (Interdisciplinary Team), supporting MAR/TAR documentation, resulting in an accurate care plan and MDS. The facility will also conduct a house wide audit to identify residents with communication and language barriers. Immediate corrective actions will be taken to include a review of accurate diagnosis, supporting progress notes and documentation from the IDT which will result in an accurate care plan and MDS. 3. The facility will initiate a daily quality assurance process that involves daily monitoring of all behavioral disturbances And communication/language barriers. The IDT team will attend the daily quality assurance meeting and will be re-educated on how to assess and document for behavioral disturbances and communication/language barriers. The education will include accurate care planning and MDS coding of these areas.	12-30-2019

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F 657	Continued From page 6 coded the resident as having no behaviors in section E. The resident's quarterly MDS, with an ARD of 04/03/19 coded the resident as having no behaviors in section E. Resident #87's significant change MDS, with an ARD of 01/03/19 coded the resident as having no behaviors in section E. Resident #87's quarterly MDS, with an ARD of 10/03/18 coded the resident as having no behaviors in section E. Resident #87's comprehensive care plan was reviewed on 10/23/19. It contained a care plan for "Resident has behavioral disturbances as related to purposely crawling from bed, purposefully self transfer to floor from wheelchair. Resident has extensive pattern of reporting 'falls' for attention seeking and 1:1 care/communication, acts of defiance with false reports in attempt to obtain demands that are unrealistic or denied. Refused compliance despite constant reminders to call for help, Refused TLSO (thoracic lumbar sacral orthosis) brace, resident intentionally crawls to floor as mode of mobility despite risk, accusatory gestures on residents believes someone is peeing on him, self-transferring, lying down on bed with legs hanging off, refusing showers, playing in residents feces". This care plan was created on 02/23/18 and revised on 10/10/19. Resident #87's nursing progress notes from 10/2018-10/2019 were reviewed. For the months of October 2018-January 2019, there were no notes related to any behaviors exhibited by the resident. For the month of February 2019, there was one note stating the Resident said someone urinated on him. For the months of March 2019-July 2019, there were no notes related to any behaviors exhibited by the resident. For the month of August 2019, there was one note, dated	F 657	4. In order to ensure ongoing compliance the facility will conduct random audits of 5 residents weekly x 4 weeks, then monthly x 4 months. All findings will be submitted to the QAA for review and recommendations. 5. The corrective action will be completed December 30, 2019.	12-30-2019

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F 657	Continued From page 7	F 657		

08/08/19, which read in part "Resident noted in bed with eyes closed, easily arouse to environmental stimuli, alter and oriented x 3, able to make needs known verbally, resident exhibited behavioral issue, by having bowel movement, digging it out, rubbing all over himself, bed side rails, also throwing it out on the floor....". For the months of September 2019-October 2019 there are no notes related to any behavioral issues.

Surveyor reviewed Resident #87's TARs (treatment administration record) for the months of August-October 2019. The TARs for these months each contained an entry, which read in part "Monitor for: Delusions, hallucinations, psychosis, distorted thoughts, paranoia, scratching, picking at skin, restlessness, agitation, hitting, increased complaints, biting, kicking, spitting, pinching, cursing, racial slurs, wandering, attempts at elopement, stealing, resistance to care, disruptive behavior, tearfulness, panic attack, clenching side rails, bed or clothing. DOCUMENT in nurse's note if behavior is observed every shift". On 08/19/19, the TAR was coded as behavior observed, but surveyor could not locate a corresponding nurse's note for this date. No other dates were coded as behaviors exhibited.

Surveyor spoke with CNA (certified nurse's aide) #1 on 10/23/19 at approximately 1:45 PM. Surveyor asked CNA #1 if she had ever witnessed Resident #87 exhibiting any behaviors of purposely placing self in floor, crawling on floor, smearing feces, or if Resident ever reported falls. CNA #1 stated she has no recollection of resident ever exhibiting these behaviors.

Surveyor spoke with CNA #2 on 10/23/19 at

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F 657	Continued From page 8 approximately 1:50 PM. Surveyor asked CNA #2 if she had ever witnessed Resident #87 exhibiting any behaviors of purposely placing self in floor, crawling on floor, smearing feces, or if Resident ever reported falls. CNA #2 stated that Resident has fallen out of bed, but stated she had not witnessed resident exhibiting any behaviors. Surveyor spoke with CNA #3 on 10/24/19 at approximately 9:15 AM. CNA # 3 stated that he was told that Resident exhibited behaviors, but has not witnessed any behaviors from resident. Surveyor spoke with RN (registered nurse) #1 on 10/25/19 at approximately 8:00 AM. Surveyor asked RN #1 if he had ever witnessed Resident #87 exhibiting any behaviors and RN #1 stated that he has witnessed resident cursing at staff and using racial slurs. Surveyor asked RN #1 if he had documented these behaviors, and he stated that he had not. Surveyor spoke with the MDS nurse on 10/24/19 regarding Resident #87's care plan for behaviors. Surveyor asked MDS nurse where she got the information to formulate a care plan for behaviors, and MDS nurse stated that she reviewed the nurse's notes, and from the social worker, who completes the behavioral interview for the MDS. Surveyor asked the MDS nurse to review the nurse's notes with her, and after reviewing the notes, MDS nurse stated, "The care plan needs to be revised since he is not having any behaviors". The concern of the inaccurate care plan was discussed with the administrative team (administrator, director of nursing, assistant director of nursing) during a meeting on 10/25/19	F 657		

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F 657	Continued From page 9	F 657		

at approximately 12:20 PM.

No further information was provided prior to exit.
2. The facility staff failed to review and revise the plan of care for Resident # 360 to reflect communication interventions.

Diagnoses included but were not limited to, early onset Alzheimer's disease, Lewy body dementia, anxiety, and mood disorder.

The clinical record for Resident # 360 was reviewed on 10/22/19 at 11:22 am. The most recent MDS (minimum data set) assessment for Resident # 360 was a quarterly assessment with an ARD (assessment reference date) of 4/4/19. Section B of the MDS assesses hearing, speech, and vision. In Section B0700, the facility staff documented that Resident # 360 rarely or never made herself understood. In Section B0800, the facility staff documented that Resident # 360 rarely or never understood others.

On 10/22/19 at 11:55 am ,the surveyor observed a psychiatry/psychologist note in the clinical record for Resident # 360 that was documented on 9/10/19 at 6:14 pm. The note contained documentation that included but was not limited to, ..."She speaks only Russian, so niece translates." ...

On 10/24/19 at 8:50 am, the surveyor interviewed LPN # 1 (licensed practical nurse). The surveyor asked LPN # 1 if she took care of Resident # 360. LPN # 1 stated that she did take care of Resident # 360. LPN # 1 informed the surveyor that at the time she cared for Resident # 360 she was working as a bath aid. LPN # 1 stated, "She was a Russian lady." "She used to wander a lot." "She

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F 657	Continued From page 10 would be combative; she would try to hit us." LPN # 1 informed the surveyor that the facility staff started waiting for the sitter to come so that she could translate while Resident # 360 received baths. The surveyor asked LPN # 1 if Resident # 360's behaviors improved once the sitter was there to translate. LPN # 1 stated, "Yes." On 10/24/19 at 9:04 am, the surveyor interviewed the facility social worker for Resident # 306. The surveyor asked the social worker if Resident # 360 spoke a different language. The facility social worker stated, "Yes, I believe it was Russian." The surveyor asked the social worker how the facility staff communicated with Resident # 360. The social worker informed that the facility staff attempted to use the language line but the interpreter on the language line reported that Resident # 360 was extremely confused. The social worker also informed the surveyor that the facility attempted to use the communication board. Social worker stated, "She was so impaired she couldn't use either one." On 10/24/19 at 10:00 am, the surveyor reviewed the plan of care for Resident # 360 with the director of nursing. The surveyor and the director of nursing reviewed the plan of care for Resident # 360. The surveyor and director of nursing reviewed a focus area for Resident # 360 that was documented as, "The resident has a communication problem r/t (related to) Alzheimer's," which was initiated on 1/18/19. The surveyor and director of nursing reviewed the interventions for the focus area which were documented as, "Ensure/provide a safe environment: Call bell within reach, adequate low glare light, bed in lowest position and wheels locked, avoid isolation." "Face resident when	F 657		

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F 657	Continued From page 11 communicating with resident." "Monitor and minimize miss communication to ensure resident needs are met." "Observe body language." "Report to nurse changes in: Ability to communicate, Possible factors which cause/make worse/make better any communication problems." The director of nursing agreed that the plan of care for Resident # 360 did not reflect interventions utilized to communicate with Resident # 360. On 10/25/19 at 9:40 am, the surveyor interviewed the activity assistant. The surveyor asked the activity assistant if she worked with Resident # 360. The activity assistant stated, "Yes." The surveyor asked the activity assistant if it was easy for her to communicate with Resident # 360. The activity assistant stated, "Verbally no, but I would get down on her level and speak softly to her." "But when she was not in the mood we just leave her alone." On 10/25/19 at 11:00 am, the administrator, director of nursing, and assistant director of nursing were made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 10/25/19.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		

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	495099	A. BUILDING ______ B. WING ______	C 10/25/2019

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F 684	Continued From page 12 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to provide care and treatment based on the comprehensive person-centered care plan to meet the needs of the resident for 1 of 42 residents, Resident #117. The findings included: For Resident #117 the facility staff failed to follow physician's order for the use of a resting hand splint. Resident #117's face sheet list an admission date of 02/07/16 and a readmission date of 11/16/18. The diagnosis list includes diagnoses of, but not limited to dementia, hemiplegia or hemiparesis, and cognitive communication deficit. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 09/26/19 assigned the resident a BIMS (brief interview for mental status) score of 9 out of 15 in section C, cognitive patterns. Section G, functional status, coded the resident as having functional limited range of motion on one side of both upper and lower extremities. Resident #117's comprehensive care plan was reviewed and contained a care plan for 'Splint r/t (related to) contracture. Interventions for this care plan include "Resident will wear splint/immobilizer per order".	F 684		

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F 684	Continued From page 13 Resident #117's physician's order summary for the month of October 2019 was reviewed and contained a physician's order, which read in part "DEVICE: Apply resting hand splint to Left hand/forearm. Apply daily and to be worn for 8 hours a day, or as tolerated every shift....". Resident #117's TAR (treatment administration record) for the month of October 2019 was reviewed and contained and entry, which read in part "DEVICE: Apply resting hand splint to Left hand/forearm. Apply daily and to be worn for 8 hours a day, or as tolerated. Put on in the morning and remove in the evening". This entry is initialed as completed for each day. Surveyor observed Resident #117 on 10/22/19 at approximately 9:50 AM. Resident was resting in bed. The hand splint was observed lying in the windowsill. Surveyor observed Resident #117 on 10/22/19 at approximately 3:05 PM. Resident was resting in bed, the hand splint was observed lying in the windowsill. Surveyor observed Resident #117 on 10/23/19 at approximately 11:35 AM. Resident was seated in ger-chair in dining room. Hand splint was observed lying in chair, beside the resident. Surveyor observed Resident #117 on 10/23/19 at approximately 12:50 PM. Resident was seated in geri-chair in dining room. The splint was observed lying in the chair beside the resident. Surveyor observed Resident #117 on 10/23/19 at approximately 3:20 PM. Resident was resting in bed, hand splint was observed lying in ger-chair. Surveyor spoke with LPN (licensed practical nurse) #1 on 10/24/19 at approximately 8:30 AM regarding Resident #117. Surveyor asked LPN #1 when the resident is to wear the hand splint, and LPN #1 stated resident is to wear the splint at	F 684	1. Resident #117 had no adverse Effects. A review and assessment of the resident was completed with a complete review of his splint order, documentation and implantation. Order was written on June 4, 2019 for "Apply resting hand splint to left hand/forearm. Apply daily and to be worn for 8 hours a day, or as tolerated." The resident has the ability to express needs and desires, as well as communicate his comfort and toleration of the splint. He frequently gestures to his left hand to remove the splint during meals, during care, etc. The resident has been observed pulling at his splint with an attempt to remove it-however, prominently gestures to the splint for removal when needed. Staff concurrently report on the day of the surveyor's observation, the resident acted in his typical pattern and requested the splint b removed as per how his order allows, "as tolerated." 2. The facility will conduct a house wide audit of all braces, splints, and devices to ensure orders reflect the resident's ability to request and remove devices as tolerated. Immediate corrective actions will be taken.	12-30-2019

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F 684	Continued From page 14 night. Surveyor pointed out to LPN #1 that the order reads to apply the splint in the morning. LPN #1 then stated the splint is applied when Resident #117 is up in the ger-chair, because "his day doesn't start until they get him up". Surveyor spoke with the ADON (assistant director of nursing) on 10.24/19 at approximately 8:45 AM regarding Resident #117. Surveyor informed ADON of the multiple observations of resident not wearing the hand splint. ADON stated to surveyor that the resident removes the splint himself at times. Surveyor spoke with CNA (certified nurse's aide) #1 on 10/24/19 at approximately 10:35 AM regarding Resident #117. Surveyor asked CNA #1 if resident was able to remove the hand splint himself, and CNA #1 stated that he could not. Surveyor spoke with the ADON on 10/24/19 at approximately 11:00 AM and informed ADON that CNA #1 had stated the resident was incapable of removing the hand splint. ADON stated that the restorative aides are responsible for putting the splint on the resident, and once it is placed, if resident gestures toward it or looks at it, the restorative aides remove it. Surveyor spoke with restorative aide #1 on 10/25/19 at approximately 10:30 AM regarding Resident #117. Surveyor asked restorative aide #1 if the resident could remove the splint himself or if he ever indicated that he wanted the splint removed. Restorative aide #1 stated that, while Resident #117 had the capability of removing the splint, she had never know him to do so. Restorative aide #1 stated, "Once we put it on him, he leaves it alone until we take it back off".	F 684	3. The facility will re-educate all nurses and CNA's on assessment, application and documentation of splints, braces and devices-to include accurate documentation to reflect when a device is removed. 4. In order to ensure ongoing compliance, the facility will conduct random audits of 5 residents weekly x 4 weeks, then monthly x 4 months. All findings will be submitted to the QAA for review and Recommendations. 5. The corrective action will be completed December 30, 2019.	12-30-2019

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F 684	Continued From page 15 Surveyor spoke with restorative aide #2 on 10/25/19 at approximately 10:35 AM regarding Resident #117. Surveyor asked restorative aide #2 if the resident could remove the splint himself and restorative aide #2 stated, "He probably can, but never does". The concern of the facility staff failing to follow the physician's order for the use of the hand splint was discussed with the administrative staff (administrator, director of nursing, ADON) during a meeting on 10/25/19 at approximately 12:20 PM. No further information was provided prior to exit.	F 684		

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	VA0084	A. BUILDING: ______ B. WING ______	10/25/2019

NAME OF PROVIDER OR SUPPLIER: FAIRFAX REHABILITATION AND NURSING CENTER

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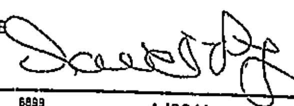
F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 10/22/19 through 10/25/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. Complaints were investigated during this survey. The census in this 200 certified bed facility was 174 at the time of the survey. The survey sample consisted of 34 current Resident review and 7 closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not it compliance with the following Virginia Rules and Regulations for Licensure of Nursing Facilities. Resident Rights 12 VAC 5-371-150-cross reference to F578. Resident Assessment and Care Planning 12 VAC 5-371-220-cross reference to F657 Nursing Services 12 VAC 5-371-250-cross reference to F684	F 001	Refer to CMS 2567 dated 10-25-19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE: Administrator

(X6) DATE: 12-13-19

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If continuation sheet 1 of 1

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