PRINTED: 03/22/2018 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|---|---|--|-------------------------------|--|
|   |   | 405407   | B. WING                                 |   |  | С                             |  |
|   |   | 495407   | B. WING _                               |   |  | 05/18/2017                    |  |
| NAME OF PE  | ROVIDER OR SUPPLIER   |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE   |  |                               |  |
| FALLS RU  | N NURSING AND REHA  | B CENTER   |   | 140 BRIMLEY DRIVE                       |  |                               |  |
|   |   |  |   | FREDERICKSBURG, VA 22406                |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PREFIX (EACH CORRECTIVE ACTION SHOULD B |  | (X5)<br>COMPLETION<br>DATE    |  |
| F 000   | INITIAL COMMENTS  |  | F 0                                     | 00                                      |  |                               |  |
| F 157<br>SS=D                                       | survey was conducted 05/18/17. Complaints the survey. Correction compliance with the first federal Long Term Casafety Code survey/red. The census in this 90 at the time of the survey consisted of 21 current (Residents #1 through and five closed record through #18). NOTIFY OF CHANGE (INJURY/DECLINE/R CFR(s): 483.10(g)(14) (g)(14) Notification of (i) A facility must immonsult with the residuction consistent with his or representative(s) where (A) An accident involves in injury and his physician intervention (B) A significant changemental, or psychosocideterioration in health | s were investigated during ans are required for collowing 42 CFR Part 483 are requirements. The Life eport will follow.  I certified bed facility was 77 rey. The survey sample ant resident reviews an #13 and #19 through #26) are reviews (Residents #14  ES COOM, ETC)  Changes.  ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ring the resident which as the potential for requiring as the potential for requiring as the potential for requiring as the resident's physical, ial status (that is, a as mental, or psychosocial reatening conditions or | F1                                      | 57                                      |  | 6/22/17                       |  |
|   | (C) A need to alter tre<br>a need to discontinue  | eatment significantly (that is, an existing form of  |   |   |  |                               |  |
| ABORATORY   | DIRECTOR'S OR PROVIDER/S  | SUPPLIER REPRESENTATIVE'S SIGNATURE  | :                                       | TITLE                                   |  | (X6) DATE                     |  |

Electronically Signed 06/08/2017

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDIN  | IPLE CONSTRUCTION  IG | ' '  | (X3) DATE SURVEY COMPLETED                       |                            |
|--|--|--|-----------------------|--|--|----------------------------|
|  |  | 495407   | B. WING _             |  |  | C<br><b>05/18/2017</b>     |
|  | ROVIDER OR SUPPLIER  | AB CENTER  |                       | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406   | l  | 00/10/2011                 |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)   | SHOULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 157  | commence a new for (D) A decision to trar resident from the fact §483.15(c)(1)(ii).  (ii) When making not (14)(i) of this section all pertinent informat is available and proving physician.  (iii) The facility must resident and the resimplement in the resimplement in the section as specified in §483.  (B) A change in room as specified in §483.  (B) A change in resident in the section (iv) The facility must update the address (phone number of the section (iv) The facility must update the address (phone number of the section (iv) The facility must update the address (phone number of the section (iv) The facility must update the address (phone number of the section (iv) The facility must update the address (phone number of the section (iv) The facility must update the address (phone number of the section (iv) The facility must update the address (phone number of the section (iv) The facility must update the address (phone number of the section (iv) The facility must update the address (phone number of the section (iv) The facility must update ( | erse consequences, or to rm of treatment); or esfer or discharge the estimated in specified in specified in specified in \$483.15(c)(2) estimated in specified in \$483.15(c)(2) estimated in specified in | F 1                   | ,  |  |                            |
|  | by: Based on staff interview, clinical record a complaint investigathe facility staff failed possible need to alteresidents in the survia. The facility staff faphysician aware that   | view, facility document d review and in the course of ation it was determined that I to notify the physician of a r treatment for one of 26 ey sample, Resident #14.  illed to make Resident #14's multiple medications were the resident as ordered on  |                       | <ol> <li>Resident #14 no longer resfacility.</li> <li>All residents have the poten affected by this deficient practicand designee(s) reviewed new admitted from 5/18/2017 thru 5 for medication availability and I notification as appropriate.</li> </ol> | ntial to be<br>ce. DON<br>residents<br>6/31/2017 |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | , ,                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |   | E SURVEY<br>PLETED         |
|---|--|--|---------------------|--|---|----------------------------|
|   |  | 495407   | B. WING             |  | 0.5   | C<br>5/ <b>18/2017</b>     |
| NAME OF F   | ROVIDER OR SUPPLIER  | <u> </u>   | <u> </u>            | STREET ADDRESS, CITY, STATE, ZIP CODE  | 1 00  | 710/2017                   |
| FALLS RI  | JN NURSING AND REHA  | AB CENTER  |                     | 140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406  |   |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY)  | SHOULD BE   | (X5)<br>COMPLETION<br>DATE |
| F 157   | Continued From pag   | e 2  | F 15                | 7  |   |                            |
| F 157   | the night of 2/7/17.  b. The facility staff fare physician aware that was not administered on the night of 2/8/17.  The findings include:  a. Resident #14 was 2/7/17 and discharge #14's diagnoses included acute cholecystitis (1 major depressive discharged with the resident as being the resident as being the resident as being the resident as being the resident #14's physical documented the resident #14's physical documented orders for including but not limit resident #14's physical documented orders for including but not limit resident #14's physical documented orders for including but not limit resident #14's physical documented orders for including but not limit resident #14's physical documented orders for including but not limit resident #14's physical documented orders for including but not limit resident #14's physical documented orders for including but not limit resident #14's physical documented orders for including but not limit resident #14's physical documented orders for including but not limit resident #14's physical documented orders for including but not limit resident #14's physical documented orders for including but not limit resident #14's physical documented orders for including but not limit resident #14's physical documented orders for including but not limit resident #14's physical documented orders for including but not limit resident #14's physical documented orders for including but not limit resident #14's physical documented orders for including but not limit resident #14's physical documented orders for including but not limit resident #14's physical documented for including but not limit resident #14's physical documented for including but not limit resident #14's physical documented for including but not limit resident #14's physical documented for including but not limit resident #14's physical documented for including but not limit resident #14's physical documented for including physical for including #15. The first form for including physical for including for including physic | illed to make Resident #14's zolpidem (sleep medication) d to the resident as ordered 7.  admitted to the facility on ed on 2/14/17. Resident uded but were not limited to: 1), high blood pressure and order. Resident #14's five sment with an ARD ce date) of 2/14/17 coded g cognitively intact.  #14's clinical record revealed sment dated 2/7/17 that dent arrived to the facility on dician's orders dated 2/7/17 for the following medications ted to:  Ing (milligrams) - one tablet (scheduled at 8:00 p.m.) one capsule by mouth at at 8:00 p.m.) one tablet by mouth at | F 15                | <ol> <li>The DON and or designee(s in-service licensed nurses on the for medication availability to income the stat box and notifying the Mandication not available.</li> <li>DON and or designee(s) will residents for medication available week for 4 weeks and then week weeks. Data collected will be to QAPI committee x3 months for and revision as needed.</li> </ol> | ne policy<br>clude use of<br>ID of<br>I audit new<br>bility 5x a<br>ekly for 8<br>aken to |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION  G |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|---|---------------------|---|-------------------------------|----------------------------|
|  |   | 495407  | B. WING _           |   |                               | C<br>05/18/2017            |
|  | ROVIDER OR SUPPLIER   | B CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406                | •                             | 03/10/2017                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION :<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 157  | three times a day (so p.m. and 10:00 p.m.) -Metronidazole (8) 50 three times a day (so p.m. and 10:00 p.m.)  Review of Resident # (medication administ resident was not administ resident was not admight dose of any of 2/7/17 (as evidenced the MAR). Further re (including MAR notes reveal Resident #14' that the above medicadministered.                                  | mg- one tablet by mouth heduled at 6:00 a.m., 2:00  00 mg- one tablet by mouth heduled at 6:00 a.m., 2:00  414's February 2017 MAR ration record) revealed the ninistered the scheduled he above medications on by an "x" documented on eview of the clinical record and nurses' notes) failed to sphysician was made aware | F1                  | 57  |                               |                            |
|  | conducted with ASM member) #5 (Reside was asked if he could that Resident #14's eadministered on 2/7/ thought that had hap stated the pharmacy facility so nurses call haven't arrived and hedications can be delivered the next daspecifically confirm he #14's evening medic on 2/7/17.  On 5/17/17 at 3:05 p conducted with LPN (the nurse caring for evening shift of 2/7/1 | (administrative staff nt #14's physician). ASM #5 d recall being made aware evening medications were not 17. ASM #5 stated he pened before. ASM #5 was a long distance from the him when medications e tells the nurses the neld that night but have to be  |                     |   |                               |                            |

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|  |  | 495407   | B. WING _             |   |                               | C<br>05/18/2017            |
|  | ROVIDER OR SUPPLIER  N NURSING AND REHA  | AB CENTER  |                       | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406              |                               | 00/10/2011                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG   | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 157  | administration. LPN the facility STAT (Im containing various m time the STAT box of medications. LPN # not contain the need notify the physician another medication of until they arrive from shown Resident #14 #1 stated she didn't scheduled evening in 2/7/17 or what was of not given. LPN #1 is she contacted the plot of 5/17/17 at 5:30 processes administrator), ASM and ASM #3 (the registerior of the facility pharmace Shortages/Unavailal "4. If an emergency Facility nurse should physician to obtain of the gallblipain." This information website: https://medlineplus.g. | medication is not available for #1 stated nurses can access mediate) box (a box nedications) and most of the ontains the needed 1 stated if the STAT box does led medications then nurses and he will say to give or to hold the medications the pharmacy. LPN #1 was the pharmacy. LPN #1 was the pharmacy if Resident #14's medications were given on done if the medications were tated she didn't remember if hysician or not.  1. M.M., ASM #1 (the #2 (the director of nursing) gional director of clinical eraware of the above findings.  1. Y policy titled, "Medication ble Medications" documented, delivery is unavailable, and contact the attending orders or directions"  1. I contact the attending orders or directions"  1. In was presented prior to exit.  1. It is is sudden swelling and adder. It causes severe belly ion was obtained from the gov/ency/article/000264.htm | F 1                   | 57  |                               |                            |
|  | This information was   | sed to treat high cholesterol. s obtained from the website: n.nih.gov/pubmedhealth/PMH   |                       |   |                               |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | IDENTIFICATION NI IMBED   |                    | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |       | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|--------------------|--|--|-------|-------------------------------|--|
|   |  | 495407  | B. WING            |  |  |       | C<br>18/2017                  |  |
|   | ROVIDER OR SUPPLIER  | B CENTER  |                    | 1                                      | TREET ADDRESS, CITY, STATE, ZIP CODE 40 BRIMLEY DRIVE FREDERICKSBURG, VA 22406                               | 1 03/ | 10/2017                       |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE    |  |
| F 157   | This information was https://medlineplus.go tml  (4) "Zolpidem is used falling asleep or stayi information was obtain https://medlineplus.go tml  (5) "Candesartan is used with other medication pressure" This information the website: https://medlineplus.go tml  (6) "Ranolazine is used medications to treat of the chest pain or pressure does not get enough was obtained from the https://medlineplus.go tml  (7) "Gabapentin is also the pain of diabetic not tingling due to nerve diabetes)" This information the website: https://medlineplus.go tml  (8) "Metronidazole elication of the website elications in the pain of diabetic not tingling due to nerve diabetes)" This information was obtained from the website: https://medlineplus.go tml | d to treat high blood ol angina (chest pain)." obtained from the website: by/druginfo/meds/a684030.h  to treat insomnia (difficulty ng asleep)." This ned from the website: by/druginfo/meds/a693025.h  sed alone or in combination s to treat high blood rmation was obtained from by/druginfo/meds/a601033.h  ed alone or with other chronic angina (ongoing e that is felt when the heart oxygen)." This information | F                  | 157                                    |  |       |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | 1 ' '  | LE CONSTRUCTION     | (X3) DATE SURVEY COMPLETED  |                 |
|---|---|--|---------------------|---|-----------------|
|   |   | 495407   | B. WING             |   | 05/18/2017      |
|   | ROVIDER OR SUPPLIER   | HAB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                            | 1 03/10/2017    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIE   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE COMPLETION |
| F 157   | vagina, and other a information was ob https://medlineplus ml  COMPLAINT DEFI  b. Review of Resid revealed a physicia zolpidem (1) 5 mg mouth at bedtime.  Review of Residen (medication adminitesident's zolpidem utilization record readministered to the physician's order.  A nurse's note date "Zolpidem Tartrate at bedtime for Inso script for medication document whether physician was conton on 5/17/17 at 9:46 conducted with LPI (the nurse who doc LPN #3 was shown confirmed zolpiden | ent #14's clinical record an's order dated 2/7/17 for (milligrams) - one tablet by  t #14's February 2017 MAR stration record) and the controlled medication evealed zolpidem, was not e resident on 2/8/17 per  ed 2/8/17 documented, 5 MG- Give 1 tablet by mouth mnia. Pharmacy needing in." The note failed to or not Resident #14's | F 15                |   |                 |
|   | Resident #14 on 2/<br>prescription was no<br>pharmacy to delive<br>stated if a medicati<br>then she contacts t  |  |                     |   |                 |

| C   495407   B. WING   |   | F DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                                       | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|--|---|--|---------------------------------------|-------------------------------|----------------------------|
| 55/10/201  |   |  | 495407  | B. WING  |                                       |                               |                            |
|  | IAME OF PRO                             | OVIDER OR SUPPLIER   | 100101  |  | STREET ADDRESS, CITY, STATE, ZIP CODE | 05/                           | 10/2017                    |
| FALLS RUN NURSING AND REHAB CENTER  140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406   | ALLS RUN                                | N NURSING AND REHA   | B CENTER  |  |                                       |                               |                            |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE)  | PREFIX                                  | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL  | PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR |                                       | 3E                            | (X5)<br>COMPLETION<br>DATE |
| F 157  Continued From page 7  LPN #3 stated if a prescription is needed then she looks for the prescription in the resident's chart and if a prescription is not present then she contacts the physician. LPN #3 was asked if she contacted the physician regarding Resident #14's zolpidem on 2/8/17. LPN #3 confirmed she could not recall if she contacted the physician.  On 5/17/17 at 5:30 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nincial services) were made aware of the above findings.  No further information was presented prior to exit.  (1) "Zolpidem is used to treat insomnia (difficulty falling asleep or staying asleep)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a693025.h tml  COMPLAINT DEFICIENCY ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j)  (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.  (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. | L s c c c c c c c c c c c c c c c c c c | LPN #3 stated if a prescription she looks for the preschart and if a prescription contacts the physicial contacted the physiciac contacted the physicial contacted the physici | escription is needed then scription in the resident's option is not present then she in. LPN #3 was asked if she an regarding Resident #14's LPN #3 confirmed she could acted the physician.  Im., ASM (administrative administrator), ASM #2 ig) and ASM #3 (the regional vices) were made aware of in was presented prior to exit.  It to treat insomnia (difficulty ing asleep)." This ined from the website: by/druginfo/meds/a693025.h  ENCY  DINATION/CERTIFIED  Sesments. The assessment of the resident's status.  Lust conduct or coordinate in professionals. |  |                                       |                               | 6/22/17                    |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1 ` ′  | PLE CONSTRUCTION  G | (X3) DATE SURVEY<br>COMPLETED   |                        |
|---|---|--|---------------------|---|------------------------|
|   |   | 495407   | B. WING             |   | C<br><b>05/18/2017</b> |
|   | ROVIDER OR SUPPLIER   | B CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406  | 1 03/10/2017           |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)                  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)                                  | ILD BE COMPLETION      |
| F 278   | Continued From page   | ÷ 8  | F 27                | 78  |                        |
|   |   | no completes a portion of the n and certify the accuracy of sessment.                                  |                     |   |                        |
|   | (j) Penalty for Falsific<br>(1) Under Medicare a<br>who willfully and know                    | nd Medicaid, an individual   |                     |   |                        |
|   |   | and false statement in a is subject to a civil money nan \$1,000 for each                              |                     |   |                        |
|   | and false statement in  | dividual to certify a material<br>n a resident assessment is<br>ey penalty or not more than<br>ssment. |                     |   |                        |
|   | material and false sta<br>This REQUIREMENT<br>by:   | is not met as evidenced  |                     | 4. Decident #40ls MD0 accommod  |                        |
|   | review, it was determ   | iew and clinical record<br>ined that the facility staff<br>omplete MDS (minimum                        |                     | Resident #10's MDS assessme corrected and submitted.  | ent was                |
|   | data set) assessment<br>the survey sample, R  | for one of 26 residents in esident #10.  |                     | All residents have the potential affected by this deficient practice.   | to be                  |
|   | mood interview for se<br>admission MDS asse<br>(assessment reference<br>significant change in | te date) of 3/1/17 and the status MDS assessment   |                     | 3. On 5/17/2017, Regional MDS no in-serviced facility MDS nurses and workers regarding accurate comples section C and D.                    | d social<br>etion of   |
|   | with an ARD of 3/30/7 The findings include:   |  |                     | 4. DON and or designee(s) will contain 10% audit of MDS assessments we for 2 weeks and then monthly for 2 months to ensure section C and D. | eekly                  |

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|   |  | 495407  | B. WING  |   |  | 1                                     | C                             |  |                            |
|   | DOLUBER OF CLIPPLIER   | 495407  | B. WING _                                      |   |  | 05/                                   | 18/2017                       |  |                            |
| NAME OF PI  | ROVIDER OR SUPPLIER  |   |  |   | FREET ADDRESS, CITY, STATE, ZIP CODE   |                                       |                               |  |                            |
| FALLS RU  | IN NURSING AND REHA  | B CENTER  |  | 14                                      | 10 BRIMLEY DRIVE   |                                       |                               |  |                            |
| 171220110   |  | 2 32.11.2.1   |  | F                                       | REDERICKSBURG, VA 22406  |                                       |                               |  |                            |
| (X4) ID<br>PREFIX<br>TAG                            |  |   | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF |   | ID<br>PREFI)<br>TAG  | FIX (EACH CORRECTIVE ACTION SHOULD BE |                               |  | (X5)<br>COMPLETION<br>DATE |
| F 278   | Continued From page  | e 9   | F 2  | 278                                     |  |                                       |                               |  |                            |
|   | Resident #10 was ad 2/22/17 and readmitted   | mitted to the facility on ed on 3/23/17. Resident ded but were not limited to:  |  |   | complete and accurate. Data collected will be submitted to the QAPI committed x3 months for review and revision as needed. |                                       |                               |  |                            |
|   | section B that docum usually understood at verbal content. Secti the BIMS (brief interv summary score, indicunable to complete the assessment for ment. Resident #10's cognimaking were severely documented, "Should be Conducted? - Atte with all residents." A       | ARD of 3/1/17 revealed ented the resident was not usually understands on C documented a "99" in iew for mental status) eating the resident was not interview. The staff al status documented tive skills for daily decision by impaired. Section D I Resident Mood Interview empt to conduct interview dash was coded and the ew was not completed; the |  |   |  |                                       |                               |  |                            |
|   | status MDS assessm revealed section B th was sometimes unde understands verbal condocumented a "99" in indicating the residenthe interview. The status documented R for daily decision makes Section D documented Interview be Conduct interview with all resident moo | the BIMS summary score, it was unable to complete aff assessment for mental resident #10's cognitive skills king were severely impaired. Ed, "Should Resident Mood ed? - Attempt to conduct dents." A dash was coded  |  |   |  |                                       |                               |  |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTI  |                    |        | (X3) DATE SURVEY<br>COMPLETED  |              |                            |
|---|--|---|--------------------|--------|--|--------------|----------------------------|
|   |  | 495407  | B. WING            |        |  | · ·          | 10/2047                    |
|   | ROVIDER OR SUPPLIER  |   |                    | S<br>1 | TREET ADDRESS, CITY, STATE, ZIP CODE  40 BRIMLEY DRIVE  REDERICKSBURG, VA 22406                              | <u>  U5/</u> | 18/2017                    |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | X      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |              | (X5)<br>COMPLETION<br>DATE |
| F 278   | social services directoresponsible for complications and assessments.  On 5/7/17 at 8:58 a.m. did not pursue the mod interview and assessments.  On 5/7/17 at 8:58 a.m. did not pursue the mod interview and the been a good historian related to the mood in was asked what refer related to MDS assess she coordinates with there is an RAI (resid manual in their office review the RAI manual speak with this survey on 5/7/17 at 4:22 p.m. conducted with OSM worker), RN (registered coordinator) and RN at \$10's mood interview attempted. RN \$3 coreferences the CMS (experiences the CMS) | m. an interview was (other staff member) #5 (the or and the person eting sections C and D on assessments). OSM #5 ially attempts the BIMS sident scores five or lower on tappropriate to pursue ith the resident. OSM #5 is attempt Resident #10's completed the staff  a., OSM #5 confirmed she and interview with Resident dent scored a 99 on the are resident would not have a to give the information afterview questions. OSM #5 ence she used for questions assents. OSM #5 stated the MDS department and ent assessment instrument) OSM #5 was asked to all with the MDS nurses and yor later on during the day.  a., an interview was #5, OSM #6 (another social ed nurse) #2 (MDS #3 (MDS coordinator). OSM ed the policy and Resident as should have been anfirmed the facility staff Centers for Medicare & all and stated she had an | F.                 | 278    |  |              |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION  IG |  | (X3) DATE SURVEY COMPLETED |                            |
|--|---|---|----------------------|--|----------------------------|----------------------------|
|  |   | 495407  | B. WING _            |  |                            | C<br>05/18/2017            |
|  | ROVIDER OR SUPPLIER  N NURSING AND REHA   | AB CENTER   |                      | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406       |                            |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |
| F 278  | documented, "Object MDS and Social servinderstanding of cool interview in the MDS regarding section D attached. The in-servinsocial workers and bottom of the director of clinical set the above findings.  The CMS RAI manue "SECTION D: MOOI Intent: The items in the distress, a serious of underdiagnosed and home and is associal it is particularly imposymptoms of mood of residents because the can be treatable  D0100: Should Resident Conducted? Item Rationale This item helps to deresident or staff mood conducted. Health-related Quality Most residents who accommunicating can atthey feel.  Obtaining informatio the resident's voice, is resident. | an D (Mood)" dated 5/16/17 tives of the In-Service: All vices will verbalize ding section D MOOD b." A copy of instructions from the RAI manual was vice was signed by both oth MDS coordinators. b.m., ASM (administrative e administrator), ASM #2 ng) and ASM #3 (the regional rvices) were made aware of al documented: D his section address mood ondition that is undertreated in the nursing sted with significant morbidity. ortant to identify signs and distress among nursing home sees signs and symptoms dent Mood Interview Be etermine whether or not a di interview should be | F 2                  | 78   |                            |                            |

|                          | DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     |   | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|---------------------|---|----------------------------|
|                          |  | 495407  | B. WING             |   | C                          |
|                          | ROVIDER OR SUPPLIER  |   | 5                   | STREET ADDRESS, CITY, STATE, ZIP CODE  40 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                           | 05/18/2017                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) |                            |
| F 278                    | disorder. D0100: Should Resid Conducted? (cont.) P Symptom-specific information interviews will allow for resident's voice in the If a resident cannot of Mood Interview (D050 Steps for Assessmen 94. Determine if the nunderstood. If rarely/n D0500, Staff Assessmen (PHQ-9-OV©). 95. Review Language if the resident needs communicate with do (A1100 = 1). If the resident needs complete the interview Coding Instructions Code 0, no: if the interview Coding Instructions Code 0, no: if the interview conducted. This optic residents who are rar who need an interprenot available. Skip to Assessment of Resid Code 1, yes: if the resconducted. This optic residents who are able whom an interpreter in | dent Mood Interview Be lanning for Care ormation from direct resident or the incorporation of the individualized care plan. Ormmunicate, then Staff (20 AJ) should be conducted. It esident is rarely/never never understood, skip to ment of Resident Mood exitem (A1100) to determine or wants an interpreter to ctors or health care staff (20 AJ) with an interpreter.  In word in the protect of the construction of the selected for ely/never understood, or ter (A1100 = 1) but one was | F 278               |   |                            |
| F 281<br>SS=E            | SERVICES PROVIDE   | n was presented prior to exit.<br>ED MEET PROFESSIONAL<br>(i)   | F 281               |   | 6/22/17                    |

|                          | DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | PLE CONSTRUCTION  G   | (X3) DATE SURVEY<br>COMPLETED                                     |
|--------------------------|---|---|---------------------|---|---|
|                          |   | 495407  | B. WING             |   | C<br><b>05/18/2017</b>  |
|                          | ROVIDER OR SUPPLIER   | IAB CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406  | 03/10/2017  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | ) BE COMPLETION   |
| F 281                    | as outlined by the comust-  (i) Meet professional This REQUIREMENT by: Based on observated document review, course of a complain determined that fact professional standaresidents in the surface Resident #14, Resident #14, Resident #14 pain for Tylenol to breakthrough pain for the Resident #14's physiciated the professional standaresidents in the surface residents in the surface resident #14, Resident #14, Resident #14's physiciated pain for the resident #14's physiciated the professional standard pain for the resident #14's physiciated partment. | ed or arranged by the facility, omprehensive care plan,  al standards of quality.  It is not met as evidenced ion, staff interview, facility linical record review and in the nt investigation, it was ility staff failed to follow rds of care for four of 26 vey sample, Resident #12, dent #2 and Resident #7.  ailed to clarify a physician's be given every four hours for for Resident #12.  ailed to accurately transcribe sician ordered renal diet to the ion form provided to the | F 28                | ,   | des in N pain I. be urrent ation if s will ervice ers, PRN iption |
|                          | 4. The facility staff   | failed to clarify the parameters<br>f PRN (as needed) pain<br>dent # 7.   |                     | orders 5x a week for 4 weeks and the weekly for 8 weeks. DON and or designee(s) will audit 5 residents a weekly for 4 weeks and then weekly for 8 weeks and then weekly for 8 weeks and orders/parameters are follows indicated. DON and or designee(audit 10 residents" diets weekly for 4 | veek<br>eeks<br>owed<br>s) will                                   |
|                          | J   | ailed to clarify a physician's  |                     | weeks and then monthly for 2 month accuracy. Results of audits will be to the QAPI committee x3 months for  | s for<br>aken   |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN   | IPLE CONSTRUCTION                              |   | (X3) DATE SURVEY COMPLETED |   |                            |
|---|---|--|--|---|----------------------------|---|----------------------------|
|   |   | 495407   | B. WING _                                      |   |                            | C<br>05/18/2017   |                            |
|   | ROVIDER OR SUPPLIER   | AB CENTER  |  | STREET ADDRESS, CITY, STATE, ZIP<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406 | CODE                       | 03/10/2017  |                            |
| (X4) ID<br>PREFIX<br>TAG  |   |  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF |   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN C<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | (X5)<br>COMPLETION<br>DATE |
| F 281   | breakthrough pain for Resident #12 was ac 4/4/13 and readmitte that included but wer weakness, demential ad high blood pressure. The most recent MD quarterly assessment reference date) of 4/4 having a BIMS (brief of 12 out of 15 indicated cognitively intact to make the companion of the care prevised on 1/26/17 drief or painIntervention ordered, prn (as need contact md [sic] (med Review of the physical properties of the physical properties and properties of the physical properties of the physical properties of the physical properties of the properties of the physical physical properties of the physical physical physical physical phy | e given every four hours for r Resident #12.  Imitted to the facility on d on 8/6/15 with diagnoses e not limited to: muscle, chronic pain, heart disease re.  S (minimum data set), a t with an ARD (assessment 4/17 coded the resident as interview for mental status) ting the resident was | F 2  |   | <u>'</u>                   |   |                            |
|   | (Acetaminophen) Giv four hours for Breakt 7/14/2016."  Review of the May 2 administration record Tablet 325 MG (millig Give 325 mg by mou Breakthrough pain. Further review of the documented that the every four hours eac #12's pain was rated  | hrough pain. Order Date  O17 MAR (medication I) documented, "Tylenol grams) (Acetaminophen) th every four hours for Start Date- 7/14/2016."  |  |   |                            |   |                            |

|   |  |  | OATE SURVEY<br>OMPLETED  |  |               |                            |
|---|--|--|--|--|---------------|----------------------------|
|   |  | 495407   | B. WING _  |  |               | 05/18/2017                 |
| A95407  NAME OF PROVIDER OR SUPPLIER  FALLS RUN NURSING AND REHAB CENTER  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 281  Continued From page 15 documented as being given even though the resident did not report having pain.  On 5/16/17 at 4:08 p.m. the medication administration observation was conducted. LPN #1 put a Tylenol 325 mg tablet into a medicine cup and took it into Resident #12's room. She asked the resident if she had pain and the resident stated she did not. She gave the medicine cup to the resident and then gave the resident water from the water pitcher. The resident took the medication.  An interview was conducted on 5/17/17 at 1:05 p.m. with LPN (licensed practical nurse) #4, the resident's nurse. When asked to review the Tylenol order for Resident #12, LPN #4 stated, "That means she has an order for Tramadol (1) and she has Tylenol for breakthrough pain." When asked if staff gave residents pain medication when residents did not report pain, |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406 | •  | 33, 13, 23 11 |                            |
| PRÉFIX  | (EACH DEFICIEN   | CY MUST BE PRECEDED BY FULL  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE     | (X5)<br>COMPLETION<br>DATE |
| F 281   | documented as beir resident did not report of the process of the p | g given even though the ort having pain.  o.m. the medication vation was conducted. LPN in mg tablet into a medicine Resident #12's room. She is she had pain and the did not. She gave the resident and then gave the the water pitcher. The edication.  Inducted on 5/17/17 at 1:05 is sed practical nurse) #4, the inen asked to review the sident #12, LPN #4 stated, is an order for Tramadol (1) for breakthrough pain." | F 2  | <u> </u>   |               |                            |
|   | but she doesn't com the resident was ass stated she was. Whe exhibited signs of pa When asked if the T ordered, LPN #4 sta staff would do in this should probably get needs it."  An interview was co p.m. with RN (regist to review Resident # stated, "It's for breal technically a prn (me  | plain to us." When asked if sessed for pain, LPN #4 en asked if the resident ain, LPN #4 stated, "No." ylenol order was followed as ted, "No." When asked what case, LPN #4 stated, "We rid of it and make it prn if she enducted on 5/17/17 at 1:15 ered nurse) #5. When asked #12's Tylenol order, RN #5   |  |  |               |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |  | (X3) DATE<br>COMP | SURVEY<br>LETED            |
|---|--|---|--|-----|--|-------------------|----------------------------|
|   |  | 495407  | B. WING                                |     |  |                   | C<br><b>18/2017</b>        |
|   | ROVIDER OR SUPPLIER  | B CENTER  | •                                      | 1   | TREET ADDRESS, CITY, STATE, ZIP CODE 40 BRIMLEY DRIVE FREDERICKSBURG, VA 22406   |                   |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                     |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 281   | the Tylenol would be her pain level was ze not. No need. I'd protonurse's notes that (th no pain."  An interview was comp.m. with OSM (other #12's physician. Whethe Tylenol for breakt OSM #5 stated, "Pair if the Tylenol should to not have pain, OSM #5 to it be." When made #5 stated, "We'll take On 5/17/17 at 5:15 p. member) #1, the admidirector of nursing we findings.  Review of the facility' for Non-Controlled So "Procedure: 1.2 Facil information is compler reconciled and is veribefore faxing or transpharmacy. 2.1.2 Facil orders include medicated in the drug is chosen, so order process by comadministration schedulother information requivolution. | rain level" When asked if given if the resident stated ro, RN #5 stated, "Absolutely bably make a note in the e resident) stated she had  ducted on 5/17/17 at 2:43 restaff member) #5, Resident an asked when he expected through pain would be given, and of one to ten." When asked be given if the resident did #5 stated, "No I don't expect aware of the concern, OSM care of it."  m. ASM (administrative staff ministrator and ASM #2, the ere made aware of the substances" documented, ity should ensure all resident atte and accurate has been fied by Physician/Prescriber | F                                      | 281 |  |                   |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` ′               | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |       | SURVEY<br>LETED            |
|---|--|--|-------------------|--|--|-------|----------------------------|
|   |  | 495407   | B. WING           | B. WING                                |  |       | C<br>18/2017               |
|   | ROVIDER OR SUPPLIER  | B CENTER   | <u>.l</u>         | 1                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>40 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406                        | 1 03/ | 10/2017                    |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE |
| F 281   | Inc.; Page 419. "The directing medical trea obligated to follow ph believe the orders are clients."  (1) Tramadol (Ultramangesic because of addiction and better swith other opiates. How adverse reactions are with tramadol-seizure This information was   | Anne Griffin Perry; Mosby, physician is responsible for the the the theorem is a commonly prescribed its relatively lower risk of cafety profile in comparison owever, two significant exhown to potentially occurse and serotonin syndrome. | F                 | 281                                    |  |       |                            |
|   | 2. The facility staff failed to accurately transcribe Resident #14's physician ordered renal diet to the dietary communication form provided to the dietary department.  Resident #14 was admitted to the facility on 2/7/17 and discharge on 2/14/17. Resident #14's diagnoses included but were not limited to: acute cholecystitis (1), high blood pressure and major depressive disorder. Resident #14's five day Medicare MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/14/17 coded the resident as being cognitively intact.  Review of Resident #14's physician orders revealed a physician's order dated 2/7/17 for a renal diet with regular texture and thin consistency. |  |                   |  |  |       |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | 1  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|---|--|--|---|-----|--|-------------------------------|----------------------------|--|
|   |  | 495407   | B. WING                                 |     |  | 1                             | C<br>/ <b>18/2017</b>      |  |
|   | ROVIDER OR SUPPLIER  |  |   | 14  | TREET ADDRESS, CITY, STATE, ZIP CODE  BOBRIMLEY DRIVE  REDERICKSBURG, VA 22406                                       | 1 03/                         | 10/2017                    |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFI<br>TAG                      | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |  |
| F 281   | on 2/8/17 failed to do regarding the resider  On 5/17/17 at 8:30 a conducted with OSM director of dietary set what process was in physician ordered die OSM #2 stated, "We slip." OSM #2 was a Resident #14's dietar On 5/17/17 at 9:40 a dietary communication documented Resider mark beside a regulatexture. The words, foods." were handwridiet was not checked. | rehensive care plan initiated cument information nt's diet.  m., an interview was (other staff member) #2 (the rvices). OSM #2 was asked place to ensure the correct et was served to residents. get a dietary communication sked if she could provide by communication slip.  m., OSM #2 presented a conform dated 2/7/17 that in t#14's name and a check or diet order and a thin 'No Red meats. No fried tten on the form. The renal off. | F                                       | 281 |  |                               |                            |  |
|   | conducted with LPN LPN #1 was asked wensure physician ord communicated to the resident is admitted. form we fill out that gout the order in the casked if the informati that is given to the dimatch the physician's "Yes."  | m., an interview was (licensed practical nurse) #1. that process was in place to ered diets are accurately dietary department when a LPN #1 stated, "We have a oes to the kitchen and we omputer." LPN #1 was on documented on the form etary department should s order. LPN #1 stated,  m., ASM (administrative   |   |     |  |                               |                            |  |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 |  | ' '     | TE SURVEY<br>MPLETED       |
|--------------------------|---|---|---------------------|--|---------|----------------------------|
|                          |   | 495407  | B. WING _           |  | 0       | C<br><b>5/18/2017</b>      |
|                          | ROVIDER OR SUPPLIER   | AB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406 | 1 3     | 0/10/2011                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWS CROSS-REFERENCED TO THE APIDEFICIENCY)  | OULD BE | (X5)<br>COMPLETION<br>DATE |
| F 281                    | (the director of nursing director of clinical set the above findings.  The facility policy title NOTIFICATION OF INURSING Services shad Department of a resi any changes in the reand food preferences new resident is admit changed, the Nurses the Food Services Donotice of the diet ord  On 5/18/17 at 8:18 and above policy was the followed when transcribed diets onto the dietary.  No further information  (1) "Acute cholecystic irritation of the gallblate pain." This information website: https://medlineplus.g.  COMPLAINT DEFIC.  3. The facility staff far for administration of medication for Resident # 2 was reador/02/14 with diagnore. | e administrator), ASM #2 ng) and ASM #3 (the regional rvices) were made aware of  ed, "INTERDEPARTMENTAL DIET" documented, "Policy: all notify the Dietary dent's diet orders, including esident's diet, meal service, s. Procedure: 1. When a tted, or diet has been Supervisor shall ensure that epartment receives a written er"  .m., ASM #2 stated the estandard of practice that is cribing physician ordered or communication forms.  In was presented prior to exit.  tis is sudden swelling and adder. It causes severe belly on was obtained from the ov/ency/article/000264.htm  IENCY  illed to clarify the parameters PRN (as needed) pain | F 2                 | 81   |         |                            |

|        |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE<br>A. BUILDING  | E CONSTRUCTION  | (X3) DATE SURVEY COMPLETED C |
|--------|--|--|---|---|------------------------------|
|        |  | 495407   | B. WING   |   | 05/18/2017                   |
|        | ND PLAN OF CORRECTION I DENTIFICATION NUMBER:  | 1  | STREET ADDRESS, CITY, STATE, ZIP CODE  40 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406 | ,   |                              |
| PRÉFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETION                |
| F 281  | muscle weakness, penign prostatic hypgastroesophageal re (4) and hypertension Resident # 2's most set), a quarterly ass (assessment referencesident # 2 as sco interview for mental - 15, 14 being cognidecisions. Resident extensive assistance activities of daily living The POS (Physiciar # 2 dated May 2017 assessment every stocument the reside (zero) - (to) 10. 10 (zero) being no pair document on pain flow flow address pain. non-pharmacological if rom "Hydrocodone-Acet (five)-325 MG (milligmouth every 6 (six) Order Date: 07/21/2 [Tramadol] (7) Give 06 (six) hours as ne Date 06/30/2016."  The eMAR (electror record) for Resident documented, "Hydrotablet 5 (five)-325 Mallet by mouth every event ablet by mouth every event ablet 5 (five)-325 Mallet by mouth event event ablet 5 (five)-325 Mallet by mouth event ev | pain, low iron, depression, perplasia (2), eflux disease (3), dysphagia in (5).  Trecent MDS (minimum data essment with an ARD ince date) of 03/07/17, coded ring a 14 on the brief status (BIMS) of a score of 0 tively intact for making daily it # 2 was coded as requiring e of one staff member for ing.  This Order Sheet) for Resident in documented, "Pain is indicated, ow log as well as what you in First intervention being all, second intervention being intervention being in the worst pain and 0 in the pain is indicated, in the pain is | F 281   |   |                              |

| C<br><b>18/2017</b>        |
|----------------------------|
|                            |
| (X5)<br>COMPLETION<br>DATE |
|                            |
|                            |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | PLE CONSTRUCTION  G   | , ,       | OMPLETED                   |
|--------------------------|---|---|---------------------|---|-----------|----------------------------|
|                          |   | 495407  | B. WING _           |   |           | C<br>05/18/2017            |
|                          | ROVIDER OR SUPPLIER   | AB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406              | <b>'</b>  | 30/10/2017                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 281                    | record) for Resident documented, "Hydroc Tablet 5 (five)-325 M tablet by mouth ever pain. Order Date: 0' MG [Tramadol] (7) Gevery 06 (six) hours Order Date 06/30/20 The eMAR dated Ma Hydrocodone-Aceta was administered or times: 05/01/17 at 2: a.m., 05/04/17 at 5:3 a.m., and 05/10/17 at Note" for each date Hydrocodone-Aceta was administered do "Hydrocodone-Aceta was administered do "Hydrocodone-Aceta Give 1 tablet by moutofr pain."  The eMAR dated Ma Tablet 50 MG was a dates and times: 05/05/12/17 at 5:40 a.m date above documer Give 2 tablet [sic] by needed for severe p | ic medication administration # 2 dated "May 2017" poodone-Acetaminophen (6) IG (milligram). Give 1 (one) by 6 (six) hours as needed for 7/21/2016." "Ultram Tablet 50 Give 2 tablet [sic] by mouth as needed for severe pain. 1016."  Tay 2017 revealed minophen Tablet 5-325 MG in the following dates and 123 a.m., 05/02/17 at 3:40 go a.m., 05/09/19 at 5:25 go | F 2                 | 81  |           |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | IDENTIFICATION NUMBER:   |                     | TIPLE CONSTRUCTION  NG |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|---------------------|------------------------|---|-------------------------------|----------------------------|
|   |   | 495407   | B. WING _           |                        |   |                               | C<br><b>18/2017</b>        |
| NAME OF P   | ROVIDER OR SUPPLIER   |  |                     | STR                    | REET ADDRESS, CITY, STATE, ZIP CODE   | 1 00/                         | 10/2011                    |
|   |   |  |                     | 140                    | BRIMLEY DRIVE   |                               |                            |
| FALLS RU  | IN NURSING AND REHA   | B CENTER   |                     | FRI                    | EDERICKSBURG, VA 22406  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | <                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 281   | Continued From page   | e 23   | F 2                 | 281                    |   |                               |                            |
|   | 03/02/2017 through 0 and failed to evidence medications were cla  The care plan for Res   | " for Resident # 2 dated<br>15/16/2017 were reviewed<br>the Resident # 2's PRN pain<br>rified.<br>Sident # 2 with an initiation<br>8/2014 and a revision date  |                     |                        |   |                               |                            |
|   | of 03/16/2017 failed the administration of  | to evidence parameters for Resident # 2's PRN pain odone-Acetaminophen and   |                     |                        |   |                               |                            |
|   | 5. When asked how pain medication shouthere is more than on stated, "If there are so (medications) there in the physician's order. I would get clarification giving the medication parameters LPN # 5 spain medication for medication for moder on the resident's pain eMARs dated March, physician's orders for medications LPN # 5 was severe pain on the that is used to assess stated, "I don't know the pain scale." | (licensed practical nurse) # it is determined what PRN lld be administered when he prescribed LPN # 5 heveral pain meds heeds to be a parameter on he fithere are no parameters on from the physician before he will be will be will be will he pain another pain hate pain. It would depend he level." After reviewing the he April and May 2017 and he Resident # 2's PRN pain has asked what pain level he pain scale of one to ten he a resident's pain. LPN # 5 he what number it would be on he asked if there was haters. LPN # 5 stated, he ters." |                     |                        |   |                               |                            |
|   | conducted with LPN  | o.m. an interview was<br># 2. When asked how it is<br>N pain medication should be  |                     |                        |   |                               |                            |

|  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 1  |   |  | DATE SURVEY<br>COMPLETED  |
|--|---|--|---|--|---|
|  | 495407  | B. WING _  |   |  | C<br>05/18/2017   |
|  | AB CENTER   |  | STREET ADDRESS, CITY, STATE, ZIP COD<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406   | E  | 33, 13, 23 11   |
| (EACH DEFICIENC  | CY MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG  | ( (EACH CORRECTIVE ACTION   | I SHOULD BE  | (X5)<br>COMPLETION<br>DATE  |
| administered when the prescribed LPN # 2 stands and physician before giving reviewing the eMAR 2017 and physician's PRN pain medication pain level was sever one to ten that is use pain. LPN # 2 stated it would be on the pathere was document 2 stated, "There are  On 05/17/17 at 2:30 conducted with ASM member) # 2, the direct 4, the assistant direct multiple PRN pain membor be administed one medication pressional be clarified." dated March, April a orders for Resident ASM # 2 was asked of parameters. "  On 05/17/17 at approximately administrator, and American aware of the pathere was document and pressional states are should be administed one medication pressional be clarified." dated March, April and orders for Resident ASM # 2 was asked of parameters. "  On 05/17/17 at approximately administrator, and American aware of the pathere was aware of the parameter awa | here is more than one stated, "If there are several ons) there needs to be a sysician's order. If there are ld get clarification from the ng the medication." After added March, April and May sorders for Resident # 2's as LPN # 2 was asked what e pain on the pain scale of ed to assess a resident's d. "I don't know what number ain scale." When asked if ation of parameters. LPN # no parameters. LPN # no parameters."  p.m. an interview was (administrative staff ector of nursing and ASM # etor of nursing regarding edications. When asked which PRN pain medication red when there is more than cribed, ASM # 2 stated, "It After reviewing the eMARs and May 2017 and physician's # 2's PRN pain medications if there was documentation if # 2 stated, "There are no eximately 5:00 p.m. ASM member) # 1 the SM # 2, director of nursing, the findings.  | F 2  | 281   |  |   |
| References:  |   |  |   |  |   |
|  | SUMMARY S' (EACH DEFICIENCE REGULATORY OR  Continued From page administered when the prescribed LPN # 2 sepain meds (medicatine) parameters I would physician before giving reviewing the eMAR: 2017 and physician's PRN pain medication pain level was sever one to ten that is use pain. LPN # 2 stated it would be on the pathere was document 2 stated, "There are  On 05/17/17 at 2:30 conducted with ASM member) # 2, the direct 4, the assistant direct multiple PRN pain medication preschould be administed one medication preschould be clarified."  dated March, April an orders for Resident # ASM # 2 was asked of parameters. ASM parameters."  On 05/17/17 at approved the parameters of the side of the parameters of the side of the parameters of the side of the parameters. The parameters of | ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 24 administered when there is more than one prescribed LPN # 2 stated, "If there are several pain meds (medications) there needs to be a parameter on the physician's order. If there are no parameters I would get clarification from the physician before giving the medication." After reviewing the eMARs dated March, April and May 2017 and physician's orders for Resident # 2's PRN pain medications LPN # 2 was asked what pain level was severe pain on the pain scale of one to ten that is used to assess a resident's pain. LPN # 2 stated, "I don't know what number it would be on the pain scale." When asked if there was documentation of parameters. LPN # 2 stated, "There are no parameters."  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No further information was provided prior to exit. | ROVIDER OR SUPPLIER  IN NURSING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 24  administered when there is more than one prescribed LPN # 2 stated, "If there are several pain meds (medications) there needs to be a parameter on the physician's order. If there are no parameters I would get clarification from the physician before giving the medication." After reviewing the eMARs dated March, April and May 2017 and physician's orders for Resident # 2's PRN pain medications LPN # 2 was asked what pain level was severe pain on the pain scale of one to ten that is used to assess a resident's pain. LPN # 2 stated, "I don't know what number it would be on the pain scale." When asked if there was documentation of parameters. LPN # 2 stated, "There are no parameters."  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WING  STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  SUMMARY STATEMENT OF DEFICIENCES  BLOAD REFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 24  administered when there is more than one prescribed LPN # 2 stated, "If there are no parameters I would get clarification from the physician's orders for Resident # 2's  PRN pain medications. PN # 2 was asked what pain level was severe pain on the pain scale of one to ten that is used to assess a resident's pain. LPN # 2 stated, "It on the masked if there was documentation of parameters."  On 05/17/17 at 2:30 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing regarding multiple PRN pain medications. When asked how it is determined which PRN pain medication should be administered when there is more than one medication prescribed, ASM # 2 stated, "it should be clarified." 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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING |   |   | (X3) DATE SURVEY<br>COMPLETED |   |            |                            |
|--|---|---|-------------------------------|---|------------|----------------------------|
|  |   | 495407  | B. WING                       |   | C<br>05/18 | 3/2017                     |
|  | ROVIDER OR SUPPLIER   |   |                               | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                      | 1 03/10    | 1120 TT                    |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE    | (X5)<br>COMPLETION<br>DATE |
| F 281  | Continued From pag  | e 25  | F 28                          | 31  |            |                            |
|  | brain stops. A stroke attack." If blood flow few seconds, the bra oxygen. Brain cells of damage. This inform website: https://medlineplus.g.  2. An enlarged prost obtained from the we https://www.nlm.nih statebph.html.  3. Stomach contents the esophagus and i was obtained from the https://www.nlm.nih 4. A swallowing diso obtained from the we https://www.nlm.nih sorders.html.  5. High blood pressu obtained from the we https://www.nlm.nih essure.html.  6. Hydrocodone is an other ingredients, an products are prescribly hydrocodone combir relieve moderate-to-hydrocodone combir relieve cough. Hydromedications called on the well-based on the products are prescribly hydrocodone combir relieve moderate-to-hydrocodone combir relieve cough. Hydromedications called on the products are prescribly hydrocodone combir relieve cough. Hydromedications called on the products are prescribly hydrocodone combir relieve cough. Hydromedications called on the products are prescribly hydrocodone combir relieve cough. Hydromedications called on the products are prescribly hydrocodone combir relieve cough. Hydromedications called on the products are prescribly hydrocodone combir relieve cough. Hydromedications called on the products are prescribly hydrocodone combir relieve cough. Hydromedications called on the products are prescribly hydrocodone combir relieve cough. | to leak back, or reflux, into rritate it. This information we website: gov/medlineplus/gerd.html.  rder. This information was ebsite: gov/medlineplus/swallowingdi  re. This information was ebsite: gov/medlineplus/shallowingdi  re. This information was ebsite: gov/medlineplus/highbloodpr  vailable in combination with d different combination oped for different uses. Some nation products are used to |                               |   |            |                            |

| AND DLAN OF CORRECTION IDENTIFICATION NUMBER   |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     |   | (X3) DATE SURVEY COMPLETED |                            |  |
|--|--|---|---------------------|---|----------------------------|----------------------------|--|
|  |  | 495407  | B. WING             |   |                            | C<br>05/49/2047            |  |
| NAME OF PROVIDER OR SUPPLIE  FALLS RUN NURSING AND   |  | 400,01  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                      |                            | 05/18/2017                 |  |
| PREFIX (EACH DEF   | ARY STATEMENT OF DE<br>ICIENCY MUST BE PREC<br>RY OR LSC IDENTIFYING   | CEDED BY FULL   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE                    | (X5)<br>COMPLETION<br>DATE |  |
| the brain and not hydrocodone reactivity in the paractivity in the website: https://medlineparactivity.  7. Used to relie severe pain. The website: https://medlineparactivity.  4. The facility of for administration medication for Resident # 7 was 05/01/14 with donot limited to: eweakness, deput hypertension (4 disease (5), dys vascular disease Resident # 7's reset), a quarterly (assessment reactivity in the paractivity in the p | elieves pain by cha<br>ervous system respelieves cough by de<br>art of the brain that<br>information was of<br>olus.gov/druginfo/materials information was<br>olus.gov/druginfo/materials information was<br>olus.gov/druginfo/materials information was<br>olus.gov/druginfo/materials information was<br>caff failed to clarify<br>on of PRN (as need<br>Resident # 7. | cond to pain. ecreasing causes btained from meds/a601006.h  oderately s obtained from meds/a695011.ht  the parameters ded) pain  facility on ded but were muscle c), dementia (3), al reflux ripheral  minimum data an ARD 3/22/17, coded the brief of a score of 0 making daily did as requiring | F 28                |   |                            |                            |  |

| STATEMENT OF DEFIC<br>AND PLAN OF CORRE   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION  NG  |  | (X3) DATE :<br>COMPI | LETED                      |
|---|--|---|-------------------------|--|--|----------------------|----------------------------|
|   |  | 495407  | B. WING _               |  |  | 05/1                 | )<br>18/2017               |
| NAME OF PROVIDER  |  | B CENTER  |                         | STREET ADDRESS, CITY, STATE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 2 |  | ,                    |                            |
| (X4) ID<br>PREFIX<br>TAG  |  |   | ID<br>PREFIX<br>TAG     | ( (EACH CORRECTI'<br>CROSS-REFERENCE                                 | AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY) |                      | (X5)<br>COMPLETION<br>DATE |
| The F# 7 da  "Acet Give as ne (grea  "Ibup [sic] t pain.  The e record docur Revie revea admir at 1:4 7:58 a 11:01 time A as do Give pain. 109."  The e Ibup at 2:1 5:50 a 12:01 12:55 "eMA 200 M "Ibup every | aminophen (8) 3 650 MG orally ( eded for pain. A ter than) 109. E rofen Tablet 200 by mouth every Date Ordered: MAR (electroni d) for Resident 3 mented the above w of the eMAR led Acetaminophistered on: 01/0 0 a.m., 01/26/1 a.m., 01/30/17 a p.m. The "eMA Acetaminophen cumented, "Acetaminophen cumented for acetaminophen commented for a | s Order Sheet) For Resident documented,  325 MG (milligram) Tablet. by mouth) every 6 (six) hours As needed for pain or fever > Date Ordered: 09/10/2014."  0 MG. Give 2 (two) tablet 6 (six) hours as needed for 07/21/2016."  c medication administration # 7 dated "January 2017 we medication orders. dated January 2017 when 325 MG was 07/17 at 2:49 a.m., 01/22/17 7 at 9:263 p.m., 01/29/17 at at 2:09 a.m., and 01/30/17 at at 2:09 a.m., and 01/30/17 at at 2:09 a.m. as needed for pain or fever > (greater than)  nuary 2017 revealed as administered on: 01/04/17 7 at 11:50 p.m., 01/07/17 at at 10:07 p.m., 01/19/17 at at 12:02 a.m., 01/28/17 at 0/17 at 12:12 a.m. The h date and time lbuprofen stered documented, Give 2 tablets by mouth | F2                      | 281  |  |                      |                            |

|                          | DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ` ′               | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|--|---------------------|---|-------------------------------|
|                          |  | 495407   | B. WING             |   | 05/18/2017                    |
|                          | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                      | 05/16/2017                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE)   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE COMPLETION             |
| F 281                    | documented the ab<br>physician order she<br>dated February 201<br>325 MG was admin<br>a.m., 02/07/17 at 11<br>p.m., 02/11/17 at 12<br>02/12/17 at 7:31 a.<br>02/14/17 at 11"00 p<br>at 10:32 p.m., 02/11<br>1:09 a.m. The "eM<br>time Acetaminophe<br>as documented, "A<br>Give 650 MG orally  | ge 28  t # 7 dated "February 2017 ove physician orders on the et. Review of the eMAR 7 revealed Acetaminophen istered on: 02/04/17 at 12:09 1:52 p.m., 02/08/17 at 7:30 2:44 a.m. and at 6:09 p.m., m., 02/13/17 at 8:13 p.m., n.m., 02/15/17 at 6:08 a.m. and 7/17 at 10:48 a.m., 02/22/17 at AR Note" for each date and n 325 MG was administered cetaminophen 325 MG Tablet. every 6 hours as needed for r pain or fever > (greater than) | F 28                | 1   |                               |
|                          | Ibuprofen 200 MG at 11:43 p.m., 02/22 p.m., 02/23/17 at 1: a.m. The "eMAR N Ibuprofen 200 MG adocumented, "Ibuprofen 200 MG at 12:06 p.m., 03/02 at 12:06 p.m., 03/02 p.m., 03 | rofen 200 MG. Give 2 tablets ours as needed for pain."  nic medication administration t # 7 dated "March 2017  |                     |   |                               |

|                          | T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  |   | CONSTRUCTION       | (X3) DATE SURVEY<br>COMPLETED |  |       |                            |
|--------------------------|---|---|--------------------|-------------------------------|--|-------|----------------------------|
|                          |   | 495407  | B. WING            |                               |  | 1     | C<br>18/2017               |
|                          | ROVIDER OR SUPPLIER  IN NURSING AND REHA  | B CENTER  |                    | 14                            | REET ADDRESS, CITY, STATE, ZIP CODE<br>0 BRIMLEY DRIVE<br>REDERICKSBURG, VA 22406  | 1 00/ | 10/2017                    |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREFI<br>TAG |                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE |
| F 281                    | 03/17/17 at 1:42 p.m. 03/22/17 at 4:38 p.m. and 03/29/17 at 3:20 each time Ibuprofen 2 documented: "Ibuprof by mouth every 6 how The eMAR (electronic record) for Resident 4 documented, docume Acetaminophen 325 I to be administered as physician order sheef April 2017 revealed A not administered duri The eMAR dated Apr 200 MG was adminis p.m., 04/07/17 at 8:32 04/12/17 at 4:05 a.m. 04/23/17 at 11:43 a.m. The "eMAR Note" for MG was administered 200 MG. Give 2 table as needed for pain." | a.m. and at 2:08 p.m., , 03/18/17 at 12:34 a.m., , 03/24/17 at 11:36 a.m., a.m. The "eMAR Note" for 200 MG was administered fen 200 MG. Give 2 tablets urs as needed for pain."  c medication administration f 7 dated "April 2017 ented the physician order for MG and Ibuprofen 200 MG documented on the tabove. The eMAR dated acetaminophen 325 MG was ng the month of April 2017. il 2017 revealed Ibuprofen tered on: 04/05/17 at 6:49 2 a.m.,04/08/17 at 6:46 a.m., , 04/18/17 at 8:38 p.m., a., and 04/25/17 at 9:38 p.m. each time Ibuprofen dets by mouth every 6 hours c medication administration f 7 dated "May 2017 | F                  | 281                           | DEFICIENCY)  |       |                            |
|                          | to be administered as<br>physician order sheet<br>May 2017 revealed A<br>not administered duri<br>The eMAR dated May<br>200 MG was adminis<br>a.m. and at 3:52 p.m.<br>05/10/17 at 12:30 a.n  | MG and Ibuprofen 200 MG   |                    |                               |  |       |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |          |  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|---|---|--|---|----------|--|-------------------------------|----------------------------|--|
|   |   | 495407   | B. WING _                               |          |  |                               | C<br>/ <b>18/2017</b>      |  |
|   | ROVIDER OR SUPPLIER   | B CENTER   |   | 140 BRIN | ADDRESS, CITY, STATE, ZIP CODE MLEY DRIVE RICKSBURG, VA 22406  | 1 03/                         | 10/2017                    |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFI<br>TAG                      | (        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |  |
| F 281   | documented: "Ibuprof by mouth every 6 hou The eMARs for Resid 2017, February 2017, May 2017 were review Resident # 7's PRN p Acetaminophen and I The "Progress Notes' 01/02/2017 through 0 and failed to evidence pain medications of A Ibuprofen were clarific. The care plan for Residate of 06/26/14 and 04/25/2017 failed to eadministration of Resmedication of Acetam On 05/17/17 at 1:40 p conducted with LPN (5. When asked how pain medication shouthere is more than on stated, "If there are so (medications) there in the physician's order. I would get clarification giving the medication eMARs dated Januar and May 2017 and ph Resident # 7's PRN p was asked if there was | 200 MG was administered fen 200 MG. Give 2 tablets ars as needed for pain."  ent # 7 dated "January March 2017, April 2017 and wed and failed to evidence ain medications of buprofen were clarified.  If for Resident # 7 dated 5/13/2017 were reviewed at that Resident # 7's PRN cetaminophen and ed.  Ident # 7 with an initiation a revision date of evidence parameters for the ident # 7's PRN pain inophen and Ibuprofen.  In an interview was dicensed practical nurse) # t is determined what PRN and be administered when the prescribed LPN # 5 everal pain meds the edge to be a parameter on the physician before the edge of the edge o | F2                                      | 81       |  |                               |                            |  |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION  G   |           | OATE SURVEY<br>OMPLETED    |
|--------------------------|---|---|--------------------------|---|-----------|----------------------------|
|                          |   | 495407  | B. WING _                |   |           | C<br><b>05/18/2017</b>     |
|                          | ROVIDER OR SUPPLIER   | AB CENTER   |                          | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406            | •         | 33/13/2317                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 281                    | conducted with LPN determined what PR administered when the prescribed, LPN # 2 pain meds (medicating parameter on the physician before giving reviewing the eMARS March, April and May for Resident # 7's PF was asked if there with parameters. LPN # 2 parameters."  On 05/17/17 at 2:30 conducted with ASM member) # 2, the direct with the assistant direct multiple PRN pain mindow it is determined should be administer one prescribed, ASM clarified." After revied January, February, Mand physician's orde pain medications AS documentation of pa "There are no paramonal Con 05/17/17 at approximation of pa "There are no paramonal Con 05/17/17 at approximation and Assistant direct pain medications AS documentation of pa "There are no paramonal Con 05/17/17 at approximation and Assistant direct paramonal control of pa "There are no | p.m. an interview was # 2. When asked how it is N pain medication should be nere is more than one stated, "If there are several ons) there needs to be a ysician's order. If there are Id get clarification from the ng the medication." After s dated January, February, y 2017 and physician's orders RN pain medications LPN # 2 as documentation of 2 stated, "There are no  p.m. an interview was (administrative staff ector of nursing and ASM # tor of nursing regarding edications. When asked what PRN pain medication ed when there is more than I # 2 stated, "It should be wing the eMARs dated March, April and May 2017 rs for Resident # 7's PRN M # 2 was asked if there was rameters. ASM # 2 stated, eters."  pximately 5:00 p.m. ASM member) # 1 the SM # 2, director of nursing, | F 2                      | 81  |           |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION  G  |          | ATE SURVEY<br>OMPLETED     |
|--------------------------|---|--|---------------------|--|----------|----------------------------|
|                          |   | 495407   | B. WING             |  |          | C<br>05/18/2017            |
|                          | ROVIDER OR SUPPLIER   | B CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                 | <u> </u> | 3371072017                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 281                    | Continued From page   | e 32   | F 28                | 31   |          |                            |
|                          | alters brain function of<br>was obtained from th<br>http://www.ninds.nih.<br>y/encephalopathy.htr | gov/disorders/encephalopath<br>n.  |                     |  |          |                            |
|                          | the brain that control<br>hard for you to read,<br>mean to say) This inf<br>the website:          | by damage to the parts of language. It can make it write, and say what you formation was obtained from gov/medlineplus/aphasia.htm |                     |  |          |                            |
|                          | affect the brain. This from the website:  | ms caused by disorders that information was obtained gov/medlineplus/dementia.ht   |                     |  |          |                            |
|                          | obtained from the we  | re. This information was<br>bsite:<br>gov/medlineplus/highbloodpr  |                     |  |          |                            |
|                          | the esophagus and ir was obtained from th   | to leak back, or reflux, into ritate it. This information e website:   |                     |  |          |                            |
|                          | obtained from the we  | der. This information was<br>bsite:<br>gov/medlineplus/swallowingdi  |                     |  |          |                            |
|                          | blood vessels. It inclu   | em is the body's network of udes the arteries, veins and blood to and from the heart.  |                     |  |          |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|---|--|-----|---|-------------------------------|----------------------------|
|   |   |   | 7 50.25                                |     |   | (                             | С                          |
|   |   | 495407  | B. WING_                               |     |   | 05/                           | 18/2017                    |
|   | ROVIDER OR SUPPLIER  N NURSING AND REHA   | B CENTER  |  | 14  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>10 BRIMLEY DRIVE<br>REDERICKSBURG, VA 22406   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                     | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  |                               | (X5)<br>COMPLETION<br>DATE |
| F 281<br>F 282<br>SS=E  | called atherosclerosis vessels and block blo Weakened blood vessels bleeding inside the boobtained from the well https://www.nlm.nih.g ases.html.  SERVICES BY QUAL CARE PLAN  CFR(s): 483.21(b)(3)(1)(b)(3) Comprehensive The services provided as outlined by the commustation.  (ii) Be provided by quaccordance with each care.  This REQUIREMENT by:  Based on staff intervireview, and clinical redetermined that the fathe written plan of care. | thick and stiff, a problem  i. Blood clots can clog od flow to the heart or brain. sels can burst, causing ody.) This information was osite: ov/medlineplus/vasculardise  UFIED PERSONS/PER  (ii)  ie Care Plans d or arranged by the facility, inprehensive care plan,  alified persons in in resident's written plan of if is not met as evidenced iew, facility document cord review, it was acility staff failed to follow ie for five of 26 residents in esident #12, Resident #9, |  | 281 | 1. Resident #12, 1, 2 and 7's care pla has been reviewed for accuracy. Resident #9 no longer reside in the facility. Resident #1 MD was notified concerning not obtaining vital signs pricto medication administration.  2. All residents have the notential to be  | or                            | 6/22/17                    |
|   | of care for the admini-<br>Tylenol to Resident #<br>2. The facility staff fa<br>for offering non-pharm  | iled to follow the care plan<br>nacological interventions to<br>ne administration of PRN (as  |  |     | <ol> <li>All residents have the potential to be affected by this deficient practice.</li> <li>DON and or designee(s) will in-serv licensed nurses on following MD orders include obtaining parameters as ordere and on following care plans to include to fno-pharmacological interventions for pain and anti-anxiety medications.</li> </ol> | ice<br>s to<br>ed<br>use      |                            |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ' '               | PLE CONSTRUCTION  G  | (X3) DATE SURVEY<br>COMPLETED                               |
|--------------------------|---|---|---------------------|--|---|
|                          |   | 495407  | B. WING             |  | C   |
| NAME OF D                | OVIDED OD CLIDDLIED   | 495407  | B. WING             | CTDEET ADDRESS SITV STATE 7/D CODE   | 05/18/2017  |
| NAME OF PI               | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |   |
| FALLS RU                 | N NURSING AND REHA  | B CENTER  |                     | 140 BRIMLEY DRIVE  |   |
|                          |   |   |                     | FREDERICKSBURG, VA 22406   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | JLD BE COMPLETION   |
| F 282                    | Continued From page   | : 34  | F 28                | 32   |   |
|                          | of care for obtaining vorders for Resident #*  4. The facility staff fail of care to provide non interventions for pain administering pain me  5. The facility staff fail comprehensive plan of | led to follow the written plan apparamacological to Resident #2 before edications.  led to follow the of care to offer intervention for pain to                             |                     | 4. DON and or designee(s) will au residents receiving PRN pain medi and or anti-anxiety for use of non-pharmacological interventions medication administration 5x a wee weeks and then weekly for 8 week DON and or designee(s) will also a residents with medication paramete weekly for 4 weeks and then month months to ensure MD orders are for Results of audits will be taken to the committee x3 months for review ar revision as needed. | prior to ek for 4 s. audit 5 ers hly for 2 bllowed. le QAPI |
|                          | The findings include:   |   |                     |  |   |
|                          | Resident #12 was add<br>4/4/13 and readmitted<br>that included but were   | plan for prn (as needed) lent #12. mitted to the facility on d on 8/6/15 with diagnoses e not limited to: muscle chronic pain, heart disease                                |                     |  |   |
|                          | quarterly assessment<br>reference date) of 4/4<br>having scored 12 out<br>interview for mental s<br>was cognitively intact  | 6 (minimum data set), a<br>, with an ARD (assessment<br>/17 coded the resident as<br>of 15 on the BIMS (brief<br>tatus) indicating the resident<br>to make daily decisions. |                     |  |   |

|                          | ITATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTR |   | (X3) DATE SURVEY COMPLETED |   |         |                            |
|--------------------------|--|---|----------------------------|---|---------|----------------------------|
|                          |  | 495407  | B. WING                    |   |         | C<br><b>5/18/2017</b>      |
|                          | ROVIDER OR SUPPLIER  | 1   |                            | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                    | 1 0     | 3/10/2017                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHI<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
| F 282                    | revised on 1/26/17 d for painIntervention ordered, prn (as nee contact md (medical Review of the physic documented, "Tylend (Acetaminophen) Gin four hours for Breakt 7/14/2016."  Review of the May 2 administration record Tablet 325 MG (millig Give 325 mg by mou Breakthrough pain Further review of the documented that the every four hours eac #12's pain was rated 54 times out of 68 ordocumented as being resident did not report An interview was corpractical nurse) #5 owhen asked the pury #5 stated, "It's to ensachieve the resident" care plan should be "Yes. If a goal is not rethink that and adjuasked if the care plan as ordered, should the stated, "Yes."  An interview was corporative was corporated as ordered, should the stated, "Yes."   | ocumented, "Focus At risk as meds (medications) as ded) medications as needed. doctor) if ineffective."  ian's orders dated May 2017 of Tablet 325 MG (milligrams) as 325 mg by mouth every hrough pain. Order Date  017 MAR (medication of the documented, "Tylenol of the day of the month. Resident as "0" (indicating no pain) opportunities. The Tylenol was given even though the rit pain.  Inducted with LPN (licensed of the care plan, LPN of the best possible care to so goals." When asked if the followed, LPN #5 stated, achievable, then we have to set the care plan." When a stated to give medications are nurse follow that, LPN #5 | F 24                       | 32  |         |                            |
|                          |  | #4, on 5/17/17 at 1:28 p.m.<br>cose of the care plan, ASM   |                            |   |         |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | (X3) DATE SURVEY COMPLETED   |  |  |                   |  |
|---|---|--|--|--|-------------------|--|
|   |   | 495407   | B. WING _  |  | 05/18/2017        |  |
|   | ROVIDER OR SUPPLIER   |  | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406 |  | 1 00/10/2011      |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE COMPLETI |  |
| F 282   | #4 stated, "It's to pro<br>each resident." When<br>should be followed, A<br>On 5/17/17 at 5:15 p<br>member) #1, the adr   | e 36 vide individualized care to n asked if the care plan ASM #4 stated, "We should."  .m. ASM (administrative staff ninistrator and ASM #2, the ere made aware of the   | F 2  | 82   |                   |  |
|   | for offering non-phar<br>Resident #9 prior to<br>needed) Tylenol [1] a<br>Resident #9 was adr<br>4/10/17 with the diag<br>diabetes, high blood<br>depression, leg fract<br>cerebrovascular dise<br>(Minimum Data Set)<br>assessment with an<br>Reference Date) of 4<br>coded as being mod<br>ability to make daily<br>out of a possible 15 of<br>for Mental Status) ex<br>coded as requiring to<br>extensive assistance<br>hygiene; independer<br>and as incontinent of | mitted to the facility on moses of but not limited to pressure, anxiety, ure, stroke, and mase. The most recent MDS was the admission/5-day ARD (Assessment M17/17. The resident was erately cognitively impaired in life decisions, scoring an 8 con the BIMS (Brief Interview mam. The resident was otal care for bathing; of for transfers, dressing, and the for eating after set-up help; fowel and bladder.  all record revealed a med 4/14/17 for "Tylenol 325 we 2 tablet by mouth every 4 |  |  |                   |  |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '               | PLE CONSTRUCTION  IG  |           | X3) DATE SURVEY COMPLETED  |
|--------------------------|--|---|---------------------|---|-----------|----------------------------|
|                          |  | 495407  | B. WING _           |   |           | C<br><b>05/18/2017</b>     |
|                          | ROVIDER OR SUPPLIER  | AB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP COD<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406 | E         | 35/16/2011                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)     | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 282                    | A review of the April Administration Reconurses notes revealed administered the Tyl 4/15/17, 4/18/17, 4/18/17, and 4/28/17 non-pharmacological as having been offer identified administrative A review of the May with the nurses note administered the Tyl 5/1/17, 5/2/17, and 5/1/17, and 5/ | 2017 MAR (Medication rd), in conjunction with the ed Resident #9 was enol on the following dates: 9/17, 4/20/17, 4/26/17, 7. There were no I interventions documented ed for any of the above tions.  2017 MAR in conjunction is revealed Resident #9 was enol on the following dates: 6/15/17. There were no I interventions documented ed for any of the above tions.  plan revealed one for "Painto) pain to CVA (stroke)."  nitiated on 4/10/17. This care ervention, "Staff to attempt I interventions." This ated on 4/11/17. | F 2                 | ·   |           |                            |
|                          | A review of the April<br>Administration Reco<br>nurses notes reveale<br>administered the Xa<br>4/10/17, 4/13/17, 4/1<br>4/25/17, 4/27/17, an<br>non-pharmacologica   | 2017 MAR (Medication rd), in conjunction with the ed Resident #9 was nax on the following dates: 6/17, 4/18/17, 4/22/17, d 4/29/17. There were no I interventions documented ed for the administrations   |                     |   |           |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULT<br>A. BUILDIN   | IPLE CONSTRUCTION  NG |  | (X3) DATE SURVEY<br>COMPLETED    |                            |  |
|--|---|---|-----------------------|--|----------------------------------|----------------------------|--|
|  |   | 495407  | B. WING _             |  |                                  | C<br><b>05/18/2017</b>     |  |
|  | ROVIDER OR SUPPLIER   | B CENTER  |                       | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406 |                                  | ,                          |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE         | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |  |
| F 282  |   | e 38<br>/17, 4/1/17, 4/18/17, and   | F 2                   | 282  |                                  |                            |  |
|  | with the nurses notes<br>administered the Xan<br>5/1/17, 5/3/17, 5/6/17<br>5/11/17, and 5/16/17.<br>non-pharmacological   | 2017 MAR in conjunction revealed Resident #9 was ax on the following dates: , 5/7/17 (twice), 5/10/17, There were no interventions documented ad for administrations on |                       |  |                                  |                            |  |
|  | having an altering efficharacterized by prob<br>neuromuscular, gastr<br>evidenced by): anxiet<br>This care plan was in<br>plan included an inter<br>interventions such as | e of psychotropic drugs<br>ect on the mind  |                       |  |                                  |                            |  |
|  | interview with LPN #4<br>she stated that if the<br>non-pharmacological  | imately 2:00 p.m., in an I (Licensed Practical Nurse), care plan says to attempt interventions, and it wasn't were done, then the care I.                               |                       |  |                                  |                            |  |
|  |   | staff must be familiar with<br>Plan and all approaches  |                       |  |                                  |                            |  |
|  | Staff Member) the Ad  | m., ASM #1 (Administrative<br>ministrator, ASM #2 the<br>and ASM #3 the regional  |                       |  |                                  |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDIN   | IPLE CONSTRUCTION  IG | (X3) DATE SURVEY<br>COMPLETED  |           |                            |
|--|--|---|-----------------------|--|-----------|----------------------------|
|  |  | 495407  | B. WING _             |  |           | C<br>05/18/2017            |
|  | ROVIDER OR SUPPLIER  | AB CENTER   |                       | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406         | •         | 00/10/2017                 |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 282  |  | ervices were made aware of the the information was provided   | F 2                   | 82   |           |                            |
|  | pain. Information of https://medlineplus.itml  [2] Xanax is used to disorders. Informat https://medlineplus.itml  3. The facility staff for care for obtaining orders for Resident  Resident #1 was ad 12/23/10 with a receivith diagnoses that to: osteoporosis, pacongestive heart fai | treat anxiety and panic on obtained from gov/druginfo/meds/a684001.h ailed to follow the written plan vital signs per the physician   |                       |  |           |                            |
|  | assessment, with an of 2/27/17, coded the BIMS (brief interindicating the reside make daily decision requiring extensive staff members for trand personal hygier   | oS (minimum data set) n assessment reference date re resident as scoring a 14 on rview for mental) status score, rent was cognitively intact to s. The resident was coded as assistance of one or more ansfers, dressing, toileting ne. The resident was coded sion of one staff member for ne unit and eating. |                       |  |           |                            |

|                          | DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | I ' '               | PLE CONSTRUCTION  G  |                              | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|--|---------------------|--|------------------------------|-------------------------------|
|                          |   | 495407   | B. WING _           |  |                              | C<br><b>05/18/2017</b>        |
|                          | ROVIDER OR SUPPLIER   | AB CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CO 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406         | DE                           | 00/10/2017                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>E APPROPRIAT |                               |
| F 282                    | 2/22/17, documented resident has hyperted and CAD (coronary a "Interventions" documedications as orded doctor) with any side.  The physician order "Atenolol Tablet (use pressure (1)) 50 MG mouth one time a dathold for systolic BP 100 HR (heartrate) <li>The April 2017 MAR record) documented Give 1 tablet by mouth the physician order and the pressure (1) to th</li> | d in part, "Focus: The nsion (high blood pressure) artery disease), CHF." The mented in part, "Give red. Call MD (medical effects."  dated, 3/28/17, documented, ed to treat high blood (milligrams); Give 1 tablet by y related to Hypertension; (blood pressure) < (less than) (blood pressure) = (less than) (less than) (less than) (medication administration), "Atenolol Tablet 50 MG; (less than) (medication administration), | F 2                 | 82   |                              |                               |
|                          | record, did not docu  | the electronic medical<br>ment any heartrates in April<br>last documented heartrate  |                     |  |                              |                               |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |                   |     | (X3) DATE SURVEY<br>COMPLETED  |       |                            |
|--|---|---|-------------------|-----|--|-------|----------------------------|
|  |   | 495407  | B. WING           |     |  | 1     | C<br>18/2017               |
|  | ROVIDER OR SUPPLIER   |   |                   | 1   | STREET ADDRESS, CITY, STATE, ZIP CODE  40 BRIMLEY DRIVE FREDERICKSBURG, VA 22406                             | 1 05/ | 16/2017                    |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE |
| F 282  | Review of the nurse's 5/16/17, did not evide heartrate measureme. An interview was conpractical nurse) #5 or When asked the purp #5 stated, "It's to ensiachieve the resident's care plan should be free "Yes. If a goal is not a rethink that and adjust asked if the care plan as ordered, should the stated, "Yes."  An interview was constaff member (ASM) # When asked the purp #4 stated, "It's to prove each resident." When should be followed, A The facility policy, "Capart, "All direct care sunderstand and follow | e 41<br>notes from 3/28/17 through<br>ence any documentation of a                                     |                   | 282 | DEFICIENCY)  | TE    | DATE                       |
|  | this can be document changed if necessary  According to Fundam Williams and Wilkins documented, "A writte communication tool a members that helps careThe nursing ca  | entals of Nursing Lippincott<br>2007 pages 65-77<br>en care plan serves as a<br>mong health care team |                   |     |  |       |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | 1 ' '  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |   | (X3) DATE SURVEY COMPLETED |                            |
|--|--|--|---|---|---|----------------------------|----------------------------|
|  |  | 495407   | B. WING _                               |   |   |                            | C<br>18/2017               |
|  | ROVIDER OR SUPPLIER  | AB CENTER  | •                                       | STREET ADDRESS, C<br>140 BRIMLEY DRIVE<br>FREDERICKSBUR |   | ,                          |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                        | ID<br>PREFIX<br>TAG                     | (EACH C   | VIDER'S PLAN OF CORRECTION<br>CORRECTIVE ACTION SHOULD<br>EFERENCED TO THE APPROPE<br>DEFICIENCY) | BE                         | (X5)<br>COMPLETION<br>DATE |
| F 282  | Continued From pagand goals. It contains   | e 42<br>ns detailed instructions for   | F 2                                     | 82  |   |                            |                            |
|  | achieving the goals of and is used to direct   | established for the patient care."   |   |   |   |                            |                            |
|  | of nursing, and ASM  | strator, ASM #2, the director<br>#3, the regional director of<br>re made aware of the above<br>at 5:25 p.m.    |   |   |   |                            |                            |
|  | No further information   | n was provided prior to exit.  |   |   |   |                            |                            |
|  | of care to provide no  | n to Resident #2 before  |   |   |   |                            |                            |
|  | 07/02/14 with diagnorm not limited to: cerebri muscle weakness, p benign prostatic hyp   | flux disease (3), dysphagia  |   |   |   |                            |                            |
|  | set), a quarterly asse<br>(assessment referent<br>Resident # 2 as scor<br>interview for mental<br>- 15, 14 being cognit<br>decisions. Resident | status (BIMS) of a score of 0 ively intact for making daily # 2 was coded as requiring of one staff member for |   |   |   |                            |                            |
|  | # 2 dated May 2017 assessment every sl   | 's Order Sheet) for Resident<br>documented, "Pain<br>nift. Please assess and<br>nt's pain on a scale of 0      |   |   |   |                            |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |        | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|---------------------|--|--------|-------------------------------|--|
|                          |  | 495407  | B. WING             |  |        | C<br><b>5/18/2017</b>         |  |
|                          | ROVIDER OR SUPPLIER  IN NURSING AND REHA   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                       | , ,    | 9/10/2017                     |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 282                    | (zero) - (to) 10. 10 be (zero) being no pain. document on pain flor did to address pain. non-pharmacological pharmacological if ne "Hydrocodone-Acetar (five)-325 MG (milligr mouth every 6 (six) h Order Date: 07/21/20 [Tramadol] (7) Give 2 06 (six) hours as nee Date 06/30/2016."  The eMAR (electronic record) for Resident 4 documented, "Hydrocodone-Acetar (Tramadol] Give 2 06 (six) hours as needed folial fo | eing the worst pain and 0 If pain is indicated, w log as well as what you First intervention being second intervention being eded." minophen (6) Tablet 5 am). Give 1 (one) tablet by ours as needed for pain. 16." "Ultram Tablet 50 MG tablet [sic] by mouth every ded for severe pain. Order  c medication administration 2 dated "March 2017 codone-Acetaminophen (6) G (milligram). Give 1 (one) 6 (six) hours as needed for /21/2016." "Ultram Tablet 50 2 tablet [sic] by mouth every for severe pain. Order Date  eMAR dated March 2017 et 50 MG was not the month of March 2017 tetaminophen Tablet 5-325 d on the following dates and 05 a.m., 03/04/17 at 5:00 0 a.m., and 03/31/17 at 1:30 tet for each date ninophen Tablet 5-325 MG | F 282               |  |        |                               |  |

| AND DUAN OF CORRECTION IDENTIFICATION NUMBER |   | (X2) MULTI<br>A. BUILDIN   | PLE CONSTRUCTION  IG |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|--|----------------------|--|-------------------------------|----------------------------|
|  |   | 495407   | B. WING _            |  |                               | C<br>05/18/2017            |
|  | ND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |  |                      | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406     | •                             | 33.13.23.1                 |
| PRÉFIX                                       | (EACH DEFICIEN  | CY MUST BE PRECEDED BY FULL  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 282  | record) for Resident documented, "Hydrorablet 5 (five)-325 Mablet by mouth every pain. Order Date: 0 MG [Tramadol] (7) Gevery 06 (six) hours Order Date 06/30/20 Further review of the revealed Ultram Tabadministered during Hydrocodone-Aceta was administered or 04/16/17 at 3:03 a.m. The "eMAR Note" for Hydrocodone-Aceta was administered do"Hydrocodone-Aceta was administered do"Hydrocodone-Aceta Give 1 tablet by mouth of pain."  The eMAR (electrom record) for Resident documented, "Hydrocodone-Aceta documented, "Hydrocodone-Aceta (Tramadol) (7) Gevery 06 (six) hours Order Date 06/30/20 The eMAR dated Mathydrocodone-Aceta was administered or times: 05/01/17 at 2 a.m., 05/04/17 at 5:3 | # 2 dated "April 2017" codone-Acetaminophen (6) IG (milligram). Give 1 (one) ry 6 (six) hours as needed for 7/21/2016." "Ultram Tablet 50 Give 2 tablet [sic] by mouth as needed for severe pain. 016."  e eMAR dated April 2017 let 50 MG was not the month of April 2017 and minophen Tablet 5-325 MG in the following dates: in, 04/31/17 at 10:00 a.m. or each date the minophen Tablet 5-325 MG coumented, aminophen Tablet 5-325 MG or the every 6 hours as needed  ic medication administration # 2 dated "May 2017" codone-Acetaminophen (6) IG (milligram). Give 1 (one) ry 6 (six) hours as needed for 7/21/2016." "Ultram Tablet 50 Give 2 tablet [sic] by mouth as needed for severe pain. 016."  ay 2017 revealed minophen Tablet 5-325 MG in the following dates and codo a.m., 05/02/17 at 3:40 and a.m., 05/09/19 at 5:25 at 5:11 a.m. The "eMAR | F 2                  | 82   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                     | (X3) DATE SURVEY<br>COMPLETED   |   |                            |
|--|---|--|---------------------|---|---|----------------------------|
|  |   | 495407   | B. WING             |   |   | C<br>5/18/2017             |
|  | ROVIDER OR SUPPLIER  JN NURSING AND REHA  | B CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406                            | • | 0/10/2011                  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |   | (X5)<br>COMPLETION<br>DATE |
| F 282  | was administered dor "Hydrocodone-Acetal Give 1 tablet by mout for pain."  The eMAR dated Mar Tablet 50 MG was ad dates and times: 05/ 05/12/17 at 5:40 a.m. date above documen Give 2 tablet [sic] by needed for severe par  Further review of the dated March 2017 the evidence documentar interventions prior to Hydrocodone-Acetan  The "Progress Notes 03/02/2017 through 0 and failed to evidence non-pharmacological administration of Hydrocodone The care plan for Res date of 03/16/2017 do Resident has risk for (cerebral vascular dis Osteoarthritis. Recei needed) pain medica 07/18/2014. Revision "Interventions" it docu for probable cause of | ninophen Tablet 5-325 MG cumented, minophen Tablet 5-325 MG. ch every 6 hours as needed  y 2017 revealed Ultram ministered on the following 11/17 at 5:10 a.m. and The "eMAR Note" for each ted, "Ultram Tablet 50 MG. mouth every 06 hours as in."  eMARs for Resident # 2 rough May 2017 failed to tion of non-pharmacological the administration of ninophen and Ultram.  "for Resident # 2 dated 15/16/2017 were reviewed the documentation of interventions prior to the rocodone-Acetaminophen  sident # 2 with a revision focumented, "Focus: pain r/t (related to) CVA tease), Osteoporosis and the ves routine and prn (as tions. Date initiated: n on: 03/16/2017." Under transport of the transport | F 2                 | 82  |   |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | I ' '  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | (X3) DATE SURVEY COMPLETED            |                            |
|--|--|--|---|---|---------------------------------------|----------------------------|
|  |  | 495407   | B. WING                                 |   |                                       | C<br>05/18/2017            |
|  | ROVIDER OR SUPPLIER  | AB CENTER  |   | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406                | · · · · · · · · · · · · · · · · · · · | 33/10/2017                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                             | (X5)<br>COMPLETION<br>DATE |
| F 282  | conducted with LPN 5. When asked to care plan LPN # 5 shave different interverse. You should for reviewing the May 2 (POS), care plan wire 03/16/2017, the Mat MARs and progress through 05/16/2017 was asked if the wrifor the use of non-prior to the administ medication. LPN # followed."  On 05/17/17 at 2:00 conducted with LPN describe the purposstated, "It's specific goals and intervention to take care of them would follow it." Afticare plan with a rev March, April, and Minotes dated 03/02/2 Resident # 2, LPN # plan of care was foll non-pharmacological administration of Prostated, "No it wasn't Con 05/17/17 at 2:30 conducted with ASM member) # 2, the di 4, the assistant dire written plan of care | p.m. an interview was (licensed practical nurse) # escribe the purpose of the tated, "To reach goals. You entions for the resident's llow the interventions." After 017 physician order sheet th a revision date of rch, April, and May 2017 notes dated 03/02/2017 for Resident # 2, LPN # 5 tten plan of care was followed narmacological interventions ration of PRN pain 5 stated, "No it wasn't  p.m. an interview was # 2. When asked to e of the care plan LPN # 2 to each patient, what their ons are and how we are going . If it's on the care plan I er reviewing May 2017 POS, sion date of 03/16/2017, the ay 2017 MARs and progress 017 through 05/16/2017 for £ 2 was asked if the written owed for the use of all interventions prior to the EN pain medication. LPN # 2 | F 24                                    | 32  |                                       |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION  G |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|---|---------------------|---|-------------------------------|----------------------------|
|  |  | 495407  | B. WING _           |   |                               | C<br><b>05/18/2017</b>     |
|  | ROVIDER OR SUPPLIER  | AB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406              | •                             | 00/10/2017                 |
| (X4) ID<br>PREFIX<br>TAG   |  |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 282  | resident." After revicare plan with a revimarch, April, and Manotes dated 03/02/2 Resident # 2, ASM aplan of care was foll non-pharmacological administration of Prostated, "No it wasn't the facility's policy, part, "All direct care understand and follow IF unable to implem your Charge Nurse of this can be documented, "D. All each resident's Care must be implemented to 15/17/17 at appropriate the implemented on 05/17/17 at appropriate the implemented o | know how to take care of the ewing the May 2017 POS, sion date of 03/16/2017, ay 2017 MARs and progress 017 through 05/16/2017 for \$\frac{1}{2}\$ was asked if the written owed for the use of all interventions prior to the taken pain medication. ASM \$\# 2\$ followed."  "Care Plan" documented in staff must always know, ow their Resident's Care Plan. eent any part of the plan, notify or MDS coordinator, so that inted or the Care Plan by. The policy further staff must be familiar with the Plan and all approaches ed."  **Coximately 5:00 p.m. ASM member) \$\# 1\$ the SM \$\# 2\$, director of nursing, | F 2                 | 82  |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIF   | PLE CONSTRUCTION  G | COMF  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|--|---|---------------------|---|-------------------------------|----------------------------|--|
|  |  | 495407  | B. WING             |   |                               | C<br>/ <b>18/2017</b>      |  |
|  | ROVIDER OR SUPPLIER  | AB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406            |                               |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE /<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |  |
| F 282  | Continued From pag   | ge 48   | F 28                | 32  |                               |                            |  |
|  | obtained from the we https://www.nlm.nih. statebph.html.  3. Stomach contents the esophagus and i was obtained from the https://www.nlm.nih.  4. A swallowing disco obtained from the we https://www.nlm.nih. sorders.html.  5. High blood pressu obtained from the we https://www.nlm.nih. essure.html.  6. Hydrocodone is a other ingredients, ar products are prescril hydrocodone combin relieve moderate-to-hydrocodone combin relieve cough. Hydromedications called of and in a class of me Hydrocodone relieve | gov/medlineplus/enlargedpro  s to leak back, or reflux, into irritate it. This information ne website: gov/medlineplus/gerd.html.  rder. This information was ebsite: gov/medlineplus/swallowingdi  ure. This information was ebsite: gov/medlineplus/highbloodpr  vailable in combination with nd different combination bed for different uses. Some nation products are used to |                     |   |                               |                            |  |
|  | Hydrocodone relieve<br>activity in the part of<br>coughing. This infor<br>the website:   | es cough by decreasing the brain that causes mation was obtained from gov/druginfo/meds/a601006.h   |                     |   |                               |                            |  |

|                          | MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING                |   | (X3) DATE SURVEY COMPLETED |   |                        |
|--------------------------|---|---|----------------------------|---|------------------------|
|                          |   | 495407  | B. WING                    |   | C<br><b>05/18/2017</b> |
|                          | ROVIDER OR SUPPLIER   | AB CENTER   |                            | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406  | 1 00/10/2017           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH CONSIDERATION SHOUTH APPORT OF THE APPORT | OULD BE COMPLETION     |
| F 282                    | 7. Used to relieve m severe pain. This interest the website:  | e 49 oderate to moderately formation was obtained from ov/druginfo/meds/a695011.ht  | F 28                       | 32  |                        |
|                          | 5. The facility staff facomprehensive plan non-pharmacologica Resident #7 prior to medications.   | of care to offer<br>I intervention for pain to  |                            |   |                        |
|                          | 05/01/14 with diagnorm not limited to: enception weakness, depression   |   |                            |   |                        |
|                          | set), a quarterly asse<br>(assessment referen<br>Resident # 7 as scor<br>interview for mental :<br>- 15, 13 being cognit<br>decisions. Resident | recent MDS (minimum data essment with an ARD ce date) of 03/22/17, coded ing a 13 on the brief status (BIMS) of a score of 0 ively intact for making daily # 7 was coded as requiring up help for activities of daily |                            |   |                        |
|                          | # 7 dated May 2017 "Acetaminophen (8) Give 650 MG orally ( as needed for pain. (greater than) 109. I  | ds Order Sheet) For Resident documented, 325 MG (milligram) Tablet. by mouth) every 6 (six) hours As needed for pain or fever > Date Ordered: 09/10/2014." D MG. Give 2 (two) tablet                                  |                            |   |                        |

|                          | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING   |   | (X3) DATE SURVEY COMPLETED |  |                        |
|--------------------------|--|---|----------------------------|--|------------------------|
|                          |  | 495407  | B. WING                    |  | C<br><b>05/18/2017</b> |
|                          | ROVIDER OR SUPPLIER  | HAB CENTER  |                            | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                     | 03/16/2017             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEI   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION          |
| F 282                    | pain. Date Ordered The eMAR (electro record) for Resident documented the ab Review of the eMA revealed Acetamina administered on: 0° at 1:40 a.m., 01/26,7:58 a.m., 01/30/17 11:01 p.m. The "eM time Acetaminophe as documented, "A Give 650 MG orally pain. As needed for 109."  The eMAR dated Jalbuprofen 200 MG at 2:15 a.m., 01/05,5:50 a.m., 01/16/17 12:01 a.m., 01/26/11 12:55 a.m. and 01/2 "eMAR Note" for ea 200 MG was adminated The eMAR (electro record) for Resident documented the ab physician order she dated February 20° 325 MG was adminam., 02/07/17 at 1° p.m., 02/11/17 at 15. | y 6 (six) hours as needed for d: 07/21/2016."  nic medication administration at # 7 dated "January 2017 bove medication orders. R dated January 2017 ophen 325 MG was 1/07/17 at 2:49 a.m., 01/22/17 //17 at 9:263 p.m., 01/29/17 at 7 at 2:09 a.m., and 01/30/17 at 1/4RR Note" for each date and an 325 MG was administered cetaminophen 325 MG Tablet. A every 6 hours as needed for or pain or fever > (greater than)  anuary 2017 revealed was administered on: 01/04/17 //17 at 11:50 p.m., 01/07/17 at 7 at 12:02 a.m., 01/28/17 at 29/17 at 12:12 a.m. The ach date and time Ibuprofen histered documented, . Give 2 tablets by mouth | F 28                       | 2  |                        |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | 1 ' '   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |       |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|---|---|-------|--|-------------------------------|----------------------------|
|  |  | 495407  | B. WING _                               |       |  |                               | C<br><b>18/2017</b>        |
|  | ROVIDER OR SUPPLIER  | AB CENTER   |   | 140 E | BRIMLEY DRIVE DERICKSBURG, VA 22406  | 1 00/                         | 10/2017                    |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | <     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 282  | 1:09 a.m. The "eMA time Acetaminophen as documented, "Ace Give 650 MG orally epain. As needed for 109."  | e 51 17 at 10:48 a.m., 02/22/17 at R Note" for each date and 325 MG was administered etaminophen 325 MG Tablet. every 6 hours as needed for pain or fever > (greater than)  oruary 2017 revealed as administered on: 02/21/17   | F2                                      | 282   |  |                               |                            |
|  | at 11:43 p.m., 02/22/p.m., 02/23/17 at 11:<br>a.m. The "eMAR No<br>Ibuprofen 200 MG wandocumented, "Ibupro<br>by mouth every 6 ho  | 17 at 3:41 p.m. and at 11:44 31 p.m., and 02/26/17 1:00 te" for each date and time as administered fen 200 MG. Give 2 tablets urs as needed for pain."  c medication administration # 7 dated "March 2017   |   |       |  |                               |                            |
|  | Acetaminophen 325 to be administered as physician order sheet March 2017 revealed was not administered 2017. The eMAR da Ibuprofen 200 MG wat 12:06 p.m., 03/02/1:26 a.m. and at 11:0 a.m., 03/16/17 at 6:5 03/17/17 at 1:42 p.m 03/22/17 at 4:38 p.m and 03/29/17 at 3:20 each time Ibuprofen documented: "Ibuprofen by mouth every 6 hor | MG and Ibuprofen 200 MG is documented on the tabove. The eMAR dated did Acetaminophen 325 MG diduring the month of March ted March 2017 revealed as administered on: 03/01/17 17 at 12:50 a.m., 03/12/17 at 15 p.m., 03/14/17 at 7:22 9 a.m. and at 2:08 p.m., ., 03/18/17 at 12:34 a.m., ., 03/24/17 at 11:36 a.m., a.m. The "eMAR Note" for 200 MG was administered fen 200 MG. Give 2 tablets urs as needed for pain." |   |       |  |                               |                            |

|                          | DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '               | PLE CONSTRUCTION  G   | ' '    | TE SURVEY<br>MPLETED       |
|--------------------------|--|--|---------------------|---|--------|----------------------------|
|                          |  | 495407   | B. WING             |   |        | C<br>5/40/2047             |
|                          | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                      | 1 0    | 5/18/2017                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY) | ULD BE | (X5)<br>COMPLETION<br>DATE |
| F 282                    | documented, docum Acetaminophen 325 to be administered a physician order sheed April 2017 revealed not administered dur The eMAR dated Ap 200 MG was adminip.m., 04/07/17 at 8:3 04/12/17 at 4:05 a.m 04/23/17 at 11:43 a. The "eMAR Note" for MG was administered 200 MG. Give 2 tab as needed for pain."  The eMAR (electron record) for Resident documented the phy Acetaminophen 325 to be administered aphysician order sheed May 2017 revealed anot administered dur The eMAR dated May 2017 revealed anot administered dur The eMAR dated May 2017 revealed anot administered dur The eMAR dated May 2017 revealed anot administered dur The eMAR dated May 2017 revealed and 05/12/17 at 7:56 each time Ibuprofen documented: "Ibuprofen documented: "I | # 7 dated "April 2017 lented the physician order for MG and Ibuprofen 200 MG as documented on the et above. The eMAR dated Acetaminophen 325 MG was ring the month of April 2017. In 2017 revealed Ibuprofen stered on: 04/05/17 at 6:49 32 a.m.,04/08/17 at 6:46 a.m., m., 04/18/17 at 8:38 p.m., m., and 04/25/17 at 9:38 p.m. or each time Ibuprofen 200 ad documented: "Ibuprofen lets by mouth every 6 hours ic medication administration # 7 dated "May 2017 resician order for MG and Ibuprofen 200 MG as documented on the et above. The eMAR dated Acetaminophen 325 MG was ring the month of May 2017. ay 2017 revealed Ibuprofen stered on: 05/06/17 at 2:54 n., 05/07/17 at 12:30 a.m., m.,05/11/17 at 11:54 a.m., 5 a.m. The "eMAR Note" for 200 MG was administered often 200 MG. Give 2 tablets ours as needed for pain." | F 2                 | 82  |        |                            |
|                          | May 2017 were review documentation of no   | ewed and failed to evidence<br>on-pharmacological  |                     |   |        |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST A. BUILDING  A. BUILDING |  |  |                     |  | LETED   |       |                            |
|--|--|--|---------------------|--|---|-------|----------------------------|
|  |  | 495407   | B. WING _           |  |   | 1     | C<br><b>18/2017</b>        |
|  | ROVIDER OR SUPPLIER  | B CENTER   |                     | STREET ADDRESS, CIT  140 BRIMLEY DRIVE  FREDERICKSBURG |   | , 00. | 10/2011                    |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CC   | DER'S PLAN OF CORRECTION<br>DRRECTIVE ACTION SHOULD B<br>FERENCED TO THE APPROPRIA<br>DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE |
| F 282  | on/02/2017 through of and failed to evidence non-pharmacological administration of Ace.  The care plan for Residucemented, "Focus has dx (diagnosis) Codisease) with hemipa (gastroesophageal reco6/26/14. Revision of "Interventions" it door (pharmacological) intwith positioning for co6/26/14."  On 05/17/17 at 1:40 conducted with LPN 5. When asked to decare plan, LPN # 5 sthave different intervecare. You should foll reviewing the care plo3/16/2017, the MAR 2017, and May 2017 dated 03/02/2017 thr Resident # 7, LPN # was followed for the interventions prior to pain medication. LPI followed."  On 05/17/17 at 2:00 conducted with LPN 5. | the administration of Ibuprofen.  "for Resident # 7 dated 05/13/2017 were reviewed e documentation of interventions prior to the taminophen and Ibuprofen.  sident # 7 dated 06/26/14 the At risk for pain. Resident WA (cerebral vascular aresis and GERD effux disease). Date Initiated: on 04/25/2017." Under umented, "Non pharm derventions such as assist comfort. Date Initiated:  p.m. an interview was (licensed practical nurse) # describe the purpose of the stated, "To reach goals. You entions for the resident's ow the interventions." After an with a revision date of the stated March 2017, April and the progress notes ough 05/16/2017 for 5 was asked if the care plan use of non-pharmacological the administration of PRN N # 5 stated, "No it wasn't | F2                  | 82   |   |       |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` ′  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|--|--|-------------------------------|----------------------------|
|   |  | 495407   | B. WING _                              |  |                               | C<br><b>5/18/2017</b>      |
|   | ROVIDER OR SUPPLIER  JN NURSING AND REHA   | B CENTER   | •                                      | STREET ADDRESS, CITY, STATE, ZIP COD<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406      |                               |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CC<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETION<br>DATE |
| F 282   | stated, "It's specific to goals and intervention to take care of them. would follow it." After a revision date of 03/March 2017, April 20 progress notes dated 05/16/2017 for Residif the care plan was for non-pharmacological administration of PRN stated, "No it wasn't for the assistant direct care plan for Resident describe the purpose stated, "To know how resident." After revier revision date of 03/16/March 2017, April 20 progress notes dated 05/16/2017 for Residif the care plan was for non-pharmacological administration of PRN stated, "No it wasn't for the care plan was for non-pharmacological administrative staff in administrator, and AS were made aware of | ne each patient, what their ns are and how we are going If it's on the care plan I reviewing the care plan with 16/2017, the MARs dated 17, and May 2017 and the 03/02/2017 through ent # 7, LPN # 2 was asked collowed for the use of interventions prior to the N pain medication. LPN # 2 collowed."  o.m. an interview was (administrative staff ector of nursing and ASM # cor of nursing regarding the out # 2. When asked to of the care plan ASM # 2 to take care of the wing the care plan with a 6/2017, the MARs dated 17, and May 2017 and the 03/02/2017 through ent # 7, ASM # 2 was asked collowed for the use of interventions prior to the N pain medication. ASM # 2 ollowed."  eximately 5:00 p.m. ASM nember) # 1 the SM # 2, director of nursing, | F 2                                    | 82   |                               |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ' '              |         | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|--------------------|---------|---|-------------------------------|----------------------------|
|   |  | 495407  | B. WING            | B. WING |   | C<br><b>05/18/2017</b>        |                            |
|   | ROVIDER OR SUPPLIER  | L   | -                  | s<br>1  | TREET ADDRESS, CITY, STATE, ZIP CODE  40 BRIMLEY DRIVE  REDERICKSBURG, VA 22406                                       | 1 05/                         | 10/2017                    |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 282   | alters brain function of was obtained from the http://www.ninds.nih.gy/encephalopathy.htm  2. A disorder caused the brain that control hard for you to read, mean to say). This infit the website: https://www.nlm.nih.gu  3. A group of symptor affect the brain. This from the website: https://www.nlm.nih.gu  4. High blood pressur obtained from the we https://www.nlm.nih.gu essure.html.  5. Stomach contents the esophagus and in was obtained from the https://www.nlm.nih.gu 6. A swallowing disord obtained from the we https://www.nlm.nih.gu sorders.html.  7. The vascular syste blood vessels. It include capillaries that carry the system of the system of the carry the system of the carry | se disease of the brain that or structure. This information e website: gov/disorders/encephalopath n.  by damage to the parts of language. It can make it write, and say what you formation was obtained from ov/medlineplus/aphasia.htm  ms caused by disorders that information was obtained  ov/medlineplus/dementia.ht  re. This information was bsite: ov/medlineplus/highbloodpr  to leak back, or reflux, into ritate it. This information e website: ov/medlineplus/gerd.html.  der. This information was | F                  | 282     |   |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |         |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|---|---|---------|--|-------------------------------|----------------------------|
|  |   | 405407  |   | B. WING |  |                               | С                          |
| NAME OF D  | ROVIDER OR SUPPLIER   | 495407  | B. WING                                 |         | REET ADDRESS, CITY, STATE, ZIP CODE  | 05/                           | 18/2017                    |
|  | IN NURSING AND REHA   | B CENTER  |   | 140     | BRIMLEY DRIVE EDERICKSBURG, VA 22406   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                      |         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 282  | vessels and block blo<br>Weakened blood ves<br>bleeding inside the bo<br>obtained from the we   | s. Blood clots can clog<br>ood flow to the heart or brain.<br>sels can burst, causing<br>ody.) This information was   | F                                       | 282     |  |                               |                            |
| F 309<br>SS=E                                    | WELL BEING CFR(s): 483.24, 483.  483.24 Quality of life Quality of life is a fun- applies to all care and residents. Each resid facility must provide t services to attain or in practicable physical, well-being, consistent comprehensive asses  483.25 Quality of care Quality of care is a fur applies to all treatment facility residents. Base assessment of a resid that residents receive accordance with profe practice, the compreh care plan, and the resident improvided to the  (k) Pain Management The facility must ensu provided to residents consistent with profess | damental principle that d services provided to facility dent must receive and the he necessary care and haintain the highest mental, and psychosocial t with the resident's esment and plan of care.  e Indamental principle that hat and care provided to ed on the comprehensive dent, the facility must ensure tereatment and care in essional standards of hensive person-centered sidents' choices, including following: | F                                       | 309     |  |                               | 6/22/17                    |

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION  | (1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | l ` ′               | IPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED   |                            |
|--|---|---------------------|--|---------------------------------|----------------------------|
|  | 495407  | B. WING             |  | 05/°                            | C<br>18/2017               |
| NAME OF PROVIDER OR SUPPLIER  FALLS RUN NURSING AND REHAB O  | CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406   |                                 |                            |
| PREFIX (EACH DEFICIENCY M  | EMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>C IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)   |                                 | (X5)<br>COMPLETION<br>DATE |
| of practice, the compreh care plan, and the reside preferences. This REQUIREMENT is by: Based on observation, document review, clinical course of a complaint in determined that the facility the necessary care and maintain the highest lever for five of 26 residents in Residents #14, #6, #9, #1.a. The facility staff failed #14's physician ordered pressure medications or 2/8/17 at 1:04 a.m., the was documented as 161 to administer as needed medication per physician b. The facility staff failed ordered gabapentin (use metronidazole (an antibic medication) to Resident 2/7/17 and failed to admizolpidem to the resident 2/8/17. All the medication | must ensure that ialysis receive such h professional standards hensive person-centered lents' goals and s not met as evidenced staff interview, facility al record review and in the nvestigation it was ility staff failed to provide services to attain or rel of physical well-being n the survey sample, #2 and #7.  led to administer Resident d scheduled blood n 2/7/17 at 8:00 p.m. On resident's blood pressure 1/93 and the nurse failed d blood pressure in's orders.  d to administer physician ed to treat neuropathy), siotic) and zolpidem ( sleep t #14 during the night of ninister physician ordered t during the night of ons were present in the e) box (a box in the facility edications).  d to follow the specialist | F3                  | 1. Resident #14 and resident #9 no longer resides in the facility. Resident #6's KUB has been obtained and MD notified. Resident #2, and #7's care p were reviewed for accuracy.  2. All residents have the potential to be affected by this deficient practice.  3. DON and or designee(s) will in-ser licensed nurses on the policy for medication availability, including MD notification. DON and or designee(s) also in-service licensed nurses on following MD orders and care plans to include following non-pharmacological interventions for pain and anti-anxiety medications.  4. DON and or designee(s) will audit residents receiving PRN pain medicat for use of non-pharmacological interventions prior to medication administration. 5x a week for 4 weeks then weekly for 8 weeks. DON and or designee(s) will also audit 5 residents medication parameters weekly for 4 weeks and then monthly for 2 months ensure MD orders are followed. Resu of audits will be taken to QAPI commit | lans e vice will on and with to |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIF  | PLE CONSTRUCTION  G |   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|--|--|---------------------|---|-------------------------------|----------------------------|--|
|  |  | 495407   | B. WING             |   |                               | C<br>05/18/2017            |  |
|  | ROVIDER OR SUPPLIER  | AB CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP COL<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406     |                               | 30, 10, 20 11              |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETION<br>DATE |  |
| F 309  | administration of PR Resident #9.  4. The facility staff f non-pharmacologica administration of PR medication for Resid physician.  5. The facility staff f non-pharmacologica administration of PR medication for Residual medication for Residual for Residual for the findings include  1.a. The facility staff #14's physician order pressure medication 2/8/17 at 1:04 a.m., was documented as to administer as neemedication per physical for the findings include  Resident #14 was a 2/7/17 and discharge #14's diagnoses included acute cholecystitis (major depressive disday Medicare assessive disday medicare | railed to offer al interventions prior to the til (as needed) Tylenol for railed to implement al interventions prior to the til (as needed) pain dent # 2 as ordered by the railed to implement al interventions prior to the til (as needed) pain dent # 7.  Failed to administer Resident as on 2/7/17 at 8:00 p.m. On the resident's blood pressure 161/93 and the nurse failed aded blood pressure rician's orders.  Idmitted to the facility on the ded on 2/14/17. Resident and the ded blood pressure and the til (as needed) pressure an | F 30                | ,   |                               |                            |  |
|  | an admission asses   | #14's clinical record revealed sment dated 2/7/17 that ident arrived to the facility on  |                     |   |                               |                            |  |

|                          | DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ` ′               | PLE CONSTRUCTION  G   |        | OATE SURVEY OMPLETED       |
|--------------------------|--|--|---------------------|---|--------|----------------------------|
|                          |  | 495407   | B. WING             |   |        | C<br><b>05/18/2017</b>     |
|                          | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                      | ı      | 03/10/2017                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPE<br>DEFICIENCY) | ULD BE | (X5)<br>COMPLETION<br>DATE |
| F 309                    | Continued From pag   | ge 59  | F 30                | 09  |        |                            |
|                          | documented orders including but not lim - Verapamil (1) 120 bedtime (scheduled pressure - Candesartan (2) 4 times a day (schedup.m.) for high blood - Clonidine (3) 0.1 m 24 hours as needed Give one daily for a greater than 160 Review of Resident (medication administresident was not adip.m. dose of Verapa (as evidenced by an MAR).  On 2/8/17 at 1:04 a. pressure was documeview of Resident # 1:04 a. pressure was documeview of Resident # 1:04 a. pressure was documented the nurse of clonidine.  Resident # 14's compon 2/8/17 failed to diregarding medicatio pressure.  On 5/17/17 at 3:05 p | mg- one capsule by mouth at at 8:00 p.m.) for high blood mg- one tablet by mouth two led at 8:00 a.m. and 8:00 pressure g- one tablet by mouth every for high blood pressure. systolic blood pressure #14's February 2017 MAR tration record) revealed the ministered the scheduled 8:00 mil or Candesartan on 2/7/17 "x" documented on the  m. Resident #14's blood nented as 161/93. Further enter as 161/93. |                     |   |        |                            |
|                          | (the nurse responsite Verapamil and Cano 2/7/17 at 8:00 p.m.).   | (licensed practical nurse) #1 ble for administering lesartan to Resident #14 on LPN #1 stated the moment led she takes paperwork from  |                     |   |        |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | ` '   | PLE CONSTRUCTION  G  |  | (X3) DATE SURVEY<br>COMPLETED  |                            |  |
|---|--|---|--|--|--------------------------------|----------------------------|--|
|   |  | 495407  | B. WING  |  |                                | C<br><b>05/18/2017</b>     |  |
|   | ROVIDER OR SUPPLIER  IN NURSING AND REHA   | AB CENTER   | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406 |  |                                | 33, 13, 23 11              |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENC | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |  |
| F 309   | orders to the pharma the pharmacy to sen- (immediately) on the pharmacy usually do STAT so if a resident medication then she they received the fax times, she does not of the orders are placed automatically go to the shown Resident #14 and asked what show systolic blood pressor #1 stated she would the resident had rece 24 hours and if not so clonidine. LPN #1 st physician if she could (Note- review of Res MAR failed to reveal administered clonidin  The nurse who docum pressure as 161/93 w interview.  On 5/17/17 at 5:30 p staff member) #1 (the (the director of nursind director of clinical sen the above findings. In physician's orders wa stated the facility did policy. | ople, faxes the physician's acy and writes a request for d the medications STAT fax. LPN #1 stated the es not send the medications is prescribed a narcotic pain calls the pharmacy to see if a. LPN #1 stated most other call the pharmacy because d in the computer and should the pharmacy. LPN #1 was as clonidine physician's order all be done if the resident's are is greater than 160. LPN check the computer to see if the evould administer ated she would call the donot administer ated she would call the donot administer clonidine. In the resident was the on 2/7/17).  The mented Resident #14's blood was not available for the eadministrator, ASM #2 and ASM #3 (the regional rivices) were made aware of A policy for following as requested. ASM #3 not have the requested in was presented prior to exit. | F 30   | 09   |                                |                            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                | TIPLE CONSTRUCTION  | 1, ,                             | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--------------------|---|----------------------------------|-------------------------------|--|
|  | 495407   | B. WING            |   | 0.5                              | C<br>5/18/2017                |  |
| NAME OF PROVIDER OR SUPPLIER  FALLS RUN NURSING AND REHA   |  | -                  | STREET ADDRESS, CITY, STATE, ZIP C 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406 |                                  | 10/2017                       |  |
| PREFIX (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |   | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| This information was https://medlineplus.g tml  (2) "Candesartan is u with other medication pressure" This info the website: https://medlineplus.g tml  (3) Clonidine is used This information was https://www.ncbi.nlm T0009680/?report=d  COMPLAINT DEFIC  b. The facility staff fa ordered gabapentin zolpidem (3) to Resid 2/7/17 and failed to a zolpidem to the resid 2/8/17. All the medic facility STAT box (a brown contains various medical and admission assess documented the residecumented the residecumented orders fincluding but not limited. | trol angina (chest pain)." s obtained from the website: gov/druginfo/meds/a684030.h  used alone or in combination ins to treat high blood formation was obtained from gov/druginfo/meds/a601033.h  It to treat high blood pressure. It is obtained from the website: Inih.gov/pubmedhealth/PMH Idetails  IENCY  It is a daminister physician (1), metronidazole (2) and Ident #14 during the night of Identifications were present in the Idetail obey in the facility that Idications).  If 14's clinical record revealed Is sement dated 2/7/17 that Ident arrived to the facility on  It ician's orders dated 2/7/17 In the following medications | F                  | 309   |                                  |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  | (X3) DATE SURVEY COMPLETED   |                     |   |                        |  |
|---|--|--|---------------------|---|------------------------|--|
|   |  | 495407   | B. WING             |   | C<br><b>05/18/2017</b> |  |
|   | ROVIDER OR SUPPLIER  JN NURSING AND REH  | AB CENTER  | 1                   | STREET ADDRESS, CITY, STATE, ZIP CODE 40 BRIMLEY DRIVE FREDERICKSBURG, VA 22406                                   |                        |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETION          |  |
| F 309   | three times a day (sp.m. and 10:00 p.m. and 10:00 p | mg- one tablet by mouth accheduled at 6:00 a.m., 2:00 a.)  me tablet by mouth at bedtime p.m.)  #14's February 2017 MAR stration record) revealed the ministered the scheduled at the above medications on ad by an "x" documented on review of the MAR revealed not administered on 2/8/17. A 2/8/17 documented, "Zolpidem at 1 tablet by mouth at bedtime macy needing script for one failed to document 14's physician was contacted.  Ty STAT box lists revealed the gabapentin metronidazole available in the STAT box. | F 309               |   |                        |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | 1 ' '   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|---|-----|---|-------------------------------|----------------------------|
|   |  | 495407  | B. WING                                 |     |   | 1                             | C<br><b>18/2017</b>        |
| NAME OF PI  | ROVIDER OR SUPPLIER  |   |   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  | 1 03/                         | 10/2017                    |
| FALLS RU  | IN NURSING AND REHA  | B CENTER  |   |     | 40 BRIMLEY DRIVE<br>REDERICKSBURG, VA 22406   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                      |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 309   | Continued From page  | e 63  | F:                                      | 309 |   |                               |                            |
| 1 309   | regarding the zolpide above note. LPN #3 administered to Reside a hard prescription with pharmacy to deliver the stated if a medication then she contacts the in this case the pharmachem the she contacts the in this case the pharmachem the she looks for the preschart and if a prescript contacts the physicial contacted the physicial contacted the physicial contacted the physicial contacted with LPN (the nurse caring for evening shift of 2/7/1 should be done if a resident's bedtime madministration. LPN the facility STAT box STAT box contains the #1 stated if the STAT needed medications physician and he will medication or to hold arrive from the pharmachem the stated she didn't remischeduled bedtime made 2/7/17 or what was donot given. LPN #1 state contacted the pharmachem the state of the pharmachem the | m). LPN #3 was shown the confirmed zolpidem was not dent #14 on 2/8/17 because as needed in order for the he medication. LPN #3 is due and not in the facility pharmacy. LPN #3 stated nacy needed a prescription. Escription is needed then scription is not present then she in. LPN #3 was asked if she an regarding Resident #14's LPN #3 confirmed she could coted the physician.  D.m., an interview was (licensed practical nurse) #1 Resident #14 during the management of the time the electron is not available for #1 stated nurses can access and most of the time the eneeded medications. LPN box does not contain the then nurses notify the say to give another the medications until they hacy. LPN #1 was shown lary 2017 MAR. LPN #1 ember if Resident #14's redications were given on one if the medications were ated she didn't remember if ysician or not. |   | 309 |   |                               |                            |
|   |  | m., ASM (administrative<br>e administrator), ASM #2   |   |     |   |                               |                            |

|                          | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` ′                |     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|--|--------------------|-----|--|-------------------------------|----------------------------|
|                          |   | 495407   | B. WING            |     |  | ·                             | C<br>18/2017               |
|                          | ROVIDER OR SUPPLIER   |  |                    | 1   | STREET ADDRESS, CITY, STATE, ZIP CODE  40 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                            | 1 03/                         | 10/2017                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 309                    | director of clinical ser the above findings.  The facility pharmacy Shortages/Unavailable "2. If a medication should call Pharmacy the order. If the mediordered, the licensed the order or reorder for delivery. 2.2 If the ned delay or a missed dos medication schedule, the medication from the Supply (STAT box) to medication shortage in Pharmacy hours: 3.1 should obtain the order Emergency Medication (1) "Gabapentin is also the pain of diabetic net tingling due to nerve of diabetes)" This information (2) "Metronidazole elimicroorganisms that or reproductive system, vagina, and other are information was obtain | g) and ASM #3 (the regional vices) were made aware of policy titled, "Medication le Medications" documented, ortage is discovered during urs: 2.1. Facility nurse to determine the status of facility nurse should place or the next scheduled ext available delivery causes se in the resident's Facility nurse should obtain the Emergency Medication administer the dose3. If a is discovered after normal a licensed Facility nurse ered medication from the | F                  | 309 |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3) DATE SURVEY COMPLETED C   |                     |   |               |  |  |  |
|---|--|--|---------------------|---|---------------|--|--|--|
|   |  | 495407   | B. WING             |   | 05/18/2017    |  |  |  |
|   | ROVIDER OR SUPPLIER  | AB CENTER  | 1                   | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                                |               |  |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETION |  |  |  |
| F 309   | Continued From pag   | ge 65  | F 309               |   |               |  |  |  |
|   | recommendations for KUB (kidney ureters) Resident #6 was add with a recent readmidiagnoses that incluquadriplegia (paralythe trunk of the body cord injury (1)), cystiurinary bladder and bladder, pain, high banxiety disorder and The most recent MD assessment, an annuassessment referencesident as being condecisions. The resident as being condecisions are quirties of daily living was coded as requirties of daily living was coded as requirties an indwelling catheter.  Observation was maded to the condecision of th | ailed to follow the specialist or Resident #6 to receive a and bladder x-ray).  mitted to the facility on 1/1/11 assion on 1/10/17 with ded but were not limited to: assis affecting all four limbs and or below the level of spinal tis (inflammation of the ureters (2)), neurogenic allood pressure, depression, urinary tract infections.  S (minimum data set) ual assessment, with an accedate of 4/17/17, coded the gnitively intact to make daily dent was coded as requiring to the tobeing totally dependent aff members for all of her ang except eating in which she ing supervision after set up ided. In Section H - Bladder tent was coded as requiring |                     |   |               |  |  |  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | , ,                 | LE CONSTRUCTION  | (X3) DATE SURVEY COMPLETED |  |
|--------------------------|--|--|---------------------|--|----------------------------|--|
|                          |  | 495407   | B. WING             |  | C<br>05/18/2017            |  |
|                          | ROVIDER OR SUPPLIER  | AB CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                       | 1 33/10/2317               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | D BE COMPLETION            |  |
| F 309                    | Continued From pag   | ge 66  | F 30                | 9  |                            |  |
|                          | Consultation" dated "Recommendations/ (every) 2-3 hours. F (a C with a line over (milliliters) NSS (nor mark) KUB (kidney of the physician orders "Flush Foley BID (a 'with'), 60 ML NSS.  Review of the April 2 administration record BID (a C with a line NSS.  Review of the KUB x-raphysician's order for the KUB x-raphysician's order for the nurse's note dated documented, "Reside p.m. for a urology agnew orders. Reside aware of the new orders. Reside aware of the new orders the new orders. The comprehensive revised on 5/9/17, do the resident has sure to neuromuscular beto spinal stenosis. Sutil (urinary tract infourprepubic) catheters | ted 4/14/17 at 2:11 p.m. lent out for appointment at 12 lopointment. Returned with nt and RP (responsible party) lders." This note was written |                     |  |                            |  |

|                          | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING   |  | (X3) DATE SURVEY COMPLETED C |  |                   |  |
|--------------------------|--|--|------------------------------|--|-------------------|--|
|                          |  | 495407   | B. WING                      |  | 05/18/2017        |  |
|                          | ROVIDER OR SUPPLIER  | AB CENTER  |                              | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                         | 03/10/2017        |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | ILD BE COMPLETION |  |
| F 309                    | Continued From pa  | _  | F 30                         | 9  |                   |  |
|                          |  | ray results was made to the<br>ASM #2 on 5/17/17 at<br>a.m.  |                              |  |                   |  |
|                          | practical nurse) #4 #4 was asked how a for residents are pro LPN #4 stated, "We doctor here and the disapprove the recowhere that conversa stated, "It should be An interview was co 5/17/17 at 11:16 a.r process recommendater a resident retu specialist, LPN #5 sour physician to agrorders." When asked documented, LPN # notes." The Urologic 4/14/17 were review if she could recall the | ommendations." When asked ation is documented, LPN #4 in the nurse's notes."  onducted with LPN #5 on m. When asked how staff dations made by a specialist rns from a consultation with a stated, "We verify them with ree or disagree with the sed where that conversation is \$45 stated, "In the nurse's st recommendations of wed with LPN #5. When asked his, LPN #5 stated, "I r for the flushes but I don't |                              |  |                   |  |
|                          | An interview was co<br>assistant director of<br>p.m. The recommen<br>4/14/17 were review<br>supposed to happe<br>from a specialist, As<br>receives these orde<br>with the attending p<br>to follow the recommasked where that co   | onducted with ASM #4, the forursing, on 5/17/17 at 1:28 and ations from the specialist of wed. When asked what is no with the recommendations SM #4 stated, "The nurse that was should verify the orders hysician and he will decide if mendations or not." When conversation with the doctor is #4 stated, "In the nurse's  |                              |  |                   |  |

|                          | DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                 | PLE CONSTRUCTION  G   |         | ATE SURVEY<br>MPLETED      |
|--------------------------|--|--|---------------------|---|---------|----------------------------|
|                          |  | 495407   | B. WING             |   |         | C<br>05/18/2017            |
|                          | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                    |         |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
| F 309                    | #4, presented a phy 2:27 p.m. that docur note was attached, of that documented, "K RP (responsible par An interview was co 5/17/17 at 3:12 p.m. information was obta (the names of ASM #2, the director of medical director) and asked why it was ob missed off the recontranscribed."  ASM #1, the administ the regional director made aware of the a 5:25 p.m. A policy of was requested.  On 5/18/17 at 8:20 a informed this survey have a policy on specific the information of t | o.m. RN (registered nurse) sician order dated, 5/17/17 at nented, "KUB." A nurse's dated, 5/17/17 at 2:49 p.m. (UB ordered and scheduled. by) notified."  Inducted with RN #4 on When asked where this ained from, RN #4 stated, [administrative staff member] ursing, and ASM #4, the nursing) called (ASM #5, the d obtained the order." When tained, RN #4 stated, "It got nmendations when they were  strator, ASM #2, and ASM #3, of clinical services, were above findings on 5/17/17 at an specialist recommendations  a.m. ASM #2 and ASM 4 or that the facility did not ecialist recommendations.  on was provided prior to exit.  ary of Medical Terms for the r, 5th edition, by Rothenberg e 489. ary of Medical Terms for the r, 5th edition, by Rothenberg | F 3(                | 09  |         |                            |

|                          | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | I ` ′              |     | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                     |
|--------------------------|---|---|--------------------|-----|--|-------------------------------|---------------------|
|                          |   | 495407  | B. WING            |     |  |                               | C<br><b>18/2017</b> |
|                          | ROVIDER OR SUPPLIER   | AB CENTER   |                    | 14  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>40 BRIMLEY DRIVE<br>REDERICKSBURG, VA 22406                          | 1 00                          | 10/2011             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE  |                     |
| F 309                    |   |   | F                  | 309 |  |                               |                     |
|                          |   | ailed to offer al interventions prior to the N (as needed) Tylenol [1] for  |                    |     |  |                               |                     |
|                          | 4/10/17 with the diag diabetes, high blood depression, leg fracticerebrovascular disc (Minimum Data Set) assessment with an Reference Date) of coded as being more ability to make daily out of a possible 15 for Mental Status) exceeded as requiring the extensive assistance hygiene; independent and as incontinent of A review of the clinic | ture, stroke, and ease. The most recent MDS was the admission/5-day ARD (Assessment 4/17/17. The resident was derately cognitively impaired in life decisions, scoring an 8 on the BIMS (Brief Interview exam. The resident was otal care for bathing; e for transfers, dressing, and int for eating after set-up help; if bowel and bladder. |                    |     |  |                               |                     |
|                          | mg (milligrams)G<br>hours as needed for<br>A review of the April<br>Administration Reco<br>nurses notes reveal  | 2017 MAR (Medication ord), in conjunction with the  |                    |     |  |                               |                     |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '               | LE CONSTRUCTION   | , ,       | OATE SURVEY<br>COMPLETED   |  |
|--------------------------|--|---|---------------------|---|-----------|----------------------------|--|
|                          |  | 495407  | B. WING             |   |           | C<br><b>05/18/2017</b>     |  |
|                          | ROVIDER OR SUPPLIER  JN NURSING AND REH  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406              |           | 05/10/2017                 |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |  |
| F 309                    | 4/15/17, 4/18/17, 4/ 4/27/17, and 4/28/1¹ non-pharmacologica as having been offe identified administra  A review of the May with the nurses note administered the Ty 5/1/17, 5/2/17, and non-pharmacologica as having been offe identified administra  On 5/17/17 at approximate interview with LPN she stated that whe pain, the nurse shoul located, the level of non-pharmacologica the assessment and documented in the companies of the residence of the residence of the residence of the interventions in attempt non-pharmacological and Pain Protocol® of Non-pharmacological of the pain and Pain Protocol® of Non-pharmacological of the pharmacological | 19/17, 4/20/17, 4/26/17, 7. There were no al interventions documented red for any of the above attions.  2017 MAR in conjunction as revealed the resident was been on the following dates: 5/15/17. There were no al interventions documented red for any of the above attions.  Eximately 2:00 p.m., in an attack (Licensed Practical Nurse), in a resident complains of all assess where the pain is pain, and attempt all interventions. She stated at interventions should be clinical record.  Sent's care plan revealed one attack (related to) pain to CVA plan was initiated on 4/10/17. Cluded one for "Staff to acological interventions." This sted 4/11/17. | F 30                |   |           |                            |  |
|                          | attempted prior to the medications"  On 5/17/17 at 5:13 p Staff Member) the A  |   |                     |   |           |                            |  |

|                          | DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '               | PLE CONSTRUCTION  G  | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--------------------------|--|---|---------------------|--|-------------------------------|--|--|
|                          |  | 495407  | B. WING             |  | 05/18/2017                    |  |  |
|                          | ROVIDER OR SUPPLIER  | HAB CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                         |                               |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>IR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC'<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRI<br>DEFICIENCY) | JLD BE COMPLÉTIC              |  |  |
| F 309                    | the findings. No furby the end of the services:  [1] Tylenol is used pain. Information of  | to relieve mild to moderate   | F 30                | 09   |                               |  |  |
|                          | non-pharmacologic administration pf P medication for Res Resident # 2 was r 07/02/14 with diagrant limited to: cerel muscle weakness, benign prostatic hy gastroesophageal (4) and hypertensic Resident # 2's mos set), a quarterly as (assessment reference | eadmitted to the facility on noses that included but were oral vascular disease (1), pain, low iron, depression, perplasia (2), reflux disease (3), dysphagia |                     |  |                               |  |  |
|                          | interview for menta<br>- 15, 14 being cogr<br>decisions. Resider<br>extensive assistant<br>activities of daily liv<br>The POS (Physicia<br># 2 dated May 201   | Il status (BIMS) of a score of 0 nitively intact for making daily nt # 2 was coded as requiring ce of one staff member for                                    |                     |  |                               |  |  |

|                          | OF DEFICIENCIES  CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION IG  |   | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|--|---------------------|--|---|----------------------------|
|                          |   | 495407   | B. WING _           |  |   | C<br><b>05/18/2017</b>     |
|                          | ROVIDER OR SUPPLIER   | B CENTER   |                     | STREET ADDRESS, CIT<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG |   | GS/10/2017                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | (EACH CO   | DER'S PLAN OF CORRECTION<br>DRRECTIVE ACTION SHOULD B<br>FERENCED TO THE APPROPRIA<br>DEFICIENCY) |                            |
| F 309                    | document the resider (zero) - (to) 10. 10 be (zero) being no pain. document on pain flor did to address pain. non-pharmacological pharmacological if ne "Hydrocodone-Acetar (five)-325 MG (milligr mouth every 6 (six) h Order Date: 07/21/20 [Tramadol] (7) Give 2 06 (six) hours as nee Date 06/30/2016."  The eMAR (electronic record) for Resident 4 documented, "Hydrocotablet 5 (five)-325 MG tablet by mouth every pain. Order Date: 07 MG [Tramadol] Give 5 06 hours as needed f 06/30/2016."  Further review of the revealed Ultram Table administered during the and Hydrocodone-Acetan was administered documented in the reversible of the revealed Ultram Table administered during the revealed Ultram Table administered | at's pain on a scale of 0 being the worst pain and 0 of pain is indicated, who gas well as what you will be priced in the remarks of the worst pain and 0. If pain is indicated, who gas well as what you will be provided in the remarks of the worst pain in the worst pain in the worst pain. The worst pain in the worst p | F3                  | 09   |   |                            |

|                          | DEFICIENCIES CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '               | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|---|---------------------|---|-------------------------------|
|                          |  | 495407  | B. WING             |   | C<br><b>05/18/2017</b>        |
|                          | ROVIDER OR SUPPLIER  | HAB CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                      | 1 33/10/2011                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEI   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY) | D BE COMPLETION               |
| F 309                    | record) for Residen documented, "Hydro Tablet 5 (five)-325 tablet by mouth every pain. Order Date: (MG [Tramadol] (7) every 06 (six) hours Order Date 06/30/2 Further review of the revealed Ultram Tale administered during Hydrocodone-Acets was administered to 04/16/17 at 3:03 a. The "eMAR Note" for Hydrocodone-Acets was administered to "Hydrocodone-Acets was administered to "Hydrocodone-Acets was administered to "Tablet by mouth every of the total pain."  The eMAR (electron record) for Resident documented, "Hydrocodone-Acets documented, "Hydrocodone-Acets (five)-325 tablet by mouth every of the eMAR dated Mydrocodone-Acets was administered to times: 05/01/17 at 2 a.m., 05/04/17 at 5 | nic medication administration It # 2 dated "April 2017" In ocodone-Acetaminophen (6) ING (milligram). Give 1 (one) In ocodone-Acetaminophen (6) ING (milligram). Give 1 (one) ING (six) hours as needed for ING (2 tablet [sic] by mouth ING as needed for severe pain. ING (3 tablet [sic] by mouth ING as needed for severe pain. ING (4 tablet 50 MG was not ING the month of April 2017 and ING the month of April 2017 and ING the month of April 2017 and ING the following dates: ING (4 tablet 5-325 MG) ING (5 tablet 5-325 MG) ING (5 tablet 5-325 MG) ING (6 tablet 6 | F 30                | 9   |                               |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '               | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|--|---------------------|---|-------------------------------|
|                          |   | 495407   | B. WING             |   | C<br><b>05/18/2017</b>        |
|                          | ROVIDER OR SUPPLIER  JN NURSING AND REH   | AB CENTER  | 1.                  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>40 BRIMLEY DRIVE<br>REDERICKSBURG, VA 22406                               | 1 00/10/2011                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETION                 |
| F 309                    | was administered d "Hydrocodone-Aced Give 1 tablet by mo for pain."  The eMAR dated M Tablet 50 MG was a dates and times: 05 05/12/17 at 5:40 a.r date above docume Give 2 tablet [sic] b needed for severe p  Further review of th dated March 2017 t evidence document interventions prior t Hydrocodone-Aceta  The "Progress Note 03/02/2017 through and failed to eviden non-pharmacologic administration of Hy and Ultram.  The care plan for R date of 03/16/2017 Resident has risk fo (cerebral vascular of Osteoarthritis. Rec needed) pain medic 07/18/2014. Revisi "Interventions" it do for probable cause | the aminophen Tablet 5-325 MG ocumented, aminophen Tablet 5-325 MG. uth every 6 hours as needed any 2017 revealed Ultram administered on the following 1/11/17 at 5:10 a.m. and m. The "eMAR Note" for each ented, "Ultram Tablet 50 MG. by mouth every 06 hours as pain."  The eMARs for Resident # 2 hrough May 2017 failed to ration of non-pharmacological to the administration of aminophen and Ultram.  The sest of Resident # 2 dated to retain the administration of aminophen and Ultram.  The every 06 hours as pain."  The emakes for Resident # 2 dated to ration of non-pharmacological to the administration of aminophen and Ultram.  The every 06 hours as pain."  The every 06 hours as pain.  The every 06 hours as pain. | F 309               |   |                               |

|                          |   |  | DATE SURVEY<br>COMPLETED |   |                              |                            |
|--------------------------|---|--|--------------------------|---|------------------------------|----------------------------|
|                          |   | 495407   | B. WING _                |   |                              | C<br><b>05/18/2017</b>     |
|                          | ROVIDER OR SUPPLIER   | AB CENTER  |                          | STREET ADDRESS, CITY, STATE, ZIP COD<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406 | )E                           | 33/10/2011                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG      | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)     | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 309                    | Continued From pag  | ge 75  | F3                       | 309   |                              |                            |
|                          | conducted with LPN 5. When asked to d administering PRN p stated, "Try to reposinterventions. If that assessment, location ten being most sever medication according follow-up approximate giving the medication effective using the p call the physician for asked how often the interventions should stated, "Every time." would document the interventions, LPN # on the MAR and in the reviewing the MARs 2017, and May 2017 dated 03/02/2017 the Resident # 2, LPN # documentation of notinterventions attemptof PRN pain medication wasn't documented.  On 05/17/17 at 2:00 conducted with LPN describe the procedupain medication, LPI resident's pain on a attempting other me Ask where the pain in pain medication sho according to the pain statempting to the pain in medication sho according to the pain in the | p.m. an interview was # 2. When asked to ure of administering PRN N # 2 stated, "Rate the scale of one to ten after thods to help alleviate pain. is and to describe it. The |                          |   |                              |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                       | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING |             |       |   | (X3) DATE<br>COMP | SURVEY<br>LETED    |
|---|-----------------------|--|-------------|-------|---|-------------------|--------------------|
|   |                       |  |             | -     |   |                   | C                  |
|   |                       | 495407   | B. WING     |       |   | 05/               | 18/2017            |
| NAME OF PI  | ROVIDER OR SUPPLIER   |  |             | 5     | STREET ADDRESS, CITY, STATE, ZIP CODE                             |                   |                    |
| EALLODI   | IN NURSING AND REH    | IAD CENTED   |             | 1     | 140 BRIMLEY DRIVE   |                   |                    |
| FALLS RU  | IN NURSING AND REN    | IAB CENTER   |             | F     | FREDERICKSBURG, VA 22406  |                   |                    |
| (X4) ID   |                       | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL             | ID<br>PREFI | · · · | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B | E                 | (X5)<br>COMPLETION |
| PREFIX<br>TAG                                       | ,                     | R LSC IDENTIFYING INFORMATION)                                     | TAG         |       | CROSS-REFERENCED TO THE APPROPRI                                  |                   | DATE               |
| F 309   | Continued From pa     | ge 76  | F           | 309   |   |                   |                    |
|   | •                     | ately 30 to 45 minutes after                                       |             |       |   |                   |                    |
|   |                       | on to determine if it was  |             |       |   |                   |                    |
|   |                       | pain scale." When asked  |             |       |   |                   |                    |
|   | where staff would d   |  |             |       |   |                   |                    |
|   |                       | al interventions, LPN # 2  |             |       |   |                   |                    |
|   |                       | ented on the MAR and in the  |             |       |   |                   |                    |
|   |                       | er reviewing the MARs dated  |             |       |   |                   |                    |
|   |                       | 2017, and May 2017 and the   |             |       |   |                   |                    |
|   |                       | ed 03/02/2017 through  |             |       |   |                   |                    |
|   |                       | ident # 2, LPN # 2 was asked                                       |             |       |   |                   |                    |
|   | if there was docume   |  |             |       |   |                   |                    |
|   |                       | al interventions attempted   |             |       |   |                   |                    |
|   | prior to the administ |  |             |       |   |                   |                    |
|   | ·                     | 2 stated, "No, it wasn't   |             |       |   |                   |                    |
|   | documented it wasr    |  |             |       |   |                   |                    |
|   | documented it wasi    | it done.   |             |       |   |                   |                    |
|   | On 05/17/17 at 2:30   | ) p.m. an interview was  |             |       |   |                   |                    |
|   | conducted with ASN    | M (administrative staff  |             |       |   |                   |                    |
|   |                       | irector of nursing and ASM #                                       |             |       |   |                   |                    |
|   | · ·                   | ector of nursing regarding the                                     |             |       |   |                   |                    |
|   | administration of PF  | RN pain medication to  |             |       |   |                   |                    |
|   |                       | n asked to describe the  |             |       |   |                   |                    |
|   | procedure of admin    | istering PRN pain medication,                                      |             |       |   |                   |                    |
|   |                       | sk the resident to rate the pain                                   |             |       |   |                   |                    |
|   |                       | e to ten, ten being most   |             |       |   |                   |                    |
|   | severe. Try interve   | ntions before administering  |             |       |   |                   |                    |
|   |                       | tions). If that doesn't work                                       |             |       |   |                   |                    |
|   | l ·                   | medication according to the  |             |       |   |                   |                    |
|   |                       | ollow-up approximately 60  |             |       |   |                   |                    |
|   |                       | the medication to determine  |             |       |   |                   |                    |
|   |                       | f not effective call the   |             |       |   |                   |                    |
|   |                       | asked how often the  |             |       |   |                   |                    |
|   |                       | al interventions should be   |             |       |   |                   |                    |
|   |                       | 2 stated, "Every time." When                                       |             |       |   |                   |                    |
|   |                       | vould document the use of  |             |       |   |                   |                    |
|   |                       | al interventions, ASM # 2  |             |       |   |                   |                    |
|   |                       | ented on the MAR and in the  |             |       |   |                   |                    |
|   | '                     | er reviewing the MARs dated  |             |       |   |                   |                    |
|   |                       | 2017, and May 2017 and the   |             |       |   |                   |                    |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING |   |   | TE SURVEY<br>MPLETED |  |          |                            |
|--|---|---|----------------------|--|----------|----------------------------|
|  |   | 495407  | B. WING _            |  |          | C<br>5/18/2017             |
|  | ROVIDER OR SUPPLIER   |   |                      | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                   |          | 5/16/2017                  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | IOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 309  | if there was document non-pharmacological prior to the administrate medication. ASM # 2 documented it wasn't.  The facility's policy "F Protocol" documented this facility to ensure to the facility to ensure to the facility is assest potential for pain in or obtain or maintain his level of physical, mer well-being in accordat assessment and plan Non pharmacological attempted prior to the medications."  On 05/17/17 at appro (administrative staff in administrator, and AS were made aware of No further information References:  1. A stroke. When blubrain stops. A stroke attack." If blood flow few seconds, the brain oxygen. Brain cells cat damage. This informat website: | o3/02/2017 through ent # 2, ASM # 2 was asked tation of interventions attempted ation of PRN pain stated, "No, it wasn't done."  Pain Management and Pain cd, "Policy: It is the policy of any resident that is admitted sed for pain and/or the reder for the resident to /her highest practicable ital and psychosocial ince with the comprehensive of care. Procedure: 5g. interventions will be administration of PRN pain eximately 5:00 p.m. ASM nember) # 1 the is M # 2, director of nursing, | F3                   | 09   |          |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION  B  | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|---------------------|--|----------------------------|
|                          |  | 495407  | B. WING             |  | C<br><b>05/18/2017</b>     |
|                          | ROVIDER OR SUPPLIER  | 1   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                         | 03/10/2017                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETION           |
| F 309                    | obtained from the we https://www.nlm.nih.g statebph.html.  3. Stomach contents the esophagus and it was obtained from the https://www.nlm.nih.g obtained from the we https://www.nlm.nih.g sorders.html.  5. High blood pressu obtained from the we https://www.nlm.nih.g sorders.html.  6. Hydrocodone is an other ingredients, an products are prescrit hydrocodone combin relieve moderate-to-shydrocodone combin relieve cough. Hydromedications called o and in a class of med Hydrocodone relieve the brain and nervou Hydrocodone relieve activity in the part of coughing. This infort the website: https://medlineplus.g tml. | ate. This information was ebsite: gov/medlineplus/enlargedpro  to leak back, or reflux, into rritate it. This information we website: gov/medlineplus/gerd.html.  rder. This information was ebsite: gov/medlineplus/swallowingdi  re. This information was ebsite: gov/medlineplus/highbloodpr  vailable in combination with different combination oped for different uses. Some nation products are used to | F 30                |  |                            |

|                          | DEFICIENCIES CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '               | E CONSTRUCTION   | (X3) DATE SURVEY COMPLETED C |
|--------------------------|---|--|---------------------|--|------------------------------|
|                          |   | 495407   | B. WING             |  | 05/18/2017                   |
|                          | ROVIDER OR SUPPLIER   | AB CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                         | 1 00/10/2011                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETION             |
| F 309                    | the website:  | ge 79<br>nformation was obtained from<br>gov/druginfo/meds/a695011.ht  | F 30                | 9  |                              |
|                          | administration of PF medication for Resident # 7 was at 05/01/14 with diagn not limited to: encepweakness, depressing hypertension (4), gar | al interventions prior to the RN (as needed) pain dent # 7.  dmitted to the facility on oses that included but were chalopathy (1), muscle ion, aphasia (2), dementia (3), astroesophageal reflux gia (6) and peripheral                                 |                     |  |                              |
|                          | set), a quarterly ass<br>(assessment reference<br>Resident # 7 as sconinterview for mental<br>- 15, 13 being cognidecisions. Residen        | recent MDS (minimum data<br>sessment with an ARD<br>nce date) of 03/22/17, coded<br>oring a 13 on the brief<br>status (BIMS) of a score of 0<br>stitively intact for making daily<br>t # 7 was coded as requiring<br>the up help for activities of daily |                     |  |                              |
|                          | # 7 dated May 2017 "Acetaminophen (8) Give 650 MG orally as needed for pain. (greater than) 109. "Ibuprofen Tablet 20                       | 325 MG (milligram) Tablet.<br>(by mouth) every 6 (six) hours<br>As needed for pain or fever ><br>Date Ordered: 09/10/2014."<br>00 MG. Give 2 (two) tablet<br>(6 (six) hours as needed for  |                     |  |                              |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA (X2) MUL <sup>-</sup> IDENTIFICATION NUMBER: A. BUILDI   |                     | CONSTRUCTION  | (X3) DATE SURVEY COMPLETED C |  |
|---|---|--|---------------------|---|------------------------------|--|
|   |   | 495407   | B. WING             |   | 05/18/2017                   |  |
|   | ROVIDER OR SUPPLIER   | AB CENTER  | 14                  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>10 BRIMLEY DRIVE<br>REDERICKSBURG, VA 22406                                 | 1 00/10/2011                 |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE COMPLETION                |  |
| F 309   | Continued From pag  |  | F 309               |   |                              |  |
|   | record) for Resident documented the abore Review of the eMAR revealed Acetamino administered on: 01. at 1:40 a.m., 01/26/7:58 a.m., 01/30/17 11:01 p.m. The "eMatime Acetaminopher as documented, "Ac Give 650 MG orally pain. As needed for 109."  The eMAR dated Jallbuprofen 200 MG wat 2:15 a.m., 01/26/17 12:01 a.m., 01/26/17 12:55 a.m. and 01/2 "eMAR Note" for ear 200 MG was admini "lbuprofen 200 MG. every 6 hours as needed for 109."  The eMAR (electron record) for Resident documented the abore physician order sheed ated February 201 325 MG was admini a.m., 02/07/17 at 11 p.m., 02/11/17 at 12 02/12/17 at 7:31 a.m 02/14/17 at 11"00 p. at 10:32 p.m., 02/17 | nor/17 at 2:49 a.m., 01/22/17 at 2:29 a.m., and 01/30/17 at at 2:09 a.m., and 01/30/17 at at 2:5 MG was administered etaminophen 325 MG Tablet. every 6 hours as needed for pain or fever > (greater than)  nuary 2017 revealed as administered on: 01/04/17 at 11:50 p.m., 01/07/17 at at 10:07 p.m., 01/19/17 at at 12:02 a.m., 01/28/17 at 9/17 at 12:12 a.m. The ch date and time lbuprofen stered documented, Give 2 tablets by mouth |                     |   |                              |  |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDII | TIPLE CONSTRUCTION  NG  |   | (X3) DATE<br>COMP | SURVEY<br>LETED            |
|--------------------------|--|--|-------------------------|---|---|-------------------|----------------------------|
|                          |  | 495407   | B. WING _               |   |   |                   | C<br><b>18/2017</b>        |
|                          | ROVIDER OR SUPPLIER  | AB CENTER  |                         | STREET ADDRESS, CITY, STAT<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA | ,   | 1 03/             | 10/2017                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG      | (EACH CORRECT<br>CROSS-REFERENC                                       | PLAN OF CORRECTION<br>FIVE ACTION SHOULD BI<br>CED TO THE APPROPRIA<br>EFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 309                    | as documented, "Acc Give 650 MG orally opain. As needed for 109."  The eMAR dated Fellbuprofen 200 MG wat 11:43 p.m., 02/22/p.m., 02/23/17 at 11:a.m. The "eMAR No Ibuprofen 200 MG wat documented, "Ibuprofen 200 MG wat 10:40 for Resident documented the phy Acetaminophen 325 to be administered a physician order shee March 2017 revealed was not administered aphysician order shee March 2017. The eMAR da Ibuprofen 200 MG wat 12:06 p.m., 03/02/1:26 a.m. and at 11:06 a.m., 03/16/17 at 6:503/17/17 at 1:42 p.m. 03/22/17 at 4:38 p.m. and 03/29/17 at 3:20 each time Ibuprofen documented: "Ibuprofen doc | a 325 MG was administered etaminophen 325 MG Tablet. Every 6 hours as needed for pain or fever > (greater than)  bruary 2017 revealed as administered on: 02/21/17 17 at 3:41 p.m. and at 11:44 31 p.m., and 02/26/17 1:00 te" for each date and time as administered ifen 200 MG. Give 2 tablets urs as needed for pain."  c medication administration # 7 dated "March 2017 sician order for MG and Ibuprofen 200 MG is documented on the at above. The eMAR dated if Acetaminophen 325 MG is during the month of March ted March 2017 revealed as administered on: 03/01/17 17 at 12:50 a.m., 03/12/17 at 105 p.m., 03/14/17 at 7:22 9 a.m. and at 2:08 p.m.,, 03/24/17 at 11:36 a.m., a.m. The "eMAR Note" for 200 MG was administered ifen 200 MG. Give 2 tablets | F                       | 309   |   |                   |                            |
|                          | The eMAR (electroni record) for Resident   | urs as needed for pain."  c medication administration  # 7 dated "April 2017  ented the physician order for  |                         |   |   |                   |                            |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|---|-----------------------------|---|-------------------------------|
|                          |   | 495407  | B. WING                     |   | C<br>05/18/2017               |
|                          | ROVIDER OR SUPPLIER   | AB CENTER   |                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406                          | 1 33/10/23/17                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETION               |
| F 309                    | to be administered a physician order shee April 2017 revealed Anot administered dur The eMAR dated Api 200 MG was adminis p.m., 04/07/17 at 8:3 04/12/17 at 4:05 a.m 04/23/17 at 11:43 a.r The "eMAR Note" for MG was administere 200 MG. Give 2 table as needed for pain."  The eMAR (electronic record) for Resident documented the phy Acetaminophen 325 to be administered a physician order shee May 2017 revealed Anot administered dur The eMAR dated Ma 200 MG was adminis a.m. and at 3:52 p.m 05/10/17 at 12:30 a.r and 05/12/17 at 7:55 each time Ibuprofen documented: "Ibuprofen | MG and Ibuprofen 200 MG st documented on the st above. The eMAR dated Acetaminophen 325 MG was ing the month of April 2017. Fil 2017 revealed Ibuprofen stered on: 04/05/17 at 6:49 2 a.m.,04/08/17 at 6:46 a.m., ., 04/18/17 at 8:38 p.m., m., and 04/25/17 at 9:38 p.m. reach time Ibuprofen 200 d documented: "Ibuprofen ets by mouth every 6 hours comedication administration 7 dated "May 2017 sician order for MG and Ibuprofen 200 MG and Ibuprofen 200 MG acetaminophen 325 MG was ing the month of May 2017. The email of the stabove of | F 309                       |   |                               |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING |  |  | (X3) DATE SURVEY<br>COMPLETED |   |                                      |                            |
|---|--|--|-------------------------------|---|--------------------------------------|----------------------------|
|   |  | 495407   | B. WING _                     |   |                                      | C<br>05/18/2017            |
|   | ROVIDER OR SUPPLIER  | AB CENTER  |                               | STREET ADDRESS, CITY, STATE, ZIP<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406 | CODE                                 | 33,13,231,                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG           | PROVIDER'S PLAN C<br>X (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN     | CTION SHOULD BE<br>O THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 309   | 01/02/2017 through (and failed to evidence   | " for Resident # 7 dated<br>05/13/2017 were reviewed<br>e documentation of   | FS                            | 309   |                                      |                            |
|   | administration of Ace The care plan for Re documented, "Focus                                | interventions prior to the taminophen and Ibuprofen. sident # 7 dated 06/26/14: At risk for pain. Resident   |                               |   |                                      |                            |
|   | disease) with hemipa<br>(gastroesophageal re<br>06/26/14. Revision of                        | VA (cerebral vascular aresis and GERD effux disease). Date Initiated: on 04/25/2017." Under umented, "Non pharm  |                               |   |                                      |                            |
|   | (pharmacological) int  | cerventions such as assist comfort. Date Initiated:  |                               |   |                                      |                            |
|   | conducted with LPN<br>5. When asked to de<br>administering PRN p<br>stated, "Try to reposi   | p.m. an interview was (licensed practical nurse) # escribe the procedure of ain medication, LPN # 5 tion to alleviate pain or other doesn't work do a pain |                               |   |                                      |                            |
|   | assessment, location<br>ten being most sever<br>medication according<br>follow-up approximat | n, use pain scale one to ten,<br>re. Administer the pain<br>g to the physician's order,<br>ely 30 to 40 minutes after<br>n to determine if it was          |                               |   |                                      |                            |
|   | effective using the pa<br>call the physician for<br>asked how often the                      | hin scale. If it wasn't effective further orders." When non-pharmacological be attempted, LPN # 5  |                               |   |                                      |                            |
|   | would document the interventions, LPN #  | When asked where they use of non-pharmacological 5 stated, "It's documented ne nurse's notes." After   |                               |   |                                      |                            |
|   | February 2017, Marc  | ch 2017, April 2017, and May ss notes dated 01/02/2017   |                               |   |                                      |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION  G   | ' '       | ATE SURVEY<br>OMPLETED     |
|--------------------------|--|---|--------------------------|---|-----------|----------------------------|
|                          |  | 495407  | B. WING _                |   |           | C<br>05/18/2017            |
|                          | ROVIDER OR SUPPLIER  | AB CENTER   |                          | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                | '         | <u> </u>                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 309                    | was asked if there we non-pharmacological prior to the administ medication. LPN # documented it was a documented it was a documented it was a documented with LPN describe the proced pain medication, LP resident's pain on a attempting other medication should be a documented with LPN describe the proced pain medication of the pain pain medication should be according to the pain medication according to the pain medication according to the pain medication according follow-up approximal giving the medication effective using the pwhere they would donon-pharmacological stated, "It's documented unurse's notes." After January 2017, February 2017, and May 2017 dated 01/02/2017 the Resident # 7, LPN # documentation of notinterventions attempt of PRN pain medical wasn't documented.  On 05/17/17 at 2:30 conducted with ASM member) # 2, the direct administration of PRN pain medical states and the assistant direct administration of PRN pain medical states and the direct administration of PRN pain medical states and the direct administration of PRN pain medical states and the direct administration of PRN pain medical states and the direct administration of PRN pain medical states and the direct administration of PRN pain medical states and the direct administration of PRN pain medical states and the direct administration of PRN pain medical states and the direct administration of PRN pain medical states and the direct administration of PRN pain medical prior to the direct administration of PRN pain medical prior to the direct administration of PRN pain medical prior to the direct administration of PRN pain medical prior to the direct administration of PRN pain medical prior to the direct administration of PRN pain medical prior to the direct administration and th | for Resident # 7, LPN # 5 vas documentation of al interventions attempted ration of PRN pain 5 stated, "No, it wasn't 't done."  p.m. an interview was # 2. When asked to ure of administering PRN N # 2 stated, "Rate the scale of one to ten after thods to help alleviate pain. is and to describe it. The uld be administered in level." Administer the pain g to the physician's order, tely 30 to 45 minutes after in to determine if it was ain scale." When asked bocument the use of al interventions, LPN # 2 inted on the MAR and in the r reviewing the MARs dated duary 2017, March 2017, April or and the progress notes rough 05/13/2017 for 2 was asked if there was on-pharmacological ofted prior to the administration tion. LPN # 2 stated, "No, it | F 3                      | 09  |           |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | PLE CONSTRUCTION  G  |             | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|---------------------|--|-------------|-------------------------------|--|
|  |  | 495407   | B. WING_            |  |             | C<br>05/18/2017               |  |
|  | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406 |             | 1 00/10/2011                  |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)  | N SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 309  | ASM # 2 stated, "Asl using pain scale one severe. Try interven pain meds. If that do pain medication accorder, follow-up appr giving the medication effective. If not effective. If not effective. If not effective when asked how oft interventions should stated, "Every time." would document the interventions, ASM # on the MAR and in the reviewing the MARs February 2017, Marc 2017 and the progresthrough 05/13/2017 was asked if there we non-pharmacological prior to the administrative to Resident #7. ASM documented it wasn'  On 05/17/17 at approximation of the companies of the compan | stering PRN pain medication, at the resident to rate the pain to ten, ten being most tions before administering besn't work administer the ording to the physician's oximately 60 minutes after in to determine if it was stive call the physician." ten the non-pharmacological be attempted, ASM # 2  When asked where they use of non-pharmacological to 2 stated, "It's documented the nurse's notes." After dated January 2017, the 2017, April 2017, and May to so notes dated 01/02/2017 for Resident # 7, ASM # 2 the stated of PRN pain medication of a interventions attempted atton of PRN pain medication of the 2 stated, "No, it wasn't to done."  Doximately 5:00 p.m. ASM member) # 1 the SM # 2, director of nursing, the findings.  In was provided prior to exit.  Lise disease of the brain that for structure. This information he website: gov/disorders/encephalopath | F3                  | 09   |             |                               |  |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|---|--|-----|---|-------------------------------|----------------------------|
|                          |   |   | 7 56.125                               | _   |   | (                             |                            |
|                          |   | 495407  | B. WING                                |     |   | 05/                           | 18/2017                    |
|                          | ROVIDER OR SUPPLIER   | B CENTER  |  | 1   | TREET ADDRESS, CITY, STATE, ZIP CODE  40 BRIMLEY DRIVE  REDERICKSBURG, VA 22406                               |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                     | Х   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 309                    | Continued From page   | e 86  | F                                      | 309 |   |                               |                            |
|                          | the brain that control hard for you to read, you mean to say). This infit the website: https://www.nlm.nih.g l  3. A group of symptor affect the brain. This from the website: https://www.nlm.nih.g ml.  4. High blood pressur obtained from the website: https://www.nlm.nih.g essure.html.  5. Stomach contents the esophagus and in was obtained from the https://www.nlm.nih.g essure.html.  6. A swallowing disord obtained from the website.//www.nlm.nih.g sorders.html.  7. The vascular syste blood vessels. It includes a personner called atherosclerosis vessels and block blood weakened blood vessels. | ov/medlineplus/highbloodpr  to leak back, or reflux, into ritate it. This information e website: ov/medlineplus/gerd.html.  der. This information was |  |     |   |                               |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | I ' '              | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |     | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|--------------------|---|--|-----|-------------------------------|--|
|                          |  |   | 7. BOILDI          |   |  | (   | c                             |  |
|                          |  | 495407  | B. WING _          |   |  | 05/ | 18/2017                       |  |
|                          | ROVIDER OR SUPPLIER  N NURSING AND REHA  | B CENTER  |                    | 140                                     | REET ADDRESS, CITY, STATE, ZIP CODE<br>O BRIMLEY DRIVE<br>REDERICKSBURG, VA 22406                                      |     |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                                   | ID<br>PREFI<br>TAG | ×                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |     | (X5)<br>COMPLETION<br>DATE    |  |
| F 309 F 329 SS=E         | ases.html.  DRUG REGIMEN IS  UNNECESSARY DRI  CFR(s): 483.45(d)(e)(e)(e)(e)(e)(e)(e)(e)(e)(e)(e)(e)(e) | FREE FROM UGS (1)-(2) ary Drugs-General. regimen must be free from An unnecessary drug is any (including duplicate drug |                    | 329                                     | DEFICIENCY)  |     | 6/22/17                       |  |
|                          | resident, the facility m<br>(1) Residents who hadrugs are not given the<br>medication is necessary     | ensive assessment of a nust ensure that ve not used psychotropic nese drugs unless the                                  |                    |   |  |     |                               |  |
|                          |  |   |                    |   |  |     |                               |  |

|                          | OF DEFICIENCIES CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE<br>A. BUILDING | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|---|------------------------------|--|-------------------------------|
|                          |   | 495407  | B. WING                      |  | C<br><b>05/18/2017</b>        |
|                          | ROVIDER OR SUPPLIER  N NURSING AND REHA   | AB CENTER   | 1                            | TREET ADDRESS, CITY, STATE, ZIP CODE<br>40 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406   |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  |                               |
| F 329                    | Continued From pag (2) Residents who us   | e 88<br>se psychotropic drugs receive   | F 329                        |  |                               |
|                          | gradual dose reducti<br>interventions, unless<br>an effort to disconting<br>This REQUIREMEN'<br>by:<br>Based on observation<br>document review and<br>was determined that<br>ensure a drug regime | ons, and behavioral clinically contraindicated, in  |                              | Resident #12's medication order w clarified. Resident #8's behavior monitoring sheet is in place. Resident #1's MD was notified of not obtaining v signs prior to medication administration.   | rital                         |
|                          | sample, Resident #1 and Resident #9.  1. The facility staff fa (PRN) Tylenol as ord   | 2, Resident #8, Resident #1  ailed to administer needed lered by the physician. The e as needed Tylenol to  |                              | Resident #9 non longer resides in the facility.  2. All residents have the potential to b affected by this deficient practice.   |                               |
|                          | Resident #12 every finad no complaints of the medication to be hours for breakthrough.  2. The facility staff fa  | our hours when the resident pain. The physician ordered administered every four   |                              | 3. DON and or designee(s) will in-serval licensed nurses on following MD order include parameters, following care plan to include us of non-pharmacological interventions prior to administration of PRN pain and/or anti-anxiety medication and on behavior monitoring  | s to                          |
|                          | <ul><li>3. The facility staff fa heartrate (pulse) per parameters for a high for Resident #1.</li><li>4. The facility staff fa non-pharmacologica administration of PR</li></ul>                  | iled to monitor the resident's the physician ordered in blood pressure medication ailed to offer I interventions prior to the N (as needed) Xanax [1] and the symptoms of anxiety for |                              | documentation.  4. DON and or designee(s) will audit residents receiving PRN pain and/or anti-anxiety medication for the use of non-pharmacological interventions pric medication administration 5x a week for weeks, then monthly for 8 weeks. DOI and or designee(s) will audit 5 resident with medication parameters weekly for weeks and then monthly for 2 months ensure orders are followed. Results for the audits will be taken to QAPI committee x3 months for review and | or 4<br>N<br>ts<br>4<br>to    |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDII |     | CONSTRUCTION   |       | PLETED                     |
|--------------------------|---|--|-------------------------|-----|--|-------|----------------------------|
|                          |   | 495407   | B. WING _               |     |  |       | C<br>1 <b>8/2017</b>       |
|                          | ROVIDER OR SUPPLIER   | B CENTER   |                         | 14  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>40 BRIMLEY DRIVE<br>REDERICKSBURG, VA 22406                                  | 1 03/ | 10/2017                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFII<br>TAG     | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE |
| F 329                    | 1. The facility staff fa (PRN) Tylenol as ord staff administered the Resident #12 every found no complaints of the medication to be hours for breakthrough Resident #12 was ad 4/4/13 and readmitter that included but were weakness, dementia, ad high blood pressu.  The most recent MDS quarterly assessment reference date) of 4/4 having a BIMS (brief of 12 out of 15 indica cognitively intact to make the complete of 1/26/17 do for painIntervention ordered, prn (as need contact md (medical excontact md (medical excontact md (medical excontact md for Breakth 7/14/2016."  Review of the May 20 administration record Tablet 325 MG (millig Give 325 mg by mouth the residual excontact md by mouth the staff of the may 20 administration record Tablet 325 MG (millig Give 325 mg by mouth the mouth the staff of the may 20 administration record Tablet 325 MG (millig Give 325 mg by mouth the maximum the maximum the maximum the staff of the maximum | illed to administer needed ered by the physician. The ered as needed Tylenol to our hours when the resident pain. The physician ordered administered every four gh pain.  mitted to the facility on don 8/6/15 with diagnoses ered ilmited to: muscle chronic pain, heart disease re.  So (minimum data set), at with an ARD (assessment lateral status) ting the resident was make daily decisions.  an initiated on 7/25/15 and occumented, "Focus At risk is meds (medications) as ded) medications as needed. doctor) if ineffective."  an's orders dated May 2017 I Tablet 325 MG (milligrams) ered 325 mg by mouth every hrough pain. Order Date | F                       | 329 | revision as needed.  |       |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDI |     | ONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED            |
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|                          |  | 495407  | B. WING _              |     |  |                   | C<br><b>18/2017</b>        |
|                          | ROVIDER OR SUPPLIER  | B CENTER  |                        | 140 | EET ADDRESS, CITY, STATE, ZIP CODE<br>BRIMLEY DRIVE<br>EDERICKSBURG, VA 22406  | 1 00              | 10,20                      |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG     | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 329                    | every four hours each #12's pain was rated 54 times out of 68 op documented as being resident did not report of 5/16/17 at 4:08 produced and part of 16/17 at 4:08 produced as being resident did not report of 16/17 at 4:08 produced as produced as produced as the first that the | Tylenol had been given h day of the month. Resident as "0" (indicating no pain) portunities. The Tylenol was given even though the rt pain.  Im. the medication vation was conducted with cal nurse) #1. LPN #1 put a t into a medicine cup and #12's room. She asked had pain and Resident #12 he gave the medicine cup to en gave Resident #12 water er. The resident took the resident #12 he en asked to review the heldent #12, LPN #4 stated, an order for Tramadol (1) for breakthrough pain." | F                      | 329 |  |                   |                            |
|                          | needs it."  An interview was cor   | ducted on 5/17/17 at 1:15   |                        |     |  |                   |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | IPLE CONSTRUCTION  NG  | \ , ,                           | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---------------------|--|---------------------------------|-------------------------------|--|
|   |  | 495407   | B. WING _           |  | 0.                              | C<br>5/18/2017                |  |
|   | ROVIDER OR SUPPLIER  | B CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406 |                                 | 3 10/2011                     |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'         | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 329   | manager. When asked Tylenol order, RN #5 pain so it's technically going to first find out pain. I'm going to ass asked if the Tylenol wistated her pain level "Absolutely not. No note in the nurse's not she had no pain."  An interview was comp.m. with OSM (other #12's physician. OSM expected the Tylenol administered, OSM # ten." When asked if the resident did not h "No I don't." When mosm #5 stated, "We'  On 5/17/17 at 5:15 p. member) #1, the admidirector of nursing we findings.  No further information (1) Tramadol (Ultramanalgesic because of addiction and better swith other opiates. How adverse reactions are with tramadol-seizure This information was | red nurse) #5, the unit of to review Resident #12's stated, "It's for breakthrough of a prn (medication). I'm number one if she's having ess the pain level" When rould be given if the resident was zero, RN #5 stated, eed. I'd probably make a stes that (the resident) stated ducted on 5/17/17 at 2:43 at staff member) #5, Resident 1 #12 was asked when he for breakthrough pain to be 5 stated, "Pain of one to the Tylenol should be given if ave pain, OSM #5 stated, ade aware of the concern, and aware of the care of it."  m. ASM (administrative staff ministrator and ASM #2, the ere made aware of the concern was provided prior to exit.  ®) is a commonly prescribed at the relatively lower risk of safety profile in comparison to the experimental procures and serotonin syndrome. | F3                  | 329  |                                 |                               |  |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION IG  |             | DATE SURVEY<br>COMPLETED   |
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|                          |  | 495407  | B. WING _               |   |             | C<br><b>05/18/2017</b>     |
|                          | ROVIDER OR SUPPLIER  | AB CENTER   |                         | STREET ADDRESS, CITY, STATE, ZIP CODI<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406      | E           | 33/10/2011                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | I SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 329                    | Continued From pag   | e 92  | F 3                     | 29  |             |                            |
|                          | _  | iled to monitor Resident #8's ninistration of Risperdal (1).  |                         |   |             |                            |
|                          | 5/31/16 with diagnos limited to: psychosis   | nitted to the facility on es that included but were not (1), depression, high blood abetes and kidney disease.  |                         |   |             |                            |
|                          | set), a quarterly asse<br>(assessment referen<br>the resident as havin<br>BIMS (brief interview<br>the resident was cog<br>decisions. The reside<br>supervision from state | ecent MDS (minimum data essment, with an ARD ce date) of 4/24/17 coded g scored 15 out of 15 on the for mental status) indicating nitively intact to make daily ent was coded as requiring ff for activities of daily living. ded as not having any |                         |   |             |                            |
|                          | revised on 9/15/16 d<br>at risk for experiencianthe use of psychotronal<br>Interventions/Tasks A   | lan initiated on 6/13/16 and ocumented, "Focus Resident ng complications related to pic drugs (2). Administer medications as sument for side effects and  |                         |   |             |                            |
|                          |  | atrist's note dated 10/21/16<br>rdal 1 mg (milligram) PO (by<br>day)."  |                         |   |             |                            |
|                          | ""RisperDAL (3) Tabl<br>two times a day for d<br>Date 10/18/16." The   | nber 2016 MAR documented,<br>e 1 MG (milligram) by mouth<br>elusional disorder. Start<br>medication was documented<br>a day for each day of the   |                         |   |             |                            |

|                          | OF DEFICIENCIES CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                 | E CONSTRUCTION   | COMPLETED         |
|--------------------------|---|--|---------------------|--|-------------------|
|                          |   | 495407   | B. WING             |  | C<br>05/18/2017   |
|                          | ROVIDER OR SUPPLIER   | HAB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                         | 03/10/2017        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE COMPLETION |
| F 329                    | monitoring record of did not have behave resident had behave one time. The remay was left blank.  Review of the Decourier RisperDAL (3) Tatwo times a day for Date 10/18/16." The as being given twice monitoring record of documentation of the 11:00 p.m. shift. Al Review of the nurse through December documentation region behaviors.  An interview was computed behaviors.  An interview was computed behaviors.  An interview was computed behavior of the nurse of the nurse through December documentation region.  An interview was computed behavior of the nurse of the | ember 2016 behavior documented that the resident viors 14 times and that the viors that required redirection ainder of the monitoring record ember 2016 MAR documented, able 1 MG (milligram) by mouth redelusional disorder. Start the medication was documented at a day for each day of the ember 2016 behavior did not evidence behaviors for the 3:00 p.m. to a spaces were left blank.  The spaces were left blank.  The spaces were left blank are in the resident's end of the ember 2016 behavior and what the blank spaces ted, "That it wasn't en asked why behaviors were dent #8, LPN #4 stated, to know if we need to reduce | F 32                | 9  |                   |
|                          | the medication she<br>reduction."  A telephone intervi<br>at 4:16 p.m. with L   | ew was conducted on 5/17/17 PN #6, the resident's night diff behaviors were monitored,   |                     |  |                   |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '  | CONSTRUCTION   | (X3) DATE SURVEY COMPLETED C |  |
|--------------------------|---|---|--|--|------------------------------|--|
|                          |   | 495407  | B. WING  |  | 05/18/2017                   |  |
|                          | ROVIDER OR SUPPLIER  JN NURSING AND REH   | AB CENTER   | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406 |  | , 33.13.23.1                 |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE COMPLETION                |  |
| F 329                    | would be document on the behavior she (medications)." Who the sheet was blank dropped the ball I w staff monitored and behaviors, LPN #6 medications have s with) behaviors we the appropriate care working the doctor medication) for app An interview was coa.m. with LPN #2, ti When asked why sti behaviors, LPN #2 document the behadocument your inteethey are doing could or cause harm to ot review the Novemb behavior monitoring blank spaces indicated document any behavior monitoring blank spaces indicated document any behavior findings.  Review of the facility Medication Document documented, "POLI psychotropic medicate effectiveness of interviews and the shadocumented in the same documented in the facility of the | es." When asked where that ed, LPN #6 stated, "Definitely et if they're on a psychotropic en asked what it meant when k, LPN #6 stated, "Somebody rould think." When asked why documented resident's estated, "A lot of these ide effects. For (residents want to make sure they get eand treatment. If it's not can go back and look (at the | F 329  |  |                              |  |

|                          | DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′  | PLE CONSTRUCTION  G   |            | MPLETED                    |
|--------------------------|--|---|--|---|------------|----------------------------|
|                          |  | 495407  | B. WING  |   | ١,         | C<br>05/49/2047            |
|                          | ROVIDER OR SUPPLIER  |   | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406 |   | 05/18/2017 |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY) | ULD BE     | (X5)<br>COMPLETION<br>DATE |
| F 329                    | (BFR)initiated on a psychotropic meds (Nurses will documer a. Number of behavi Behavior/Interventio updated with any chamedication, dosage, effects by the nurse change. a. The Physignificant change in med changes recomphysician other than physician other than physician"  No further information (3) Risperdal RISF indicated for the acutreatment of schizopobtained from: https://dailymed.nlmm?setid=01859e07-6-b7ed-5a273cbf0c33. The facility staff faheartrate (pulse) per parameters for the ahigh blood pressure  Resident #1 was add 12/23/10 with a recewith diagnoses that it to: osteoporosis, paicongestive heart faill | on of psychotropic d and documented. Resident receiving ation will have a n Monthly Flow Record admission or whenever medications) are ordered. B. at on the following every shift: or episodes. C. The n Monthly Flow Record will be anges in psychotropic new behaviors and/or side on duty at the time of the sician will be notified of any behaviors, side effects or mended by another resident's primary  on was provided prior to exit.  PERDAL® (risperidone) is the and maintenance hrenia. This information was anih.gov/dailymed/drugInfo.cf 1262-4 cc aniled to monitor Resident #1's the physician ordered dministration of Atenolol (a | F 33   | 29  |            |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING |  |  | (X3) DATE SURVEY<br>COMPLETED |   |                                 |                            |
|---|--|--|-------------------------------|---|---------------------------------|----------------------------|
|   |  | 495407   | B. WING                       |   |                                 | C<br><b>05/18/2017</b>     |
|   | ROVIDER OR SUPPLIER  |  |                               | STREET ADDRESS, CITY, STATE, ZIP C  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406 | ODE                             | 03/10/2017                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG           | PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC      | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 329   | of 2/27/17, coded the the BIMS (brief intervindicating the resident make daily decisions. requiring extensive as staff members for transand personal hygiene.  The physician order of "Atenolol Tablet (used pressure (1)) 50 MG (mouth one time a day Hold for systolic BP (100 HR (heartrate) <  The April 2017 MAR (record) documented, Give 1 tablet by mouth Hypertension; Hold for above where the nursadministration; the residents pulse or heart for the May 2017 MAR of 50 MG; Give 1 tablet related to Hypertension 100 HR < 60." The medication was administration of the May 2017 MAR of 50 MG; Give 1 tablet related to Hypertension 100 HR < 60." The medication was also make the market for the May 2017 MAR of 50 MG; Give 1 tablet related to Hypertension 100 HR < 60." The medication was also make the market for the medication and make the market for the medication of the medication and make the market for the market for the medication and make the market for the medication and make the market for th | assessment reference date resident as scoring a 14 on ew for mental) status score, towas cognitively intact to assistance of one or more asfers, dressing, toileting atted, 3/28/17, documented, atted to treat high blood amilligrams); Give 1 tablet by a related to Hypertension; blood pressure) < (less than) 60 (beats per minute)."  In the time a day related to a resystolic BP < 100 HR < a decimal to the artrate.  In the time a day related to a respective blood pressure was sendedled for 6:00 a.m. and the artrate.  In the time a day beautiful and the artrate.  In the time a day beautiful and the artrate artrate.  In the time a day beautiful and the artrate.  In the time a day beautiful and the artrate.  In the time a day beautiful and the artrate.  In the time a day beautiful and the artrate.  In the time a day beautiful and the artrate.  In the time a day beautiful and the artrate.  In the time a day beautiful and the artrate.  In the time a day beautiful and the artrate.  In the time a day beautiful and the artrate.  In the time a day beautiful and the artrate.  In the time a day beautiful and the artrate.  In the time a day beautiful and the artrate.  In the time a day beautiful and the artrate artrate.  In the time a day beautiful and the artrate artrate artrate.  In the time a day beautiful and the time artrate artrate.  In the time artrate are artrated at the time artrated at th | F3                            | 329   |                                 |                            |

|                          | DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '               | PLE CONSTRUCTION  G   | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|---------------------|---|----------------------------|
|                          |  | 495407  | B. WING             |   | C<br><b>05/18/2017</b>     |
|                          | ROVIDER OR SUPPLIER  | 11.1  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                            | 03/16/2017                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE COMPLETION            |
| F 329                    | date of 2/22/17, docuresident has hyperte and CAD (coronary a "Interventions" documedications as order doctor) with any side.  The vital signs tab in record, did not docur and May 2017. The was taken on 3/29/1.  Review of the nurse' 5/16/17, did not evid heartrate measurem.  An interview was corpractical nurse) #4 o #4 was asked what i physician has ordere parameters to hold the pressure is less than (pulse) is less than (pulse) is less than (pulse) is less than (nurse) #4 stated, "The blood pressure and the pul #4 stated, "If that's we pulse and blood pressure and the pulse a | and 10/14/16, with a revised on amented in part, "Focus: The insion (high blood pressure) artery disease), CHF." The mented in part, "Give red. Call MD (medical effects."  The electronic medical ment any heartrates in April last documented heartrate 7 at 10:29 p.m.  Is notes from 3/28/17 through ence any documentation of a ent.  Inducted with LPN (licensed in 5/17/17 at 10:30 a.m. LPN is expected of staff, when the end a medication with the emedication if the blood in 100 and the heartrate in the ence and hold the interest and hold the ow the prescribed easked if both the blood is should be obtained, LPN what the parameters are, issure, then the nurse has to ked where this would be 4 stated, "The MAR should iment the blood pressure and who puts the orders into the blood pressure and pulse LPN #4 stated, "All nurses DS nurses, they don't put in | F 32                | 29  |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION  G  |             | DATE SURVEY<br>COMPLETED   |  |
|--------------------------|--|--|--------------------------|--|-------------|----------------------------|--|
|                          |  | 495407   | B. WING _                |  |             | C<br><b>05/18/2017</b>     |  |
|                          | ROVIDER OR SUPPLIER  | AB CENTER  |                          | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406         |             | •                          |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE | (X5)<br>COMPLETION<br>DATE |  |
| F 329                    | Continued From pag   | ge 98  | F3                       | 29   |             |                            |  |
|                          | staff member (ASM) nursing, on 5/17/17 asked what is expect physician has ordered parameters to hold to pressure is less than (pulse) i | strator, ASM #2, the director I #3, the regional director of re made aware of the above at 5:25 p.m.  Amentals of Nursingand Wilkins 2007 page 169, written medication order, working document approved facilityread the order te on copying it correctly, |                          |  |             |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCT A. BUILDING |   | ONSTRUCTION  | (X3) DATE           | SURVEY<br>PLETED |  |       |                            |
|---|---|--|---------------------|------------------|--|-------|----------------------------|
|   |   | 495407   | B. WING _           |                  |  |       | C<br>1 <b>18/2017</b>      |
|   | ROVIDER OR SUPPLIER   | B CENTER   |                     | 140              | EET ADDRESS, CITY, STATE, ZIP CODE BRIMLEY DRIVE EDERICKSBURG, VA 22406  | 1 03/ | 10/2017                    |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFII<br>TAG | <                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE |
| F 329   | m?setid=9aacaa30-0<br>4   | nih.gov/dailymed/drugInfo.cf<br>4b7-47d4-9ebf-b801cacf3ab  | F                   | 329              |  |       |                            |
|   | administration of PRN   | iled to offer<br>interventions prior to the<br>N (as needed) Xanax [1] and<br>e symptoms of anxiety for  |                     |                  |  |       |                            |
|   | diabetes, high blood pression, leg fractucerebrovascular disease (Minimum Data Set) wassessment with an Areference Date) of 4 coded as being moderability to make daily life out of a possible 15 of for Mental Status) exceeded as requiring to extensive assistance | noses of but not limited to pressure, anxiety, ure, stroke, and ase. The most recent MDS was the admission/5-day ARD (Assessment /17/17. The resident was erately cognitively impaired in ife decisions, scoring an 8 on the BIMS (Brief Interview am. The resident was tal care for bathing; for transfers, dressing, and t for eating after set-up help; |                     |                  |  |       |                            |
|   | (Xanax)0.25 mg (m<br>mouth every 6 hours<br>A review of the April 2<br>Administration Recor-<br>nurses notes reveale<br>administered the Xan  | ed 4/10/17 for "Alprazolam illigrams). Give 1 tablet by as needed for anxiety."  2017 MAR (Medication d), in conjunction with the  |                     |                  |  |       |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION  IG  |           | ATE SURVEY<br>DMPLETED     |
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|                          |  | 495407  | B. WING _               |  |           | C<br><b>05/18/2017</b>     |
|                          | ROVIDER OR SUPPLIER  | AB CENTER   |                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406     | •         |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF COF<br>( (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 329                    | non-pharmacologica as having been offer that occurred on 4/14/22/17. In addition 4/13/17, 4/16/17, 4/4/29/17, non-pharmattempted, however the resident's signs/ A review of the May with the nurses note administered the Xa 5/11/17, 5/3/17, 5/6/15/11/17, and 5/16/11/17, and 5/16/11/17, and 5/10/17 non-pharmacologica as having been offer 5/3/17 and 5/10/17, 5/10/17, non-pharmattempted, however the resident's signs/ On 5/17/17 at approximatempted, however the resident's signs/ On 5/17/17 at approximatempted in the control of the symptoms of anxiet non-pharmacological the assessment and documented in the control of the resident it was not documented in the control of the resident | and 4/29/17. There were no all interventions documented red for the administrations 0/17, 4/13/17, 4/18/17, and , for the dates of 4/10/17, 18/17, 4/22/17, 4/25/17, and accological interventions were the facility did not document symptoms of anxiety.  2017 MAR in conjunction as revealed the resident was anax on the following dates: 7, 5/7/17 (twice), 5/10/17, 7. There were no all interventions documented red for administrations on In addition, for the dates of 7, 5/7/17 (second dose), and accological interventions were the facility did not document symptoms of anxiety.  Eximately 2:00 p.m., in an 44 (Licensed Practical Nurse), an a resident complains of hould assess the resident's y, and attempt all interventions. She stated a interventions should be clinical record. She stated cumented, then it wasn't done. | F3                      | 29   |           |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>PLETED           |
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|                          |  |  |                    |     |  | (                 | c                          |
|                          |  | 495407   | B. WING _          |     |  | 05/               | 18/2017                    |
|                          | ROVIDER OR SUPPLIER  N NURSING AND REHA  | B CENTER   |                    | 14  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>40 BRIMLEY DRIVE<br>REDERICKSBURG, VA 22406                                    |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | х   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 329                    | one for "Non-pharm (pinterventions such as encourage to express was dated 4/11/17.  A review of the facility Management" docum pain has been identifi behavior, the resident Management Prograr been evaluated and it not the issue, refer to Correction for Exhibite non-pharmacological did not have a policy antianxiety medication.  On 5/17/17 at 5:13 p.: Staff Member) the Ad Director of Nursing, a director of clinical services. | The interventions included pharmacological) redirection, rest periods, a feelings." This intervention policy "Behavior ented, "2. In the event that ed as the contributing to the twill be referred to the Pain and 3. Once the resident has a set is determined that pain is the "Immediate Plan of ed Behaviors" for interventions" The facility specific to the use of an and and a set in the "Immediate Plan of ed Behaviors" for interventions | F                  | 329 |  |                   |                            |
|                          | disorders. Information   | ov/druginfo/meds/a684001.h<br>APPEAR,<br>R TEMP  | F                  | 364 |  |                   | 6/22/17                    |
|                          |  | es and the facility provides-  |                    |     |  |                   |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | PLE CONSTRUCTION  G  |  | (X3) DATE<br>COMP | SURVEY<br>LETED            |
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|                          |   | 495407   | B. WING _           |  |  | 1                 | C<br><b>18/2017</b>        |
|                          | ROVIDER OR SUPPLIER   | B CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406   | -<br>IDE   | 1 00              | 10/2011                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BI<br>IE APPROPRIA   |                   | (X5)<br>COMPLETION<br>DATE |
| F 364                    | Continued From pag  (d)(1) Food prepared nutritive value, flavor  (d)(2) Food and drink and at a safe and ap This REQUIREMEN' by: Based on observation staff interview, and fawas determined that serve food at palatate facility dining rooms a units (both on the second floor dining rooms).  The findings include:  On 5/16/17 at 2:00 p conducted with 6 curthis group interview, food, especially brea second floor dining room 5/17/17 at 7:57 a breakfast meal service. | by methods that conserve, and appearance; a that is palatable, attractive, petizing temperature; I is not met as evidenced on, resident group interview, acility document review, it the facility staff failed to ble temperatures for one of 2 and one of 2 facility nursing cond floor).  I.m., a group interview was rent facility residents. During residents stated that the kfast, was served cold in the bom and nursing unit.  I.m., an observation of the ce was conducted. | F 3                 | DEFICIENCY   | s re-checked tential to be detice.  vill in-service temperature initor holding vice. Plate defor 2nd flow the point of the service and there is and the committee committee. | ed ee ees ng poor |                            |
|                          |   | e quiche - 172 degrees<br>quiche - 164 degrees<br>degrees<br>2 degrees<br>5 degrees  |                     |  |  |                   |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '               | PLE CONSTRUCTION  G   | (X3      | ) DATE SURVEY<br>COMPLETED |
|--------------------------|--|---|---------------------|---|----------|----------------------------|
|                          |  | 495407  | B. WING _           |   |          | C<br><b>05/18/2017</b>     |
|                          | ROVIDER OR SUPPLIER  JN NURSING AND REHA   | B CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406          | I        | 03/10/2017                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 364                    | conducted of the merkitchen that was used the nursing unit of the temperatures were as Cheese and broccoli Sausage patties - 100 Oatmeal - 145.6 degrifus Two surveyors tasted to be not warm enougenjoyment. OSM (oth dietary manager also stated that she though meal enjoyment.  B. On 5/17/17 at 8:00 the steam table in the were obtained, and with the were obtained, and with the were obtained, and with the steam table in the were obtained, and with the steam table in the were obtained, and with the steam table in the were obtained, and with the steam table in the were obtained, and with the steam table in the were and broccoli Cheese and sausage Sausage patties - 149.  On 5/17/17 at 8:41 a. from the second floor was conducted. At the were as follows:  Oatmeal - 130 degree Sausage patties - 100 Cheese and broccoli. | nu items from the main of to serve the residents on e second floor. The second floor and found it of the food and found it of for palatability for mealmer staff member) # 2, taste tested the food and hat it was warm enough for second floor dining room were as follows:  The second floor dining room were as follows: | F3                  | 64  |          |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                 | IPLE CONSTRUCTION   | 1, , | SURVEY<br>PLETED           |
|--|--|---------------------|---|------|----------------------------|
|  | 495407   | B. WING             |   |      | C                          |
| NAME OF PROVIDER OR SUPPLIES   |  | D: WillO            | STREET ADDRESS, CITY, STATE, ZIP CODE   | 05/  | /18/2017                   |
| FALLS RUN NURSING AND R  |  |                     | 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406  |      |                            |
| PREFIX (EACH DEFIC   | RY STATEMENT OF DEFICIENCIES<br>CIENCY MUST BE PRECEDED BY FULL<br>Y OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY) | D BE | (X5)<br>COMPLETION<br>DATE |
| (other staff memi 5/17/17 at 9:10 a meal from the se table were serve table at room ten the kitchen were that this may acc with food being so the factor of the factor of the factor of clinical the findings. No by the end of the THERAPEUTIC PHYSICIAN CFR(s): 483.60(e) (e) Therapeutic E (e)(1) Therapeutic E (e)(2) The attending physical service of the factor of clinical the findings of the factor of the factor of the findings. No by the end of the THERAPEUTIC PHYSICIAN CFR(s): 483.60(e) (e) Therapeutic E (e)(1) Therapeutic E (e)(2) The attending physical service or lice prescribing a result of the factor of the f | ew conducted with OSM #2 per) the dietary manager on h.m., it was revealed that the cond floor dining room steam d on plates that were stored on a hiperature; whereas the plates in stored in a plate warmer, and count for some of the concerns herved at low temperatures.  Accility policy, "Food bocumented, "3. Hot food items w 135 (degrees) while holding hot food should be at least 135 hated, which is defined as point of high plates were made aware of further information was provided survey.  DIET PRESCRIBED BY  E)(1)(2)  Diets  To do was revealed that the cond manager on high plates in | F3                  |   |      | 6/22/17                    |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ` ′  | PLE CONSTRUCTION  G  |  | (X3) DATE SURVEY<br>COMPLETED |  |
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|   |   | 495407  | B. WING _  |  | l  | C<br>5/18/2017                |  |
| NAME OF P   | ROVIDER OR SUPPLIER   |   | <del>                                     </del> | STREET ADDRESS, CITY, STATE, ZIP CODE  | 05   | 0/10/201/                     |  |
| TWANE OF TH   | TOVIDER OR OUT FEIER  |   |  |  |  |                               |  |
| FALLS RU  | IN NURSING AND REHA   | B CENTER  |  | 140 BRIMLEY DRIVE  |  |                               |  |
|   |   |   |  | FREDERICKSBURG, VA 22406   |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY)  | HOULD BE                                     | (X5)<br>COMPLETION<br>DATE    |  |
| F 367   | Continued From page by:   |   | F 3  |  |  |                               |  |
|   | Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that |   |  | Resident #14 no longer resifacility.   | des in the                                   |                               |  |
|   | prescribed therapeuti in the survey sample,   |   |  | <ol> <li>All residents have the potent<br/>affected by this deficient practic<br/>residents' diets have been audit<br/>accuracy.</li> </ol>  | e. Current                                   |                               |  |
|   | physician prescribed  | to provide Resident #14's<br>renal diet.  |  | DON and or designee(s) will licensed nurses on transcribing  | diet   |                               |  |
|   | The findings include:   |   |  | orders to the dietary communication  |  |                               |  |
|   | 2/7/17 and discharged<br>#14's diagnoses incluacute cholecystitis (1)<br>major depressive disc<br>day Medicare assess                             | e date) of 2/14/17 coded  |  | 4. DON and or designee(s) will resident diets weekly for 4 weel accuracy to ensure they are as and then monthly for 2 months. of audits will be taken to QAPI of for review and revision as need | ks for<br>prescribed<br>Results<br>committee |                               |  |
|   | Review of Resident #<br>revealed a physician's<br>renal diet with regular<br>consistency.   | s order dated 2/7/17 for a  |  |  |  |                               |  |
|   | Resident #14's complete on 2/8/17 failed to do regarding the residen  |   |  |  |  |                               |  |
|   | director of dietary ser<br>what process was in p<br>physician ordered die<br>OSM #2 stated, "We<br>slip (from nursing)."                          | m., an interview was (other staff member) #2 (the vices). OSM #2 was asked blace to ensure the correct t was served to residents. get a dietary communication DSM #2 stated dietary staff iet on the tray card served |  |  |  |                               |  |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION IG  | (>                             | (3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|---|---------------------|--|--------------------------------|------------------------------|
|                          |   | 495407  | B. WING _           |  |                                | C<br><b>05/18/2017</b>       |
|                          | ROVIDER OR SUPPLIER   | B CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406   | DE                             | 03/10/2017                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETION<br>DATE   |
| F 367                    | card system on the casked how she ensure the physician order. The physician prescrius attending the daily risunit managers or reverecord. OSM #2 was Resident #14's dietan On 5/17/17 at 9:40 a dietary communication documented Resider mark beside a regulatexture. The words, foods." were handwridiet was not checked diet documented on form is the diet that we the tray card system been served to Resident form we fill out that yen communication form the facility.  On 5/17/17 at 3:05 p conducted with LPN LPN #1 was asked we ensure physician ord communicated to the resident is admitted. form we fill out that g put the order in the casked if the information that is given to the dimatch the physician's | ne puts the diet into the tray omputer. OSM #2 was res the diet served matches OSM #2 stated she ensures bed diet is provided by sk meetings and talking to iewing the resident's clinical asked if she could provide by communication slip.  The communication slip.  The communication slip.  The communication slip.  The form dated 2/7/17 that and the state or der and a thin should be should be she could provide a son form dated 2/7/17 that and the she could provide the she dietary communication would have been entered into and the diet that would have the she she could have been entered into and the diet that would have the she she she could have the she she she she she she she she she s | F3                  | 67   |                                |                              |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION  G   | , ,       | ATE SURVEY<br>DMPLETED     |
|--------------------------|---|---|---------------------|---|-----------|----------------------------|
|                          |   | 495407  | B. WING             |   |           | C<br><b>05/18/2017</b>     |
|                          | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406            |           | 03/16/2017                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 367                    | (the director of nursir director of clinical set the above findings.  The facility policy title NOTIFICATION OF I Nursing Services shad Department of a resident set any changes in the reand food preferences new resident is admit changed, the Nurses the Food Services Denotice of the diet ord.  The facility dietary dedocumented:  "RENAL DIET (80 gram protein, 3 gram proteins. This diet may patients. This diet may patients requiring strimicronutrients sodium phosphorus. This diet protein, potassium, seruid intake should be the liberal renal diet grams of protein, 3,0 sodium, 3,000 mg of phosphorus. Although biological value protein per day due to phosp restrictions" | e administrator), ASM #2 ng) and ASM #3 (the regional rvices) were made aware of ed, "INTERDEPARTMENTAL DIET" documented, "Policy: all notify the Dietary dent's diet orders, including esident's diet, meal service, s. Procedure: 1. When a tted, or diet has been Supervisor shall ensure that epartment receives a written er" escription of a renal diet  gram sodium, Limited phorus) is for patients with acute, e renal disease and is pre-dialysis and hemodialysis ay not be appropriate for ict limits on protein or the | F 3                 | 67  |           |                            |

| C<br>5/18/2017<br>(X5)<br>COMPLETION<br>DATE |
|--|
| (X5)<br>COMPLETION                           |
| COMPLETION                                   |
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|  |
| 6/22/17                                      |
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| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | ` ′   | PLE CONSTRUCTION    | ` '   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|---------------------|---|-------------------------------|----------------------------|
|   |  |   |                     |   |                               | С                          |
|   |  | 495407  | B. WING             | <del> </del>  |                               | 05/18/2017                 |
| NAME OF P   | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                            |
| E4110 DI  |  | D OFNITED   |                     | 140 BRIMLEY DRIVE   |                               |                            |
| FALLS RU  | IN NURSING AND REHA  | B CENTER  |                     | FREDERICKSBURG, VA 22406  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)                             | HOULD BE                      | (X5)<br>COMPLETION<br>DATE |
| F 371   | Continued From page  | e 109   | F 37                | 71  |                               |                            |
|   | staff failed to prepare  | food in a sanitary manner.  |                     | hairnet.  |                               |                            |
|   |  | d to ensure hair restraints<br>ead and contained all hair,<br>kfast on 5/17/17.   |                     | 2. All residents have the potent affected by this deficient practice  | e.                            |                            |
|   | The findings include:  |   |                     | DM and or designee(s) will in dietary staff on the proper weari hairnets to ensure all hair is cov                    | ng of                         |                            |
|   | On 5/17/17 at 8:30 at was conducted in the   | .m., observation of tray line<br>kitchen.   |                     | DM and or designee(s) will a dietary employees daily for prop   |                               |                            |
|   | member) #1, the diet plating breakfast and food cart. OSM #1's around her head. He of her head to the ba bottom part of her ha   | n 5/17/17 at 8:35 a.m., OSM (other staff ember) #1, the dietary aide was observed ating breakfast and placing the plates onto the od cart. OSM #1's hair net was halfway ound her head. Her hair net covered the front her head to the back of her ponytail. The ottom part of her hair was uncovered. Wisps of air were also hanging out of the side of her hair et. |                     | placement daily for 4 weeks and weekly for 8 weeks. Results of be taken to QAPI committee for and revision as needed. | then<br>audits will           |                            |
|   | asked the purpose of that the purpose of the food from getting into that the hair net show enters the kitchen are net was on properly, pulling the back of new of her hair. OSM #1 a hair on the side of her | #1, the dietary aide. When the hair net, OSM #1 stated he hair net was to prevent the food. OSM #1 stated hald be worn by all staff that hea. When asked if her hair hea. When asked if her hair hea. When asked her hair net by het down covering the bottom halso tucked in the wisps of head. OSM #1 confirmed hairing the hair net properly.                      |                     |   |                               |                            |
|   | conducted with OSM<br>When asked the purpostated that the purpo  | #2, the Dietary Manager. cose of the hair net, OSM #2 se of the hair net was to staminating the food. When  |                     |   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | I ' '  | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED   |                 |
|---|--|--|---------------------|---|-----------------|
|   |  | 495407   | B. WING             |   | C<br>05/18/2017 |
|   | ROVIDER OR SUPPLIER  | I  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                                  | 1 03/10/2017    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)        |                 |
| F 371   | stated that the hair mentire head. OSM #2 in the food service are net.  On 5/17/17 at 11:07 a staff member) #1, the regional director of claware of the above fire aware of the above fire recipitation of the procedure: 1. Wear clothes" No further prior to exit.  PHARMACEUTICAL PROCEDURES, RPF CFR(s): 483.45(a)(b)  (a) Procedures. A far pharmaceutical service that assure the accurdispensing, and admibiologicals) to meet to the service Consultation. | et should be worn, OSM #2 et should be covering the et stated that all staff working ea should be wearing a hair  a.m., ASM (administrative e administrator and ASM #3, inical services, were made ndings.  Employee Sanitary es in part, the following: hair restraints and clean information was presented  SVC - ACCURATE H (1) | F 371               |   | 6/22/17         |
|   | provision of pharmac<br>This REQUIREMENT<br>by:<br>Based on staff interv<br>review, clinical record<br>a complaint investiga   | tion on all aspects of the y services in the facility; is not met as evidenced riew, facility document dreview and in the course of tion, it was determined that to ensure medications were  |                     | <ol> <li>Resident #14 no longer resides in the facility.</li> <li>All residents have the potential to be</li> </ol> |                 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |   |     | (X3) DATE SURVEY<br>COMPLETED   |    |                       |
|--|--|---|---|-----|---|----|-----------------------|
|  |  | 495407  | B. WING   |     |   | l  | C<br>/ <b>18/2017</b> |
| NAME OF PI   | ROVIDER OR SUPPLIER  | 1,00.00   |   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  | 05 | 110/2017              |
|  |  |   |   | 1   | 40 BRIMLEY DRIVE  |    |                       |
| FALLS RU   | IN NURSING AND REHA  | B CENTER  |   | F   | REDERICKSBURG, VA 22406   |    |                       |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES  ID  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY) |   |     | (X5)<br>COMPLETION<br>DATE  |    |                       |
| F 425  | Continued From page  | e 111   | F4  | 425 |   |    |                       |
|  | available for administ<br>one of 26 residents ir<br>Resident #14.  | ration in a timely manner for   | urvey sample, and or designee(s) reviews residents admitted from 5/5/31/2017 for medication a |     | affected by this deficient practice. DOI and or designee(s) reviewed new residents admitted from 5/18/2017 thru 5/31/2017 for medication availability ar notification.                          |    |                       |
|  | #14's Verapamil and  |   |   |     | The DON and or designee(s) will in-service licensed nurses on the policy  |    |                       |
|  | b. The facility staff failed to acquire Resident #14's ranolazine (used to treat chest pain) for administration on 2/7/17 at 8:00 p.m. and on 2/8/17 at 8:00 a.m. due to an untimely response to a pharmacy concern regarding a drug interaction. On 2/8/17 at 6:38 p.m. as needed Nitroglycerin was administered to the resident for a complaint of chest pain. |   |   |     | for medication availability, including MI notification when medication is not available.  | J  |                       |
|  |  |   |   |     | 4. DON and or designee(s) will audit n residents for medication availability 5x each week for 4 weeks and then week for 8 weeks. Results of audits will be taken to the QAPI committee x3 month | у  |                       |
|  | The findings include:  |   |   |     | for review and revision as needed.  |    |                       |
|  |  | led to acquire Resident<br>nd Candesartan (2) for<br>/17 at 8:00 p.m.   |   |     |   |    |                       |
|  | 2/7/17 and discharge<br>#14's diagnoses incluacute cholecystitis (3<br>major depressive disc<br>day Medicare assess  | ce date) of 2/14/17 coded   |   |     |   |    |                       |
|  | an admission assess  | 14's clinical record revealed<br>ment dated 2/7/17 that<br>dent arrived to the facility on  |   |     |   |    |                       |
|  | Resident #14's physic  | cian's orders dated 2/7/17  |   |     |   |    |                       |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN   | PLE CONSTRUCTION  G |   | ATE SURVEY<br>OMPLETED |                            |
|--|---|--|---------------------|---|------------------------|----------------------------|
|  |   | 495407   | B. WING _           |   |                        | C<br><b>05/18/2017</b>     |
|  | ROVIDER OR SUPPLIER   | AB CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406            |                        | 00/10/2017                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | I SHOULD BE            | (X5)<br>COMPLETION<br>DATE |
| F 425  | Continued From pag  | ge 112   | F 4                 | 25  |                        |                            |
|  | including but not lim - Verapamil 120 mg-<br>bedtime (scheduled - Candesartan 4 mg  | one capsule by mouth at  |                     |   |                        |                            |
|  | (medication adminis resident was not adminis p.m. dose of the above evidenced by an "x" Further review of the MAR notes and nurs Resident #14's physical procession of the control of the | #14's February 2017 MAR tration record) revealed the ministered the scheduled 8:00 ove medications on 2/7/17 (as documented on the MAR). e clinical record (including ses' notes) failed to reveal ician was made aware that ns were not administered.   |                     |   |                        |                            |
|  | revealed the prescri<br>Candesartan were n  |  |                     |   |                        |                            |
|  | conducted with RN (stated if medications resident haven't arrive should be obtained if RN #1 stated if the medication then nursuand the pharmacy with Conference of the conducted with OSM consulting pharmacians.  | a.m., an interview was fregistered nurse) #1. RN #1 is for a newly admitted wed then the medications from the STAT box if in stock. Interview was an unusual sees can make a STAT order will send the medication faster.  D.m., an interview was frequency (other staff member) #3 (the st). OSM #3 was asked to that was in place to ensure |                     |   |                        |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULT<br>A. BUILDIN  | IPLE CONSTRUCTION IG | ' '   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|----------------------|---|-------------------------------|----------------------------|
|   |   | 495407   | B. WING _            |   |                               | C<br>05/18/2017            |
|   | ROVIDER OR SUPPLIER   | AB CENTER  |                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406          |                               |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF COF<br>( (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE /<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
|   | pharmacy has set ditimes (a time when the be sent to the pharm medication on the number of time (other than the has to call the pharm medication is needed facility STAT box (a medications) then the from a local pharma some specialty drug specialty drug specialty pharmacy of those drugs and to those drugs. OSM of Candesartan were not considered specialty drugs and those drugs. OSM of Candesartan were not considered specialty drugs and the set of the pharmacy drugs. Osm of the nurse responsible verapamil and Cando 2/7/17 at 8:00 p.m.). The sidents are admitted the transportation per orders to the pharmacy to ser (immediately) on the pharmacy usually do STAT so if a resident medication then she they received the factimes, she does not the orders are place. | dents received their cons. OSM #3 stated the elivery times and set cut off the medication order has to nacy in order to receive the ext delivery). OSM #3 stated ded right away or at another delivery times) then the nurse nacy. OSM #3 stated if the d right away and is not in the box containing various he medication can be sent cy. OSM #3 stated there are s that have to come from a and the facility is made aware he processes for obtaining #3 confirmed Verapamil and not in the STAT box but were cialty drugs.  D.m.an interview was (licensed practical nurse) #1 | F 4                  | 25  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                    |     | (X3) DATE SURVEY<br>COMPLETED   |       |                            |
|---|---|--|--------------------|-----|---|-------|----------------------------|
|   |   | 495407   | B. WING            |     |   | 1     | C<br>/ <b>18/2017</b>      |
|   | ROVIDER OR SUPPLIER   | B CENTER   | 1                  | 1   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>40 BRIMLEY DRIVE<br>REDERICKSBURG, VA 22406                         | 1 03/ | 10/2017                    |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE |
| F 425   | stated nurses can acc and most of the time needed medications. box does not contain then nurses notify the give another medicatimedications until they LPN #1 was shown R 2017 MAR. LPN #1 s Resident #14's sched were given on 2/7/17 medications were not didn't remember if shoot.  On 5/17/17 at 5:30 p. staff member) #1 (the (the director of nursin director of clinical ser the above findings.  The pharmacy deliverorders received by 9: pharmacy by 10:00 a 11:00 p.m. depart the The schedule docume orders needed after 6 accompanied by a phenomenature. The facility pharmacy for Non-Controlled Staff the medication is no scheduled delivery ar Emergency Medicatic Facility staff should: 5.1.1 Fax or transmit | the STAT box contains the LPN #1 stated if the STAT the needed medications is physician and he will say to on or to hold the varrive from the pharmacy. It is is estated she didn't remember if it is is included evening medications or what was done if the given. LPN #1 stated she is contacted the physician or included evening medications or what was done if the given. LPN #1 stated she is contacted the physician or included evening medications or what was done if the given. LPN #1 stated she is contacted the physician or included evening medications or what was done if the given. ASM (administrative experience) administrator), ASM #2 g) and ASM #3 (the regional vices) were made aware of included evening medications. In the included in the included the exact include | F                  | 425 |   |       |                            |

| NAME OF PROVIDER OR SUPPLIER  FALLS RUN NURSING AND REHAB CENTER  FALLS RUN NURSING AND REHAB CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406  (XA) ID SUMMARY STATEMENT OF DEFIDIENCIES [EACH DEPICIENCY MUST as PRICCIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FALTS  Continued From page 115 No further information was presented prior to exit.  (1) "Verapamil is used to treat high blood pressure and to control angina (chest pain)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684030.h tml  (2) "Candesartan is used alone or in combination with other medications to treat high blood pressure" This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601033.h tml  (3) "Acute cholecystitis is sudden swelling and irritation of the gallbladder. It causes severe belly pain." This information was obtained from the website: https://medlineplus.gov/ency/article/000264.htm  COMPLAINT DEFICIENCY  b. The facility staff failed to acquire Resident #14's ranolazine (1) for administration on 27717 at 8:00 p.m. and on 2/8/17 at 8:00 a.m. due to an untimely response to a pharmacy concern regarding a drug interaction. On 2/8/17 at 6:38 p.m. as needed Nitroglycerin (2) was administered to the resident for a complaint of chest pain.   | AND DUAN OF CORRECTION INTEREST IDENTIFICATION NUMBER: |   | ` ′   | PLE CONSTRUCTION  G |   | COMPLETED |                |
|--|--|---|---|---------------------|---|-----------|----------------|
| NAME OF PROVIDER OR SUPPLIER  FALLS RUN NURSING AND REHAB CENTER    CAPITOR   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTIVA AND REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTIVA BOULD BE CONFIDENCE   CROSS-REFERENCE TO TO IN SUMMARY STATEMENT OF DEFICIENCY BY TAG   PREFIX   CROSS-REFERENCE TO TO IN A PHYROPRIATE   DEFICIENCY   D |  |   | 495407  | B. WING             |   |           | C<br>=/49/2047 |
| FREEIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 425  Continued From page 115  No further information was presented prior to exit.  (1) "Verapamil is used to treat high blood pressure and to control angina (chest pain)."  This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684030.h tml  (2) "Candesartan is used alone or in combination with other medications to treat high blood pressure" This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601033.h tml  (3) "Acute cholecystitis is sudden swelling and irritation of the gallbladder. It causes severe belly pain." This information was obtained from the website: https://medlineplus.gov/ency/article/000264.htm  COMPLAINT DEFICIENCY  b. The facility staff failed to acquire Resident #14's ranolazine (1) for administration on 2/7/17 at 8:00 p.m. and on 2/8/17 at 8:00 a.m. due to an untimely response to a pharmacy concern regarding a drug interaction. On 2/8/17 at 6:38 p.m. as needed Nitroglycerin (2) was administered to the resident for a complaint of chest pain.   |  |   |   |                     | 140 BRIMLEY DRIVE   |           | 5/16/2017      |
| No further information was presented prior to exit.  (1) "Verapamil is used to treat high blood pressure and to control angina (chest pain)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684030.h tml  (2) "Candesartan is used alone or in combination with other medications to treat high blood pressure" This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601033.h tml  (3) "Acute cholecystitis is sudden swelling and irritation of the gallbladder. It causes severe belly pain." This information was obtained from the website: https://medlineplus.gov/ency/article/000264.htm  COMPLAINT DEFICIENCY  b. The facility staff failed to acquire Resident #14's ranolazine (1) for administration on 2/7/17 at 8:00 p.m. and on 2/8/17 at 8:00 a.m. due to an untimely response to a pharmacy concern regarding a drug interaction. On 2/8/17 at 6:38 p.m. as needed Nitroglycerin (2) was administered to the resident for a complaint of chest pain.  | PRÉFIX   | (EACH DEFICIEN  | CY MUST BE PRECEDED BY FULL   | PREFIX              | (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR | ULD BE    | COMPLETION     |
| Review of Resident #14's clinical record revealed an admission assessment dated 2/7/17 that documented the resident arrived to the facility on 2/7/17 at 4:30 p.m. Further review of Resident #14's clinical record revealed a physician's order dated 2/7/17 for ranolazine 1000 mg (milligrams)-   | F 425  | No further information  (1) "Verapamil is use pressure and to con This information was https://medlineplus.gtml  (2) "Candesartan is with other medication pressure" This information the website: https://medlineplus.gtml  (3) "Acute cholecystirritation of the gallbipain." This information website: https://medlineplus.gtml  b. The facility staff fafult's ranolazine (1) at 8:00 p.m. and on untimely response to regarding a drug into p.m. as needed Nitra administered to the chest pain.  Review of Resident an admission assest documented the rese 2/7/17 at 4:30 p.m. #14's clinical recording the superior of the condition of the superior of the chest pain. | ed to treat high blood trol angina (chest pain)." sobtained from the website: gov/druginfo/meds/a684030.h used alone or in combination insito treat high blood formation was obtained from gov/druginfo/meds/a601033.h ditis is sudden swelling and adder. It causes severe belly ion was obtained from the gov/ency/article/000264.htm cities to acquire Resident for administration on 2/7/17 2/8/17 at 8:00 a.m. due to an of a pharmacy concerning eraction. On 2/8/17 at 6:38 coglycerin (2) was resident for a complaint of the facility on Further review of Resident revealed a physician's order | F 4:                | 25  |           |                |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | 1 ' '   | LE CONSTRUCTION     | , ,   | (X3) DATE SURVEY COMPLETED C |                            |  |
|---|--|---|---------------------|---|------------------------------|----------------------------|--|
|   |  | 495407  | B. WING             |   |                              | 05/18/2017                 |  |
|   | ROVIDER OR SUPPLIER  | IAB CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406            | 1                            | 00/10/2011                 |  |
| (X4) ID<br>PREFIX<br>TAG  | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD BE                     | (X5)<br>COMPLETION<br>DATE |  |
| F 425   | (medication admini- resident was not ac 2/7/17 at 8:00 p.m.  Review of the facilit box containing varia ranolazine was not  A nurse's note date documented, "Rano Release) Tablet Ex MG- Give 1 tablet bangina; pharmacys (4) (another medic #14) could not be g 1000 mgs (milligrar notified." The clinic the date/time the pl above note and wh was.  A nurse's note date documented Reside nitroglycerin at that pain. A nurse's not documented the nit  Further review of R MAR revealed the r ranolazine on 2/8/1  Resident #14's com | at #14's February 2017 MAR stration record) revealed the Iministered ranolazine on or on 2/8/17 at 8:00 a.m.  By STAT (immediate) box (a bus medications) list revealed available in the STAT box.  If 2/8/17 at 1:03 p.m.  Clazine ER (Extended tended Release 12 Hour 1000 by mouth two times a day for said ranolazine and verapamil action prescribed to Resident iven together in high dose of ins). md (medical doctor) cal record failed to document hysician responded to the at the physician's response  If 2/8/17 at 6:38 p.m.  Bent #14 was administered time for a complaint of chest e dated 2/8/17 at 7:03 p.m.  By STAT (immediate) box (a complaint of chest e dated 2/8/17 at 7:03 p.m.  By STAT (immediate) box (a complaint of chest e dated 2/8/17 at 7:03 p.m.  By STAT (immediate) box (a complaint of chest e dated 2/8/17 at 7:03 p.m.  By STAT (immediate) box (a complaint of chest e dated 2/8/17 at 7:03 p.m.  By STAT (immediate) box (a complaint of chest e dated 2/8/17 at 7:03 p.m.  By STAT (immediate) box (a complaint of chest e dated 2/8/17 at 7:03 p.m.  By STAT (immediate) box (a complaint of chest e dated 2/8/17 at 7:03 p.m.  By STAT (immediate) box (a complaint of chest e dated 2/8/17 at 7:03 p.m.  By STAT (immediate) box (a complaint of chest e dated 2/8/17 at 7:03 p.m.  By STAT (immediate) box (a complaint of chest e dated 2/8/17 at 7:03 p.m.  By STAT (immediate) box (a complaint of chest e dated 2/8/17 at 7:03 p.m. | F 42                | 5   |                              |                            |  |
|   | regarding medication   | document information on administration or angina.  a.m., an interview was   |                     |   |                              |                            |  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION   | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|---------------------|--|----------------------------|
|                          |  | 495407   | B. WING             |  | C<br>05/18/2017            |
|                          | ROVIDER OR SUPPLIER  | AB CENTER  | ,                   | STREET ADDRESS, CITY, STATE, ZIP CODE 40 BRIMLEY DRIVE FREDERICKSBURG, VA 22406                        | 03/10/2017                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETION            |
| F 425                    | nurse responsible for Resident #14 on 2/8 stated she didn't rer was shown the above documented on 2/8, the physician doesn recommendations is regarding the pharminteraction of admin ranolazine with verathe physician's responders. RN #1 state continue." RN #1 state continue. RN #1 state administrative staff director of nursing) conversations can't conversations have  On 5/17/17 at 3:05 conducted with LPN (the nurse responsi ranolazine to Residing. LPN #1 state admitted she takes transportation peoporders to the pharmacy to set (immediately) on the | (registered nurse) #1 (the or administering ranolazine to 3/17 at 8:00 a.m.) RN #1 member Resident #14. RN #1 we nurse's note that she /17 at 1:03 p.m. RN #1 stated of the allow and the istering a high dose of apamil. RN #1 could not verify onse to the pharmacy on 2/8/17. RN #1 on 2/8/17. RN #1 on a computer on a compute | F 425               |  |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |                     | (X3) DATE SURVEY<br>COMPLETED   |           |                            |
|---|---|---|---------------------|---|-----------|----------------------------|
| <b>495407</b> B. WING   |   |   |                     | C<br>/ <b>18/2017</b>   |           |                            |
|   | ROVIDER OR SUPPLIER  JN NURSING AND REHA  | B CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406              |           | 110/2011                   |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 425   | medication then she of they received the fax. times, she does not of the orders are placed automatically go to the orders are placed automatically go to the The pharmacy "Grid I pharmacy and presers staff member) #2 (the 5/17/17 at 3:34 p.m. of at 9:44 p.m. the pharminteraction between reconsideral to the pharmacy spoke with she would clarify the physician. On 2/8/17 told the pharmacy the okay to administer the and the nurse reques STAT. The pharmacy Resident #14's ranola facility on 2/8/17 at 9:  On 5/17/17 at 5:30 p. administrator), ASM # and ASM #3 (the registervices) were made A policy for following requested. ASM #3 shave the requested pharmacy "Physician/Prescriber Communication of Ordocumented," 6. Pha staff via fax or telepharmedication when the | is prescribed a narcotic pain calls the pharmacy to see if  LPN #1 stated most other all the pharmacy because in the computer and should e pharmacy.  Notes" obtained from the need by ASM (administrative edirector of nursing) on documented that on 2/7/17 macy identified an anolazine and verapamil.  In an employee from the a facility nurse who stated interaction with the at 7:10 p.m. another nurse exphysician stated it was the ranolazine to Resident #14 ted the medication be sent of manifest documented azine was delivered to the 52 p.m.  m., ASM #1 (the #2 (the director of nursing) onal director of clinical aware of the above findings. physician's orders was stated the facility did not olicy.  Topolicy titled, Authorization and | F 4:                | 25  |           |                            |

|                          | OF DEFICIENCIES  CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '               | PLE CONSTRUCTION  3   | · /      | ATE SURVEY<br>DMPLETED     |
|--------------------------|--|--|---------------------|---|----------|----------------------------|
|                          |  | 495407   | B. WING             |   |          | C<br><b>05/18/2017</b>     |
|                          | ROVIDER OR SUPPLIER  | B CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406          | <u> </u> | 03/10/2017                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 425                    | vague, contraindicate interaction. 6.1 Facil machine(s) for any pl 6.2 Pharmacy will ho Physician/Prescriber 6.3 Facility should cowhen staff is notified requiring clarification the issue to the Physician the issue to the Physician and creceived. 6.5 Facility communicate the residirections to the Pharman No further information (1) "Ranolazine is us medications to treat contest pain or pressur does not get enough was obtained from the https://medlineplus.g. tml  (2) Nitroglycerin is us pain). This information website: https://www.ncbi.nlm. T0001281/  (3) "Acute cholecystif irritation of the gallblate pain." This information website: https://medlineplus.g. (4) "Verapamil is use | unclear, incomplete or ed, or has a drug-drug ity staff should check the fax harmacy communication. Id medication orders until is able to clarify the order. Intact Physician/Prescriber by Pharmacy of an order of the fax harmacy of th | F 42                | 25  |          |                            |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     |  | , ,                            | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|---------------------|--|--------------------------------|-------------------------------|--|
|                          |   |  | 7 56.25             |  |                                | С                             |  |
|                          |   | 495407   | B. WING _           |  | o                              | 5/18/2017                     |  |
|                          | ROVIDER OR SUPPLIER  N NURSING AND REHA   | B CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406 | DDE                            |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY      | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 425                    |   | e 120<br>obtained from the website:<br>ov/druginfo/meds/a684030.h  | F4                  | 425  |                                |                               |  |
|                          | COMPLAINT DEFICI<br>DRUG REGIMEN RE<br>IRREGULAR, ACT O<br>CFR(s): 483.45(c)(1)(          | EVIEW, REPORT<br>N   | F 4                 | 428  |                                | 6/22/17                       |  |
|                          | c) Drug Regimen Rev   | riew   |                     |  |                                |                               |  |
|                          |   | of each resident must be e a month by a licensed   |                     |  |                                |                               |  |
|                          | brain activities associ<br>and behavior. These  | ug is any drug that affects atted with mental processes drugs include, but are not e following categories: |                     |  |                                |                               |  |
|                          | (i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic. |  |                     |  |                                |                               |  |
|                          | to the attending physi  | ctor and director of nursing,  |                     |  |                                |                               |  |
|                          | drug that meets the c   | le, but are not limited to, any riteria set forth in paragraph an unnecessary drug.                        |                     |  |                                |                               |  |
|                          | during this review mu<br>separate, written repo   | noted by the pharmacist set be documented on a port that is sent to the nd the facility's medical          |                     |  |                                |                               |  |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                   | LE CONSTRUCTION   | СОМ  | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|-----------------------|---|--|-------------------------------|--|
|                          |  | 495407   | <b>495407</b> B. WING |   | C<br><b>05/18/2017</b>                         |                               |  |
|                          | ROVIDER OR SUPPLIER  |  |                       | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406  | 03   | 110/2017                      |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY)   | OULD BE  | (X5)<br>COMPLETION<br>DATE    |  |
| F 428                    | minimum, the reside and the irregularity the (iii) The attending pheresident's medical reirregularity has been action has been take be no change in the physician should door the resident's medical (5) The facility must and procedures for the review that include, the frames for the different steps the pharmacist identifies an irregular to protect the resident This REQUIREMENT by:  Based on staff interview, and clinical redetermined that facility medication regiment completed and readifiled in the clinical rein the survey sample #10.  1. The facility staff farmedication regiment review and or filed in Resident # 7, and fair monthly medication regiment 2016 were completed. | of nursing and lists, at a nt's name, the relevant drug, he pharmacist identified.  ysician must document in the cord that the identified reviewed and what, if any, an to address it. If there is to medication, the attending rement his or her rationale in all record.  develop and maintain policies he monthly drug regimen rout are not limited to, time and steps in the process and a must take when he or she rity that requires urgent action att.  To is not met as evidenced view, facility document record review, it was the staff failed to ensure reviews (MRRs) were by available for review and or cord for four of 26 residents, Residents #7, #1, #5 and willed to have monthly reviews readily available for the clinical record for led to provide evidence the reviews for June and July | F 42                  | 1. MRR of residents #7, 1, 5, and now with the residents medical re  2. All residents have the potential affected by this deficient practice. Records of current residents have audited to ensure MRR's are cont within the resident record.  3. DON and or designee has insunit managers and medical record on the process for maintaining an accurate medical record and the profiling pharmacy review/recommendation into the redical record, this also includes pharmacist ability to document into | to be to been tained serviced ds clerk process |                               |  |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING          |       |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|--|--|-------|--|-------------------------------|----------------------------|
|                          |  | 495407   | B. WING _  |       |  | C<br><b>05/18/2017</b>        |                            |
| NAME OF PI               | ROVIDER OR SUPPLIER  | l  |  | S1    | TREET ADDRESS, CITY, STATE, ZIP CODE   | 1 00/                         | 10/2017                    |
|                          |  |  |  | 14    | 10 BRIMLEY DRIVE   |                               |                            |
| FALLS RU                 | IN NURSING AND REHA  | B CENTER   |  | FI    | REDERICKSBURG, VA 22406  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX |       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  |                               | (X5)<br>COMPLETION<br>DATE |
| F 428                    | Continued From page 122  |  | F4   | F 428 |  |                               |                            |
| F 420                    | clinical record or reach failed to provide evide reviews were comple December 2016.  3. The facility staff fair medication regimen in recommendations for available for review of the facility staff fair March 2017 and April readily available for reclinical record.  The findings include:  Resident # 7 was addressed of 105/01/14 with diagnoral not limited to: enceptions. | lily available for review and ence the medication regimen ted in November and led to have the monthly eviews and pharmacy Resident #5, readily r filed in the clinical record.  Iled to have Resident #10's 2017 pharmacy reviews eview and or filed in the mitted to the facility on sees that included but were halopathy (1), muscle n, aphasia (2), dementia (3), troesophageal reflux | F 2  | 128   | 4. The MRR's and pharmacy recommendations will be audited again the pharmacists list by the medical records clerk weekly for 2 weeks and the monthly for 2 months. Results of audit will be taken to QAPI x3 months for review and revision as needed. | nen                           |                            |
|                          | set), a quarterly asse<br>(assessment reference<br>Resident # 7 as scori<br>interview for mental s<br>- 15, 13 being cogniti-<br>decisions. Resident s   | ce date) of 03/22/17, coded  |  |       |  |                               |                            |
|                          |  | record revealed that<br>medication regimen reviews<br>April 2017 could not be  |  |       |  |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '               | PLE CONSTRUCTION  G   | (X3       | COMPLETED                  |  |
|--|--|---|---------------------|---|-----------|----------------------------|--|
|  |  | 495407  | B. WING             |   |           | C<br><b>05/18/2017</b>     |  |
|  | ROVIDER OR SUPPLIER  JN NURSING AND REHA   | I   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406              |           |                            |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |  |
| F 428  | located.  On 05/17/17 at 4:50 conducted ASM (adm 2, the director of nurs regimen reviews (MF through April 2017 fo to describe the proce MRRs, ASM # 2 state into the facility during month and completes and leaves me the rethe recommendations them and go over the up with the recomme then filed in a binder then asked to provide dated May 2016 through April 20 On 05/18/17 at 10:15 director of nursing state locate the MRRs for 2016 through April 20 On 05/18/17 at approinterview was conducted pharmacist. When a for completing and fill stated, "I review the recommendations are DON (director of nursing stated about the missing dated May 2016 through April 20 on 05/18/17 at approinterview was conducted the missing the form of the resistence of the missing dated May 2016 through April 20 on 05/18/17 at approinterview was conducted the missing dated May 2016 through April 20 on 05/18/17 at approinterview was conducted the missing dated May 2016 through April 20 on 05/18/17 at approinterview was conducted the missing dated May 2016 through April 20 on 05/18/17 at approinterview was conducted the missing dated May 2016 through April 20 on 05/18/17 at approinterview was conducted the missing dated May 2016 through April 20 on 05/18/17 at approinterview was conducted the missing dated May 2016 through April 20 on 05/18/17 at approinterview was conducted the missing dated May 2016 through April 20 on 05/18/17 at approinterview was conducted the missing dated May 2016 through April 20 on 05/18/17 at approinterview was conducted the missing dated May 2016 through April 20 on 05/18/17 at approinterview was conducted the missing dated May 2016 through April 20 on 05/18/17 at approinterview was conducted the missing dated May 2016 through April 20 on 05/18/17 at approinterview was conducted the missing dated May 2016 through April 20 on 05/18/17 at approinterview was conducted the missing dated May 2016 through April 20 on 05/18/17 at approinterview was conducted the date of 05/18/17 at approinterview was conducted the missing dat | o.m. an interview was ininistrative staff member) # sing regarding the medication (Rs) dating May 2016 r Resident # 7. When asked as regarding a resident's ed, "The pharmacist comes the first seven days of each is the MRRs for each resident commendations. I review so by the pharmacist, sign em with the physician, follow indations. The MRRs are in my office." ASM # 2 was enthe MRRs for Resident # 7 augh April 2017.  The a.m. ASM # 4, assistant atted that they were unable to Resident # 7 dated May 217. | F 4:                | 28  |           |                            |  |

| _ ` · · ·  |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '  | PLE CONSTRUCTION  G  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|---|--|--|-------------------------------|--|
|  |   | 495407  | B. WING  |  | C<br><b>05/18/2017</b>        |  |
| NAME OF PROVIDER OR SUPPLIER  FALLS RUN NURSING AND REHAB CENTER |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406 | 1 30/10/2011   |                               |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORREC'<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRI<br>DEFICIENCY) | JLD BE COMPLETION             |  |
| F 428  | the facility from the place Resident #7 dated Mathrough April 2017. The evidence that the MR were completed.  No further information  The facility's policy "Mathrough April 2017. The facility's policy "Mathrough April 2018. The facility's policy "Mathrough Application of the recomm MRR are act upon the recomm MRR. For those issue Physician/Prescriber encourage Physician/Prescriber encourage Physician/Application of the recommendation was maintain copies of MI either as part of the record or in a special Applicable Law."  On 05/17/17 at approduction of the record or in a special Applicable Law."  On 05/17/17 at approduction of the record or in a special Applicable Law."  On 05/17/17 at approduction of the record or in a special Applicable Law."  On 05/17/17 at approduction of the record or in a special Applicable Law."  On 05/17/17 at approduction of the record or in a special Applicable Law."  On 05/17/17 at approduction of the record or in a special Applicable Law."  On 05/17/17 at approduction of the record or in a special Applicable Law." | the MRRs that were faxed to narmacist on 05/18/17 for ay 2016, August 2016 The facility was unable to Rs for June and July 2016  Medication Regimen Review" dility should encourage or other Responsible Parties and the Director of Nursing to endations contained in the est hat require intervention, Facility should (Prescriber to either (a) the recommendations MRR, or (b) reject all or endations contained in the explanation as to why the explanation as to why the explanation as to why the strejected. 9. Facility, esident's permanent medical file, in accordance with  Eximately 5:00 p.m. ASM member) # 1 the EM # 2, director of nursing, the findings. | F 42   | <u> </u>   |                               |  |
|  | alters brain function of was obtained from the  | gov/disorders/encephalopath   |  |  |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |  | LE CONSTRUCTION     | (X3) DATE SURVEY<br>COMPLETED  |                 |  |
|---|--|--|---------------------|--|-----------------|--|
|   |  | 495407   | B. WING             |  | 05/18/2017      |  |
|   | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                   | 03/10/2017      |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE COMPLET |  |
| F 428   | Continued From pag   | e 125  | F 42                | 8  |                 |  |
|   | the brain that control hard for you to read, mean to say). This in the website: https://www.nlm.nih.gl  3. A group of sympto affect the brain. This from the website: https://www.nlm.nih.gml.  4. High blood pressu obtained from the we https://www.nlm.nih.gessure.html.  5. Stomach contents | gov/medlineplus/highbloodpr<br>to leak back, or reflux, into<br>rritate it. This information   |                     |  |                 |  |
|   | 6. A swallowing disor  | gov/medlineplus/gerd.html.  rder. This information was  ebsite: gov/medlineplus/swallowingdi   |                     |  |                 |  |
|   | 7. The vascular syste blood vessels. It includes that carry Arteries can become called atherosclerositivessels and block blowesterned blood vessels.   | em is the body's network of udes the arteries, veins and blood to and from the heart. Thick and stiff, a problem s. Blood clots can clog bod flow to the heart or brain. Seels can burst, causing ody.) This information was ebsite: |                     |  |                 |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |        |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|---|---|--------|--|-------------------------------|----------------------------|
|   |   | 495407  | B. WING _                               |        |  |                               | C<br>/ <b>18/2017</b>      |
|   | ROVIDER OR SUPPLIER   |   |   | 140 BF | T ADDRESS, CITY, STATE, ZIP CODE RIMLEY DRIVE SERICKSBURG, VA 22406  | 1 03/                         | 10/2017                    |
| (X4) ID<br>PREFIX<br>TAG  | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |   | ID<br>PREFIX<br>TAG                     | <      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | 3E                            | (X5)<br>COMPLETION<br>DATE |
| F 428   | https://www.nlm.nih.gases.html.  2. The facility staff fa pharmacy medication clinical record or read failed to provide evid reviews were complet December 2016.  Resident #1 was adm 12/23/10 with a receivith diagnoses that in to: osteoporosis, pair congestive heart failure.  | e 126 gov/medlineplus/vasculardise  illed to have Resident #1's n regimen reviews in the dily available for review and ence the medication regimen eted in November and  nitted to the facility on nt readmission on 3/28/17 ncluded but were not limited n, anemia, psychosis, ure (CHF), seizure disorder, omnia, diabetes and high | F                                       | 128    |  |                               |                            |
|   | assessment, with an of 2/27/17, coded the the BIMS (brief intervindicating the resider make daily decisions requiring extensive a staff members for training and personal hygiene.  The clinical record whad a complete elect have a paper record.  Review of the clinical documentation that the Regimen Review was There were no pharm the electronic medical | as reviewed. Resident #1 rronic record. She did not  I record did not reveal any he monthly Medication s completed for Resident #1. nacist recommendations in   |   |        |  |                               |                            |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE<br>A. BUILDING _ | CONSTRUCTION  | (X3) DATE SURVEY COMPLETED |  |
|--------------------------|---|---|--------------------------------|---|----------------------------|--|
|                          |   | 495407  | B. WING                        |   | C<br>05/18/2017            |  |
|                          | ROVIDER OR SUPPLIER  JN NURSING AND REHA  | AB CENTER   | 1                              | TREET ADDRESS, CITY, STATE, ZIP CODE<br>40 BRIMLEY DRIVE<br>REDERICKSBURG, VA 22406                     | , 00.10.2011               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETION              |  |
| F 428                    | nursing, presented a Reports" for July 20 October 2016, from the second | member) #2, the director of binder with the "Consultant 16, September 2016 and the pharmacist for Resident will lacked documentation of by medication regimen .m. another interview was #2. ASM #2 was asked the macy medication regimen ted, "She (the pharmacist) wen days of the month. She eaves me the review them. I sign that I As soon as (ASM #5 - the | F 428                          |   |                            |  |
|                          | with him." When ask #2 stated, "We follow recommendations ar ASM #2 stated, "The listed by month." WI of the medication recommands in the cline. "They are using the subut in May, this year documenting directly record."  ASM #1, the administ the regional director made aware of the as 5:25 p.m.  On 5/18/17 at 8:00 as "Medication Regimental commendation Regimental commendation as the second as | nd file them in a binder."  by are in a binder in my office then asked if she has any part gimen review process by the hical record, ASM #2 stated, sign off sheets in the record   |                                |   |                            |  |

| ` '                      |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | E CONSTRUCTION   | (X3) DATE SURVEY COMPLETED C |  |  |
|--------------------------|--|---|---------------------|--|------------------------------|--|--|
|                          |  | 495407  | B. WING             |  | 05/18/2017                   |  |  |
|                          | ROVIDER OR SUPPLIER  JN NURSING AND REH  | AB CENTER   | 1                   | STREET ADDRESS, CITY, STATE, ZIP CODE 40 BRIMLEY DRIVE FREDERICKSBURG, VA 22406                          | 05/16/2017                   |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION                |  |  |
| F 428                    | December 2016 and On 5/18/17 at 8:07 conducted with ASM assistant director of that a stack of medifound in medical red "Done," indicating the been scanned in to She verified that the in to the computer a clinical record.  On 5/18/17 at 10:15 made aware that the December of 2016 amissing.  On 5/18/17 at 10:32 surveyor that they of the medication re #1 in November and January 2017.  On 5/18/17 at 10:55 was conducted with #3, the pharmacist. the process for comregimen reviews, O medication reviews, O med | were November and   | F 428               |  |                              |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | ` ′   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |       |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|---|---|-------|--|-------------------------------|----------------------------|
|  |  | 495407  | B. WING                                 |       |  | 1                             | C<br>/ <b>18/2017</b>      |
|  | ROVIDER OR SUPPLIER  | B CENTER  |   | 140 B | ET ADDRESS, CITY, STATE, ZIP CODE RIMLEY DRIVE DERICKSBURG, VA 22406   | 1 03/                         | 10/2017                    |
| (X4) ID<br>PREFIX<br>TAG   | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |   | ID<br>PREFII<br>TAG                     | <     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 428  | OSM #3 checked her saw Resident #1 on was in the hospital at her on 1/19/17 and make went to the hosp She stated the recommedication and the use medications.  There was no docum or provided by the factor pr | r computer. She stated, "I 11/14/16. In December she the time of my visit. I saw nade recommendations, but ital after I had made them." Inmendations were for a dose of many PRN (as needed)  entation in the clinical record cility of the November, January 2017 medication  In was provided prior to exit.  Italied to have the monthly reviews and pharmacy or Resident #5, readily or filed in the clinical record.  In the clinical record.  In the clinical record.  In the clinical record. | F                                       | 128   |  |                               |                            |
|  | assessment reference<br>resident as scoring a<br>interview for mental s  | in the blood (1)).  |   |       |  |                               |                            |
|  | The clinical record wa   | as reviewed. Resident #5  |   |       |  |                               |                            |

| ` ,                      |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '               | IPLE CONSTRUCTION IG   | (X3) DATE SURVEY COMPLETED |                        |
|--------------------------|--|--|---------------------|--|----------------------------|------------------------|
|                          |  | 495407   | B. WING _           |  |                            | C<br><b>05/18/2017</b> |
|                          | ROVIDER OR SUPPLIER  JN NURSING AND REHA   | AB CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406  |                            | 00/10/2011             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>( (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE             |                        |
| F 428                    | had a complete elect have a paper record.  Review of the clinical documentation that the Regimen Review was There were no pharm the electronic medical on 5/17/17 at approximation (administrative staff in ursing, presented a Reports" for July and pharmacist for Resident The documentation of medication regiment provided.  On 5/17/17 at 4:50 producted with ASM process for the pharm reviews, ASM #2 stated on the first severe was the charts, for the pharm reviews the charts, for the pharm reviews the charts, for the pharm review of them with him." When ask #2 stated, "We follow recommendations and ASM #2 stated, "The listed by month." ASI keeping them in a bit medical record." Who of the medication recommendation recommen | I record did not reveal any he monthly Medication s completed for Resident #5. nacist recommendations in al record.  I record.  I record did not reveal any he monthly Medication s completed for Resident #5. nacist recommendations in al record.  I record | F 4                 | 28   |                            |                        |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION  | (X3) DATE SURVEY COMPLETED |  |  |
|--|---|--|---------------------|---|----------------------------|--|--|
|  |   | 495407   | B. WING             |   | C<br><b>05/18/2017</b>     |  |  |
|  | ROVIDER OR SUPPLIER   | IAB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406                  | 1 33/10/2317               |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY) | D BE COMPLETION            |  |  |
| F 428  | record."  ASM #1, the adminithe regional director made aware of the 5:25 p.m.  On 5/18/17 at 8:00 "Medication Regime through April 2017 twere completed.  On 5/18/17 at 8:07 conducted with ASM assistant director of that a stack of medifound in medical record." Indicating the been scanned in to She verified that the in to the computer a clinical record.  No further information following website: https://aidsinfo.nih.gssary/785/hyperlipic | istrator, ASM #2, and ASM #3, r of clinical services, were above findings on 5/17/17 at  a.m. the facility presented a en Review" logs for June 2016 that documented the reviews  a.m. an interview was  #2 and ASM #4, the foursing. ASM #2 explained location regimen logs had been cords in a drawer and marked, these records had already the electronic medical record. The electronic medical records and were not part of the  on was provided prior to exit.  was obtained from the gov/understanding-hiv-aids/glo demia | F 428               |   |                            |  |  |
|  | March 2017 and Ap readily available for clinical record.  Resident #10 was a 2/22/17 and readmi   | railed to have Resident #10's bril 2017 pharmacy reviews review and or filed in the admitted to the facility on tted on 3/23/17. Resident cluded but were not limited to:  |                     |   |                            |  |  |

|               |                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:        | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |                        |  | (X3) DATE SURVEY<br>COMPLETED |       |                    |
|---------------|--------------------------|---|---|------------------------|--|-------------------------------|-------|--------------------|
|               | 495407 B. WING           |   |   | C<br><b>05/18/2017</b> |  |                               |       |                    |
| NAME OF PI    | ROVIDER OR SUPPLIER      |   |   |                        | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               | 1 03/ | 10/2017            |
|               |                          |   |   |                        | 140 BRIMLEY DRIVE  |                               |       |                    |
| FALLS RU      | IN NURSING AND REHA      | B CENTER  |   |                        | FREDERICKSBURG, VA 22406   |                               |       |                    |
| (X4) ID       | SUMMARY ST               | ATEMENT OF DEFICIENCIES                                   | ID                                      |                        | PROVIDER'S PLAN OF CORRECT   | TION                          |       | (X5)               |
| PREFIX<br>TAG | ,                        | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFI:<br>TAG                           |                        | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) |                               |       | COMPLÉTION<br>DATE |
| F 428         | Continued From page      | e 132   | F4                                      | 428                    | 8  |                               |       |                    |
|               | seizures, liver transpl  | ant and urinary tract                                     |   |                        |  |                               |       |                    |
|               | infection. Resident #    | 10's significant change in                                |   |                        |  |                               |       |                    |
|               |                          | n data set) assessment with                               |   |                        |  |                               |       |                    |
|               | `                        | reference date) of 3/30/17,                               |   |                        |  |                               |       |                    |
|               |                          | cognitive skills for daily                                |   |                        |  |                               |       |                    |
|               | decision making as so    | everely impaired.   |   |                        |  |                               |       |                    |
|               | Povious of Posidont #    | 10's electronic clinical                                  |   |                        |  |                               |       |                    |
|               |                          | I a March 2017 pharmacy                                   |   |                        |  |                               |       |                    |
|               |                          | 017 pharmacy review.                                      |   |                        |  |                               |       |                    |
|               |                          | clinical record for Resident                              |   |                        |  |                               |       |                    |
|               | #10.                     |   |   |                        |  |                               |       |                    |
|               | On 5/17/17 at 7:52 a.    |   |   |                        |  |                               |       |                    |
|               |                          | (other staff member) #4 (the                              |   |                        |  |                               |       |                    |
|               |                          | loyee). OSM #4 stated she                                 |   |                        |  |                               |       |                    |
|               |                          | n March 2017 and ASM<br>nember) #2 (the director of       |   |                        |  |                               |       |                    |
|               |                          | paperless so she went                                     |   |                        |  |                               |       |                    |
|               | through all the paper    |   |   |                        |  |                               |       |                    |
|               |                          | floor. OSM #4 stated once                                 |   |                        |  |                               |       |                    |
|               |                          | rt, she goes through the                                  |   |                        |  |                               |       |                    |
|               |                          | t by how it should be logged                              |   |                        |  |                               |       |                    |
|               |                          | SM #4 stated Resident #10                                 |   |                        |  |                               |       |                    |
|               | no longer had a pape     | r chart and all documents                                 |   |                        |  |                               |       |                    |
|               | were scanned into the    | e computer during the                                     |   |                        |  |                               |       |                    |
|               | •                        | week before. OSM #4                                       |   |                        |  |                               |       |                    |
|               |                          | es at the front desk assist                               |   |                        |  |                               |       |                    |
|               | _                        | cuments into the computer.                                |   |                        |  |                               |       |                    |
|               |                          | Resident #4's pharmacy                                    |   |                        |  |                               |       |                    |
|               |                          | anned into the electronic                                 |   |                        |  |                               |       |                    |
|               |                          | #4 stated, "Yeah. It would that if it was part of her     |   |                        |  |                               |       |                    |
|               |                          | scanned it in." OSM #4                                    |   |                        |  |                               |       |                    |
|               |                          | an documents into the                                     |   |                        |  |                               |       |                    |
|               | electronic clinical reco |   |   |                        |  |                               |       |                    |
|               | receives the documer     | •   |   |                        |  |                               |       |                    |
|               |                          | no or ano more day.                                       |   |                        |  |                               |       |                    |
|               | On 5/17/17 at 5:30 p.    | m. ASM #1 (the  |   |                        |  |                               |       |                    |

|                          | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |     |   | (X3) DATE SURVEY<br>COMPLETED |         |
|--------------------------|---|--|---|-----|---|-------------------------------|---------|
|                          |   |  |   |     | С   |                               |         |
|                          |   | 495407   | B. WING   |     |   | 05/                           | 18/2017 |
|                          | ROVIDER OR SUPPLIER IN NURSING AND REHA   | B CENTER   |   | 1   | TREET ADDRESS, CITY, STATE, ZIP CODE 40 BRIMLEY DRIVE REDERICKSBURG, VA 22406 |                               |         |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY) |     |   | (X5)<br>COMPLETION<br>DATE    |         |
| F 441<br>SS=E            | administrator), ASM # director of clinical sente the above findings.  On 5/18/17 at 8:07 a. (the assistant director presented Resident # 2017 pharmacy review other residents' pharm stated most residents the paper chart on the order tab. ASM #2 cono paper chart on the pharmacy reviews we reviews for multiple redrawer in the medical note that documented No further information INFECTION CONTROLINENS CFR(s): 483.80(a)(1)(a) Infection prevention The facility must estal and control program (a minimum, the follow (1) A system for preventions and control disease volunteers, visitors, a providing services unarrangement based u conducted according | the properties of the properti |   | 428 |   |                               | 6/22/17 |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|---|-----|---|-------------------------------|----------------------------|
|   |   | 405407   |   |     |   | С                             |                            |
|   |   | 495407   | B. WING                                 |     |   | 05/                           | 18/2017                    |
|   | ROVIDER OR SUPPLIER                               | B CENTER   |   |     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406                        |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)                                  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)                              | ID<br>PREFI<br>TAG                      |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 441   | Continued From page                               | e 134  | F.                                      | 441 |   |                               |                            |
|   |   | , policies, and procedures<br>h must include, but are not  |   |     |   |                               |                            |
|   | possible communicab                               | llance designed to identify<br>ole diseases or infections<br>ad to other persons in the                            |   |     |   |                               |                            |
|   |   | m possible incidents of se or infections should be   |   |     |   |                               |                            |
|   |   | nsmission-based precautions<br>rent spread of infections;  |   |     |   |                               |                            |
|   | (iv) When and how isc<br>resident; including bu   | olation should be used for a t not limited to:   |   |     |   |                               |                            |
|   | involved, and<br>(B) A requirement tha            | ation of the isolation, infectious agent or organism it the isolation should be the ble for the resident under the |   |     |   |                               |                            |
|   | must prohibit employed disease or infected ske    | or their food, if direct   |   |     |   |                               |                            |
|   | (vi) The hand hygiene<br>by staff involved in dir | e procedures to be followed rect resident contact.   |   |     |   |                               |                            |
|   | (4) A system for recorunder the facility's IPC    | rding incidents identified<br>CP and the corrective  |   |     |   |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495407 |  | ` ′  | LE CONSTRUCTION     | (X3) DATE SURVEY<br>COMPLETED   |                        |
|--|--|--|---------------------|---|------------------------|
|  |  | 495407   | B. WING             |   | C<br><b>05/18/2017</b> |
|  | VIDER OR SUPPLIER  | B CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406  | 1 00/10/2011           |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)   |                        |
| a (e ps (fa pp T b) E d fa pp T b) E d c m u th T C (i) T to h re  | rocess, and transport pread of infection.  The Annual review. The nnual review of its Ill rogram, as necessath is REQUIREMENT y: Based on observation ocument review, it vacility staff failed to represent the resident of the dication administration of the facility staff failed to represent the medication administration of the facility staff failed uring the medication and failed sed in the resident's the medication cart.  The findings include:  The medication administration on the findings include:  The medication cart.  The findings include:  The medication administration on the findings include:  The medication cart.  The sident of the medication administration administration administration the resident of the medication cart.  The medication administration ad | facility.  If must handle, store, and the second se | F 44                | <ol> <li>Residents #19, 20, 21, 22, 23, 24, 26, 12, 13, and 1 display no adverse effects from infection control issue on 5/16/2017.</li> <li>All residents have the potential to be affected by this deficient practice.</li> <li>DON and or designee(s) will in-servicensed nurses on proper hand washi and sanitizing techniques.</li> <li>DON and or designee(s) will condurandom medication administration observations weekly for 4 weeks and to monthly for 2 months to ensure proper hand washing and equipment is sanitized appropriately. Results of audits will be taken to QAPI committee for review ar revision as needed.</li> </ol> | e vice ng ct hen zed   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULT<br>A. BUILDIN  | IPLE CONSTRUCTION  NG |   | (X3) DATE SURVEY COMPLETED     |                            |
|--|---|--|-----------------------|---|--------------------------------|----------------------------|
|  |   | 495407   | B. WING _             |   |                                | C<br>05/18/2017            |
|  | ROVIDER OR SUPPLIER   | AB CENTER  |                       | STREET ADDRESS, CITY, STATE, ZIP CO 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406  | DE .                           | 0.10.2011                  |
| (X4) ID<br>PREFIX<br>TAG   |   |  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 441  | LPN #1 then put the 25-250 MG for Resident went into the resident washed her hands put checked Resident #1. LPN #1 discarded washed her hands put checked Resident #1. LPN #1 removed the without washing her nurse's station and discarded it. LP the resident's medic Resident #20's room gave the resident thand washed her har accuchek monitor washed her har accuchek monitor washed her har accuchek monitor and did not wash her har monitor. LPN #1 the took the insulin out of drawer and returned put on a pair of glovinsulin. She took off | Carbidopa-Levodopa Tablet dent #20 into a medicine cup sident's room. The resident and gave the cup back to LPN and the cup. LPN #1 then out on a pair of gloves and 20's accuchek (blood sugar). A gloves and left the room hands. LPN #1 went to the called the physician for an en entered the order into the led to the medication cart. It can be put on a pair of gloves, a insulin removed her gloves and sith an alcohol wipe.  The accuchek monitor into put on a pair of gloves, at's blood sugar with the land removed the gloves. She had or clean the accuchek in went to the medication cart of the resident's medication to the resident's rooms, she less and administered the the gloves and washed her | F 4                   | 141   |                                |                            |
|  | and documented that given.  LPN #1 then put Tylemedicine cup and to   | ened to the medication cart at the medication had been enol 325 mg tablet into a ok it into Resident #12's e resident if she had pain and  |                       |   |                                |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | ' '   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|---|---|---|-------------------------------|----------------------------|
|  |   | 495407  | B. WING _                               |   |                               | C<br><b>05/18/2017</b>     |
|  | ROVIDER OR SUPPLIER   | AB CENTER   |   | STREET ADDRESS, CITY, STATE, ZIP COD<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406 | •                             | 00/10/2017                 |
| (X4) ID<br>PREFIX<br>TAG   |   |   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)   | N SHOULD BE                   | (X5)<br>COMPLETION<br>DATE |
| F 441  | Continued From pag  | ge 137  | F 4                                     | 41  |                               |                            |
|  | medicine cup to the Resident #12 water  | he did not. She gave the resident and then gave from the water pitcher. LPN out washing her hands.  |   |   |                               |                            |
|  | the accuchek monitor<br>and put them into he<br>Resident #21's room<br>monitor and test strip | the medication cart and took or and the vial of test strips or pocket. She then went into n, placed the accuchek os on the resident's bedside |   |   |                               |                            |
|  | resident's blood sug-<br>removed the gloves,<br>the accuchek monito                           | pair of gloves, checked the ar with the monitor. LPN #1 washed her hands and put or and test strips into her                                  |   |   |                               |                            |
|  | returned to the medi<br>resident's insulin and<br>room. LPN #1 wash                           | zing the items. LPN #1<br>cation cart, took out the<br>d returned to the resident's<br>ed her hands, put on a pair of                         |   |   |                               |                            |
|  | gloves. LPN #1 was<br>to the cart and place   | If the insulin and removed the hed her hands and returned and the accuchek monitor on a later than the monitor.                               |   |   |                               |                            |
|  | into a medication cu<br>Resident #22's room   | Divalproex 250 mg tablets<br>p and took them into<br>n. She placed her hands on<br>the table and gave her the                                 |   |   |                               |                            |
|  | medication. LPN #1<br>#1 then went back to<br>took the thermometer                            | did not wash her hands. LPN<br>o the medication cart and<br>er out of the cart and returned   |   |   |                               |                            |
|  | into her pocket and I   | m and checked her  1 then put the thermometer  eft the room. LPN #1 did not anitize the thermometer.  |   |   |                               |                            |
|  | door with a cup in he and went to the med   | aiting outside Resident #22's<br>er hand. LPN #1 took the cup<br>lication room and filled the<br>anded it to Resident #23. LPN                |   |   |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN   | PLE CONSTRUCTION  G | , ,   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|---|--|---------------------|---|-------------------------------|----------------------------|--|
|  |   | 495407   | B. WING _           |   |                               | C<br><b>05/18/2017</b>     |  |
|  | ROVIDER OR SUPPLIER   | IAB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406            |                               | 00/10/2011                 |  |
| (X4) ID<br>PREFIX<br>TAG   |   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |  |
| F 441  | went into Resident accuchek monitor a bedside table and t put on a pair of glow sugar, LPN #1 remstrips back into her monitor on top of the wash her hands or LPN #1 then put Resident #24's whe doorway, patted Resident #24's whe doorway, patted Resident the raglass of water to the bathroom, dishands.  LPN #1 then went is resident had his rig LPN #1 put his leg up with a sheet. She bag and left the roce sanitize her hands and LPN #1 then went is wrote a note in the faced. Resident #1's station in a wheelch | r hands.  ed to the medication cart and #24's room. She put the ind test strips on the resident's hen washed her hands and ives. After checking the blood oved her gloves, put the test pocket and put the accuchek e medication cart. She did not sanitize the equipment.  esident #25's Xarelto 20 mg up. LPN #1 then moved selchair out of Resident #25's issident #24's shoulder and sation to Resident #25. She he medication cup and handed in She took the medication cup scarded it and washed her  into Resident #26's room. The into Resident #26's room into Resident #26's room. The into Resident #26's room into Resident #26's | F 4                 | ,   |                               |                            |  |
|  | pushed Resident #<br>room. LPN #1 picked<br>dialed a number (re<br>the phone to Resident  | gs in." LPN #1 got up and 13 in her wheelchair to her ed up the phone receiver and esident's daughter) and gave ent #13. LPN #1 spoke on the dent's daughter, patted the   |                     |   |                               |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |                                   | (X3) DATE SURVEY COMPLETED |  |
|---|---|--|---|---|-----------------------------------|----------------------------|--|
|   |   | 495407   | B. WING                                 |   |                                   | C                          |  |
|   | ROVIDER OR SUPPLIER  IN NURSING AND REHA  |  |   | STREET ADDRESS, CITY, STATE, ZIP C<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406 | ODE                               | 05/18/2017                 |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENCE   | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |  |
| F 441   | washing her hands. I medication cart. LPN the cart and put it into took the medications and outside to let the dog resident into the day.  An interview was con a.m. with LPN #5. Wi washed their hands, after contact with the gloves. Touching any have gloves on becaunderneath it (the glotoo."  An interview was con p.m. with ASM (admit the assistant director when staff washed the "Before and after care enter and leave the rownedication administra" "Before each residen medications). They can three times and then hands." When asked hands, ASM #4 state asked about the proceedingment in a reside "Use sanitizing wipes was acceptable to puresident into your poor infection control. Always between residents are | der and left the room without LPN #1 returned to the #1 took Ativan 0.5 mg out of a medication cup. LPN #1 to Resident #13 who refused demanded to be taken in LPN #1 pushed the room and asked for help.  ducted on 5/17/17 at 9:40 men asked when staff LPN #5 stated, "Before and residents, when you take off thing that's soiled even if you use stuff can still get oves) and you're sweating  ducted on 5/17/17 at 1:30 mistrative staff member) #4, of nursing. When asked eir hands, ASM #4 stated, e of the residents. When you dom. Between residents."  tess followed by staff during ation, ASM #4 stated, t and after (giving the an use hand sanitizer up to they need to wash their why staff washed their d, "Infection control." When ess staff follows after using ent's room, ASM #4 stated, to clean it." When asked if it tequipment used with a cket, ASM #4 stated, "No, its | F 4                                     | 41  |                                   |                            |  |

| STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER: |   | , ,   | PLE CONSTRUCTION  G | · /   | (X3) DATE SURVEY COMPLETED C |                            |  |
|--|---|---|---------------------|---|------------------------------|----------------------------|--|
|  |   | 495407  | B. WING_            |   |                              | 05/18/2017                 |  |
|  | ROVIDER OR SUPPLIER   | 1   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406        |                              | 03/10/2017                 |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE                     | (X5)<br>COMPLETION<br>DATE |  |
| F 441  | An interview was corp.m. with LPN #1. W washed their hands, almost all the time, b treatment, after we ender anytime we take off of staff washed their hainfection control." With followed after they us LPN #1 stated, "Wipowas to be used use work to be used used with the wipes with the wipes with the wipes wiped the accuched don't think that clean my hands in between When asked if reside stored in staff pocked in my pocket?" When appropriate, LPN #1  On 5/17/17 at 5:15 padministrator and AS were made aware of Review of the manuficleaning the accuched "Cleaning the Meter. (trademark) Vital bloinstrument. Please houtside of the meter | A request for the ing instructions for the ometer were requested.  Inducted on 5/17/17 at 2:55 hen asked when staff LPN #1 stated, "We wash efore and after wound at, after the bathroom. Interact with the patient and gloves." When asked why inds, LPN #1 stated, "For men asked what process staff sed equipment on a resident, is it off." When asked what wipe off equipment, LPN #1 ith the red top on them." In the medication administration 17, LPN #1 stated, "I know I is to wipe them down so I with an alcohol wipe but I is it. I think I forgot to wash in a couple of the residents." It ent equipment could be so, LPN #1 stated, "I put them in asked if that was stated, "No."  Important in the stated if the director of nursing the findings.  In accturer's instructions for each monitor documented, | F 44                |   |                              |                            |  |

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |         | (X3) DATE SURVEY COMPLETED C |  |
|--------------------------|---|---|---|---|---------|------------------------------|--|
|                          |   | 495407  | B. WING                                 |   |         | 05/18/2017                   |  |
|                          | ROVIDER OR SUPPLIER   | AB CENTER   |   | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                    | ·       | 5571672517                   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHI<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE   |  |
| F 441                    | Preparation and Me documented, "Proce administering medic competent Facility s infection control police." Review of the facility Washing" document is the most important the spread of infecti replace the need for rubbing or hand was hygiene: a. Before a with residents. b. Af handling an invasive whether or not glove caref. After contact (including medical evicinity of the reside Review of the facility Control" documente work areas shall be manufacturer's specific Resident #19 was a | or obtained.  O's policy titled, "General Dose dication Administration" edure: 2. Prior to preparing or ations, authorized and taff should follow Facility's cy (e.g. handwashing)."  O's policy titled, "Hand ed, "POLICY: Hand washing at component for preventing on. Use of gloves does not hand cleaning by either hand shing. 3. Perform hand after having direct contact the removing gloves. c. Before e device (regardless of es are used) for resident to with inanimate objects quipment) in the immediate nt"  O's policy titled, "Infection d, "PURPOSE: To protect and cleaned according to | F 44                                    | ,   |         |                              |  |
|                          | tract infection, anem MDS (minimum data with an ARD (asses 5/2/17 coded the resinterview for mental indicating the reside cognitively. Review   | neartbeat, weakness, urinary hia and pain. The most recent his set), an annual assessment, his sment reference date) of his sident as having a BIMS (brief his status) of 9 out of 15 hit was moderately impaired his of the May 2017 physician's  "Acetaminophen (Tylenol)   |   |   |         |                              |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | 1 ' '   | E CONSTRUCTION      | COMPLETED   |                        |  |
|--|--|---|---------------------|---|------------------------|--|
|  |  | 495407  | B. WING             |   | C<br><b>05/18/2017</b> |  |
|  | ROVIDER OR SUPPLIER  JN NURSING AND REH  | AB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                              |                        |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETION        |  |
| F 441  | two times a day for  Resident #20 was a 9/11/15 and readmit that included but we disease (1), high ble cancer. The most re assessment, with a resident as having a indicating the reside make daily decision physician's orders o "Carbidopa-Levodo 1 tablet six times pe NovoLOG (3)FlexPe UNIT/MLinject pe  Resident #21 was a 2/16/17 with diagno limited to: dementia edema (swelling). T quarterly assessme coded the resident a indicating the reside cognitively. Review orders documented Solution Pen-injecto inject as per sliding  Resident #22 was a 7/8/16 and readmitt that included but we weakness, anemia, and lung disease. T quarterly assessme | o) Give 2 tablet (sic) by mouth pain."  Idmitted to the facility on ted on 12/1/15 with diagnoses ere not limited to: Parkinson's cod pressure, diabetes and ecent MDS, a quarterly in ARD of 6/4/17 coded the a BIMS of 14 out of 15 ent was cognitively intact to is. Review of the May 2017 locumented, pa (2) Tablet 25-250 MG Give er day for parkinson's [sic]. en Solution Pen-injector 100 in seit statistically on ses that included but were not in, high blood pressure and the most recent MDS, a int, with an ARD of 4/24/17 as having a BIMS of 10 ent was moderately impaired of the May 2017 physician's in, "HumaLOG (4) KwikPen or 100 UNIT/ML (milliliter) | F 441               |   |                        |  |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '               | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|---------------------|--|-------------------------------|--|
|                          |  | 495407  | B. WING             |  | C<br>05/18/2017               |  |
|                          | ROVIDER OR SUPPLIER  | HAB CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                         | 1 03/10/2017                  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETION              |  |
| F 441                    | Sodium (5) Tablet I 2 tablet (sic) by mo Disorder."  Resident #23 was a 3/22/12 and readm that included but w dementia with beha walking. The most assessment, with a resident as having indicating the resid make daily decision  | age 143 occumented, "Divalproex Delayed Release 250 MG Give uth in the evening for Bipolar admitted to the facility on itted on 3/2/17 with diagnoses ere not limited to: anxiety, avioral disorders and difficulty recent MDS, a quarterly in ARD of 3/3/17 coded the a BIMS of 14 out of 15 ent was cognitively intact to ins. Review of the May 2017 occumented, "May have one   | F 44                | 1  |                               |  |
|                          | 3/26/13 and readm that included but w pressure, heart distributed by the pressure, heart distributed by the most recent M with an ARD of 2/2 having a BIMS of 1 resident was cognit decisions. Review orders documented ASpart)before m coverage."  Resident #25 was a 3/13/12 with diagnoral limited to: stroke, s and high blood presa quarterly assessing coded the resident 15 indicating the remake daily decision. | dinner"  Idmitted to the facility on itted on 7/2/16 with diagnoses ere not limited to: high blood ease, arthritis and diabetes. DS, a quarterly assessment, /17 coded the resident as 5 out of 15 indicating the tively intact to make daily of the May 2017 physician's d, "NovoLOG Solution (Insulin eals and at bedtime for insulin eals and at bedtime for insulin eases that included but were not houlder pain, kidney disease soure. The most recent MDS, ment, with an ARD of 4/12/17 as having a BIMS of 13 out of sident was cognitively intact to ease. Review of the May 2017 documented, "Xarelto Tablet" |                     |  |                               |  |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | I ' '               | E CONSTRUCTION   | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|---------------------|--|----------------------------|
|                          |  | 495407  | B. WING             |  | C<br>05/49/2047            |
|                          | ROVIDER OR SUPPLIER  IN NURSING AND REHA   | I   | 5                   | STREET ADDRESS, CITY, STATE, ZIP CODE 40 BRIMLEY DRIVE FREDERICKSBURG, VA 22406                          | 05/18/2017                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION              |
| F 441                    | 8/22/16 with diagnose limited to: brain dama difficulty swallowing a most recent MDS, a can ARD of 4/10/17 co short and long term in severely impaired co. 2017 physician's order mI H2O (water) via G (every) 4 hours"  Resident #12 was ad 4/4/13 and readmitted that included but wer weakness, dementia, ad high blood pressu (minimum data set), an ARD (assessment coded the resident as interview for mental sindicating the resident make daily decisions orders dated May 20 Tablet 325 MG (millig Give 325 mg by mou Breakthrough pain. Co. Resident #13 was ad 9/16/13 and readmitted diagnoses that including blood pressure, arthritis. The most reassessment, with an resident as having a | mitted to the facility on es that included but were not age due to lack of oxygen, and muscle weakness. The quarterly assessment, with oded the resident as having nemory problems and was gnitively. Review of the May ers documented, "Flush 300 (gastrostomy) tube q  mitted to the facility on don 8/6/15 with diagnoses e not limited to: muscle chronic pain, heart disease re. The most recent MDS a quarterly assessment with a reference date) of 4/4/17 is having a BIMS (brief status) as a 12 out of 15 at was cognitively intact to a Review of the physician's 17 documented, "Tylenol arams) (Acetaminophen) the every four hours for order Date 7/14/2016."  mitted to the facility on ed on 10/21/16 with led but were not limited to: depression, pain and cent MDS, a quarterly ARD of 4/30/17 coded the | F 441               |  |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION  G   |           | DATE SURVEY<br>COMPLETED   |
|--------------------------|--|--|--------------------------|---|-----------|----------------------------|
|                          |  | 495407   | B. WING _                |   |           | C<br>05/18/2017            |
|                          | ROVIDER OR SUPPLIER  | AB CENTER  |                          | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406              | <b>!</b>  | 36, 16, 23 11              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 441                    | orders documented tablet by mouth ever increased anxiety."  Resident #1 was ad 12/23/10 with a recover with diagnoses that to: osteoporosis, pare congestive heart fair disorder, insomnia, pressure. The most set) assessment, with date of 2/27/17, cool 14 on the BIMS (briscore, indicating the intact to make daily 2017 physician's or Solution (Insulin AS bedtime for insulin of the work of t | of the May 2017 physician , "Ativan (7) 0.5 MGGive 1 ry 12 hours as needed for  mitted to the facility on ent readmission on 3/28/17 included but were not limited in, anemia, psychosis, lure, seizure disorder, anxiety diabetes and high blood recent MDS (minimum data ith an assessment reference led the resident as scoring a ef interview for mental) status e resident was cognitively decisions. Review of the May ders documented, "NovoLOG part)before meals and at coverage."  on was provided prior to exit.  mentals of Nursing, 5th Villiams & Wilkins, page 568, Medications: Procedure - 1. nale - Reduces transfer of | F 4                      | ,   |           |                            |
|                          | and Wilkins, page 1<br>washing and the us<br>hands are conduits<br>potential pathogens   | Nursing, Lippincott Williams<br>40-143, concerning hand<br>e of hand sanitizer: "The<br>for almost every transfer of<br>from one patient to another,<br>d object to the patient, or from   |                          |   |           |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT<br>A. BUILDIN  | IPLE CONSTRUCTION  IG  | ` '                 | (X3) DATE SURVEY<br>COMPLETED   |           |                            |
|--|--|--|---------------------|---|-----------|----------------------------|
|  |  | 495407   | B. WING _           |   |           | C<br><b>05/18/2017</b>     |
|  | ROVIDER OR SUPPLIER  | AB CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406              | <b>'</b>  | 33,13,2311                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF COF<br>( (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 441  | the single most imprinfectiontypically before coming on dindirect patient cont administering medic hands with soap aftusing hand sanitized alcohol-based hands. Rub hands product has dried (u. A review of a pages Fundamentals of Nuedition, the facility's provided to the surv wound care policy, as the procedure to dressing has been a gloves and dispose hand hygiene."  (1) Parkinson's dise (PD) is a type of mowhen nerve cells in enough of a brain of Sometimes it is gen | e patient. Hand hygiene is ortant procedure in preventing hands are washed with soap uty; before and after direct or act;before preparing or rationsalways wash your er removing gloveswhen r, apply a small amount of the rub to all surfaces of the together until the entire sually about 30 seconds)." | F4                  | ,   |           |                            |
|  | (2) Carbidopa-Levor<br>levodopa extended<br>in the treatment of the<br>Parkinson 's diseas<br>postencephalitic par<br>parkinsonism which<br>nervous system by  | gov/parkinsonsdisease.html dopa Carbidopa and release tablets are indicated ne symptoms of idiopathic e (paralysis agitans), kinsonism, and symptomatic may follow injury to the carbon monoxide intoxication ntoxication. This information  |                     |   |           |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION  G   |                     | (X3) DATE SURVEY COMPLETED   |             |                            |
|--|---|---|---------------------|--|-------------|----------------------------|
|  |   | 495407  | B. WING _           |  |             | C<br>05/18/2017            |
|  | ROVIDER OR SUPPLIER   | IAB CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP COD<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406      |             | 00/10/2017                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | I SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 441  | m?setid=abff005f-2  (3) Novolog Novo indicated to improve and children with di This information with the street of the street | n.nih.gov/dailymed/drugInfo.cf 3fc-4d1e-b469-88aa07589a43  DLog is an insulin analog e glycemic control in adults abetes mellitus (1.1). as obtained from: n.nih.gov/dailymed/archives/fd hiveid=9636  JMALOG is a rapid acting og indicated to improve adults and children with his information was obtained  n.nih.gov/dailymed/drugInfo.cf A-0E22-4FC7-A503-FAA58C  um DIVALPROEX SODIUM anticonvulsant properties used epilepsy. This information was bi.nlm.nih.gov/compound/dival | F 4                 | <u> </u>   |             |                            |
|  | risk of stroke and sy<br>with nonvalvular atr<br>was obtained from:<br>https://dailymed.nln<br>m?setid=10db92f9-<br>10<br>(7) Ativan Loraze<br>as an anti-anxiety a<br>also has hypnotic, a   | LTO is indicated to reduce the systemic embolism in patients ial fibrillation. This information n.nih.gov/dailymed/drugInfo.cf 2300-4a80-836b-673e1ae916  pam is a benzodiazepine used igent with few side effects. It anticonvulsant, and ve properties and has been   |                     |  |             |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ' '                 | PLE CONSTRUCTION  G  |   | TE SURVEY<br>MPLETED          |
|--|---|---------------------|--|---|-------------------------------|
|  | 495407  | B. WING             |  |   | C<br><b>5/18/2017</b>         |
| NAME OF PROVIDER OR SUPPLIER  FALLS RUN NURSING AND RE   | HAB CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                   | '   | <b>9</b> , 19, <b>2</b> 9 1 1 |
| PREFIX (EACH DEFICIE   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) | HOULD BE  | (X5)<br>COMPLETION<br>DATE    |
| information was obhttps://pubchem.ndepam#section=TopLAB REPORTS INNAME/ADDRESS CFR(s): 483.50(a)(a) Laboratory Serical (2) The facility must (iv) File in the residence reports that are dated address of the test This REQUIREME by:  Based on staff into and facility document that the facility staff on the clinical reconsurvey sample; Reference with the surrough and the surrough that the physic C-Reactive Proteir maintained on the clinical record.  1. For Resident # ensure that physic C-Reactive Proteir maintained on the clinical record.  2. The facility staff (basic metabolic pacilinical record.  3. The facility staff result in Resident and the surrough that the surrough that the surrough that the surrough that the surr | anesthetic agent. This brained from: BECORD - LAB  (2)(iv)  vices  st-  dent's clinical record laboratory ted and contain the name and ing laboratory.  NT is not met as evidenced erview, clinical record review, ent review, it was determined from failed to file laboratory results and for 5 of 26 residents in the esidents #13, #11, #5, #10, and and another text of the sidents and the sidents and the sidents are failed to file laboratory results and for 5 of 26 residents in the sidents #13, #11, #5, #10, and another text of the sidents #13, #11, #5, #10, and another text of the sidents #13, #11, #5, #10, and [13], and ESR [4] were | F 4                 |  | cal record.  cal to be cal.  in-service s of inical  audit lab co ensure into the s will be | 6/22/17                       |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDIN   | IPLE CONSTRUCTION  IG |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|---|-----------------------|---|-------------------------------|----------------------------|
|  |  | 495407  | B. WING _             |   |                               | C<br>05/18/2017            |
|  | ROVIDER OR SUPPLIER  | B CENTER  |                       | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406              | •                             | 5571672017                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG   | PROVIDER'S PLAN OF COF<br>( (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 507  | record.  5. The facility staff fa ordered laboratory to Resident # 7's clinical The findings include:  1. For Resident #13 ensure that physician C-Reactive Protein [3 maintained on the clinical Resident #13 was ac 9/16/13 and readmitt diagnoses of but not arthritis, high blood posteoporosis, pulmor anxiety, gastrointesti pain, and polymyalging recent MDS (Minimulassessment with an Reference Date) of 4 coded as being modernake daily life decisions possible 15 on the B Mental Status) examinates are for transference for transference for transference incontinent of bowel A review of the clinical physician's order data (complete blood course | iled to ensure a physician st result was filed in all record.  The facility staff failed to a ordered CBC [1], CMP [2], and ESR [4] were nical record.  Imitted to the facility on ed on 10/21/16 with the limited to rheumatoid ressure, glaucoma, nary embolism, dementia, nal bleed, dysphagia, chronic a rheumatica. The most m Data Set) was a quarterly ARD (Assessment /30/17. The resident was erately impaired in ability to ons, scoring a 6 out of a lMS (Brief Interview for . The resident was coded as or bathing; extensive ers, dressing, toileting and for eating; and as and bladder.  all record revealed a ed 11/2/16 for a weekly CBC at on Wednesdays. Review | F                     | 007   |                               |                            |
|  | assistance for transfe hygiene; supervision incontinent of bowel  A review of the clinic physician's order dat (complete blood cour of the lab (laboratory clinical record reveal  | ers, dressing, toileting and for eating; and as and bladder.  al record revealed a ed 11/2/16 for a weekly CBC  |                       |   |                               |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION  NG   |                              | ATE SURVEY<br>OMPLETED     |
|--------------------------|---|---|-------------------------|---|------------------------------|----------------------------|
|                          |   | 495407  | B. WING _               |   |                              | C<br><b>05/18/2017</b>     |
|                          | ROVIDER OR SUPPLIER   | AB CENTER   |                         | STREET ADDRESS, CITY, STATE, ZIP COI<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406       | •                            | 03/10/2017                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG     | PROVIDER'S PLAN OF CO<br>( (EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 507                    | Continued From page 5/10/17 were not in   |   | F 5                     | 507   |                              |                            |
|                          | CBC was to be draw lab results maintained   | dated 5/6/17 documented a<br>yn on 5/12/17. Review of the<br>ed on the clinical record<br>sult for this CBC was not in  |                         |   |                              |                            |
|                          | CMP (complete met<br>protein, and ESR-W<br>sedimentation rate)<br>Review of the lab re  | dated 3/2/17 documented a abolic panel), C - reactive estergren (erythrocyte was to be drawn on 3/3/17. sults maintained on the led that the results for these chart.   |                         |   |                              |                            |
|                          | CBC, CMP, C - read<br>ESR-Westergren wa<br>Review of the lab re   | as to be drawn on 3/8/17. sults maintained on the led that the results for these  |                         |   |                              |                            |
|                          | CBC, CMP, C - read<br>ESR-Westergren wa<br>Review of the lab re   | as to be drawn on 5/5/17. sults maintained on the led that the results for these  |                         |   |                              |                            |
|                          | (Licensed Practical above missing labor #13. On 5/17/17 at results for these mis had them faxed ove results were not in the available on the clin | ximately 2:00 p.m., LPN #4 Nurse) was asked about the atory test results for Resident 3:16 p.m., she provided the sing labs and stated that she r from the lab because the ne building, and therefore, not ical record. When asked why aintained on the record in the |                         |   |                              |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING | (X3) DATE SURVEY COMPLETED C   |   |                     |  |               |
|---|--|---|---------------------|--|---------------|
|   |  | 495407  | B. WING             |  | 05/18/2017    |
|   | ROVIDER OR SUPPLIER  | HAB CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                     | 1 33/10/2017  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION |
| F 507   | the fax machine the the facility on, was there may have be received.  A review of the facility of the facility of the facility of the facility will immediate results to the physical of the p | ted that at one point in time, at the lab faxes the results to not working and therefore, en lab results that they never dility policy, "Lab /Test Tracking sted, "5. When the results are lity, the nurse receiving the ately report any abnormal cian, and document time and if any new orders from the bislip. The results will be cian's communication book for his/her review at the once lab report signed, the niclinical record."  p.m., ASM #1 (Administrative Administrator, ASM #2 the and ASM #3 the regional services were made aware of orther information was provided | F 50                | 7  |               |
|   | of chemical tests p<br>(the part of blood the  | ve metabolic panel is a group erformed on the blood serum nat doesn't contain cells).   |                     |  |               |

|                          |  | (X3) DATE SURVEY<br>COMPLETED  |                     |   |                        |
|--------------------------|--|--|---------------------|---|------------------------|
|                          |  | 495407   | B. WING             |   | C<br><b>05/18/2017</b> |
|                          | ROVIDER OR SUPPLIER  | AB CENTER  | 1                   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>40 BRIMLEY DRIVE<br>REDERICKSBURG, VA 22406                               |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIOI<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETION          |
| F 507                    | include sodium, pota others. The rest of that reflect liver and helps provide inform metabolism. It gives about how your kidn and can be used to cholesterol, and calc things. This information website: <a href="http://www.nlm.nih."></a> 003468.htm>  [3] The CRP (C - read general test to check body. It is not a special to calculate that you have your body, but it can location. The CRP to or sed rate test which information obtained that he can be used that indirectly manifold in the case of the | res. Electrolytes in the body assium, chlorine, and many he tests measure chemicals kidney function. This test ation about your body's a your doctor information eys and liver are working, evaluate blood sugar, sium levels, among other tion was obtained from the gov/medlineplus/ency/article/  active protein) test is a conformation in the cific test. That means it can inflammation somewhere in not pinpoint the exact est is often done with the ESR he also looks for inflammation. I from gov/ency/article/003356.htm  erythrocyte sedimentation called a "sed rate." It is a easures how much est body.  I rate" may be done include: vers arthritis ms mptoms that cannot be  e used to monitor whether an | F 507               |   |                        |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '               | PLE CONSTRUCTION  G  |           | OMPLETED                   |
|--------------------------|--|---|---------------------|--|-----------|----------------------------|
|                          |  | 495407  | B. WING             |  |           | C<br><b>05/18/2017</b>     |
|                          | ROVIDER OR SUPPLIER  JN NURSING AND REHA   | AB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP COD<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406      | •         | 03/10/2011                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 507                    | monitoring:  " Autoimmune dis  " Bone infections  " Certain forms of  " Inflammatory dis symptoms  " Tissue death Information obtained https://medlineplus.g  2. The facility staff fa (basic metabolic pan clinical record.  Resident #11 was ad 12/3/10 and readmitt diagnoses that includ stroke, high blood pro depression, urinary to  The most recent MDs quarterly assessmen reference date) of 2/2 having scored 10 out interview mental stat was moderately impa decisions of daily livin as requiring assistan of daily living.  Review of the May 20 documented, "BMP of 05/05/2017."  Review of the May 20 administration record | orders arthritis seases that cause vague  from ov/ency/article/003638.htm  illed to file the 5/5/17 BMP el (1)) on Resident #11's  mitted to the facility on ed on 4/20/16 with led but were not limited to: essure, weakness, ract infection and dementia.  S (minimum data set), a t, with an ARD (assessment 27/17 coded the resident as t of 15 on the BIMS (brief us) indicating the resident aired cognitively to make ng. The resident was coded ore from staff for all activities | F 50                | 07   |           |                            |

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING   |   |                    | (X3) DATE SURVEY<br>COMPLETED |   |     |                            |
|--------------------------|--|---|--------------------|-------------------------------|---|-----|----------------------------|
|                          |  | 405407  | B. WING            |                               |   |     |                            |
|                          |  | 495407  | B. WING            |                               |   | 05/ | 18/2017                    |
|                          | ROVIDER OR SUPPLIER  | B CENTER  |                    | 1                             | STREET ADDRESS, CITY, STATE, ZIP CODE 40 BRIMLEY DRIVE FREDERICKSBURG, VA 22406                                       |     |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |     | (X5)<br>COMPLETION<br>DATE |
| F 507                    | Continued From page documented, "(Nurse (Indicating the BMP ha.m.)  Review of Resident # evidence documental laboratory results.  On 5/17/17 at 5:15 p. laboratory results was (administrative staff in nursing.  On 5/18/17 at 8:00 a. laboratory report was the bottom of the pag of staff member) on 1 p.m.)"  On 5/18/17 at 9:40 a. conducted with ASM When asked if the late Resident #11's record not. When asked if it facility on 5/17/17 AS | e 154 's initials) 0615 (6:15 a.m.)." lad been obtained at 6:15  e11's clinical record did not tion of the 5/5/17 BMP  m. a request for the BMP made to ASM member) #2, the director of  m. a copy of the BMP received. Documented at e was, "Prepared for (Name 7 May 2017 16:06 (4:06 |                    | 507                           | DEFICIENCY)   |     |                            |
|                          | different chemicals in usually are done on the blood. The tests can eabout your muscles (if and organs, such as information was obtain https://www.nhlbi.nih.cs/bdt/types  | the blood. These tests the fluid (plasma) part of give doctors information including the heart), bones, the kidneys and liver. This ned from: gov/health/health-topics/topi led to file a laboratory test   |                    |                               |   |     |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   | ' '   |  | COMPLE   | (X3) DATE SURVEY<br>COMPLETED  |  |
|---|---|---|--|--|--|--|
|   | 495407  | B. WING   |  | _  | /2017  |  |
| ROVIDER OR SUPPLIER   | AB CENTER   |   | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406   | •  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  |  |
| (EACH DEFICIEN  | CY MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG   | (EACH CORRECTIVE ACTION  | SHOULD BE  | (X5)<br>COMPLETION<br>DATE   |  |
| result in Resident #8 Resident #5 was ad 5/31/16 with diagnor limited to: high blood dementia, and histo hyperlipidemia (Exc triglycerides, or both The most recent ME assessment, a quar assessment referen resident as scoring interview for mental was moderately imp decisions. The resident as some extensive assistance members for all of heating in which she supervision after set The physician order documented, "Fastin triglycerides) every day until 12/15/2017 Review of the electre evidence a copy of the fasting lipid test.  A copy of the fasting requested on 5/17/1 staff member) #4, the supervision after was the fasting lipid test. | mitted to the facility on ses that included but were not d pressure, heart disease, ry of broken hip, pain, and ess lipids [cholesterol, n] in the blood) (1).  OS (minimum data set) terly assessment, with an ce date of 3/7/17, coded the a "9" on the BIMS (brief status) scale, indicating she haired to make daily cognitive dent was coded as requiring er from one or more staff er activities of living except was coded as requiring tup assistance was provided.  In dated, 12/15/16, ng Lipids (cholesterol and 12 months on the 16th for 1 onic clinical record did not these test results.  In December 2016 were son documentation related to g lipids laboratory test was 7 from ASM (administrative ne assistant director of | F 50  | 77   |  |  |  |
|   | ROVIDER OR SUPPLIER  SUMMARY S (EACH DEFICIEN REGULATORY OF  Continued From page result in Resident #8  Resident #5 was ad 5/31/16 with diagnoral limited to: high blood dementia, and histo hyperlipidemia (Exc triglycerides, or both  The most recent ME assessment, a quar assessment referen resident as scoring a interview for mental was moderately imp decisions. The resid extensive assistance members for all of h eating in which she supervision after ser  The physician order documented, "Fastin triglycerides) every day until 12/15/2017  Review of the electr evidence a copy of the fasting lipid test.  A copy of the fasting requested on 5/17/1 staff member) #4, th  | ROVIDER OR SUPPLIER  IN NURSING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 155 result in Resident #5's clinical record.  Resident #5 was admitted to the facility on 5/31/16 with diagnoses that included but were not limited to: high blood pressure, heart disease, dementia, and history of broken hip, pain, and hyperlipidemia (Excess lipids [cholesterol, triglycerides, or both] in the blood) (1).  The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/7/17, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) scale, indicating she was moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance from one or more staff members for all of her activities of living except eating in which she was coded as requiring supervision after set up assistance was provided.  The physician order dated, 12/15/16, documented, "Fasting Lipids (cholesterol and triglycerides) every 12 months on the 16th for 1 day until 12/15/2017."  Review of the electronic clinical record did not evidence a copy of these test results.  The nurse's notes for December 2016 were revealed. There was no documentation related to the fasting lipid test.  A copy of the fasting lipids laboratory test was requested on 5/17/17 from ASM (administrative staff member) #4, the assistant director of | A BUILDING  495407  ROVIDER OR SUPPLIER  N NURSING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 155 result in Resident #5's clinical record.  Resident #5 was admitted to the facility on 5/31/16 with diagnoses that included but were not limited to: high blood pressure, heart disease, dementia, and history of broken hip, pain, and hyperlipidemia (Excess lipids [cholesterol, triglycerides, or both] in the blood) (1).  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A copy of the fasting lipids laboratory test was requested on 5/17/17 from ASM (administrative staff member) #4, the assistant director of | ROUDER OR SUPPLIER  N NURSING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 155 result in Resident #5's clinical record.  Resident #5 was admitted to the facility on 5/31/16 with diagnoses that included but were not limited to: high blood pressure, heart disease, dementia, and history of broken hip, pain, and hyperlipidemia (Excess lipids (cholesterol, triglycerides, or both) in the blood) (1).  The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/7/17, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) scale, indicating she was moderately impaired to make daily cognitive decisions. 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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDIN   | IPLE CONSTRUCTION  IG | \ , ,  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|---|--|---|-----------------------|--|-------------------------------|----------------------------|--|
|   | 495407   |   | B. WING _             |  |                               | C<br><b>5/18/2017</b>      |  |
|   | ROVIDER OR SUPPLIER  | AB CENTER   |                       | STREET ADDRESS, CITY, STATE, ZIP COD<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406        | •                             | 5/10/2017                  |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CC<br>( (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETION<br>DATE |  |
| F 507   | Continued From pag   | ge 156<br>ve staff member (ASM) #4  | F 5                   | 507  |                               |                            |  |
|   | presented a copy of<br>dated 12/16/16. Who<br>results had come fro<br>them faxed over from   | the laboratory test results<br>en asked where the test<br>em, ASM #4 stated, "We had<br>in the lab (laboratory)." When<br>ults were not on the clinical   |                       |  |                               |                            |  |
|   | practical nurse) #5 c<br>When asked the pro<br>laboratory test result<br>faxed over to the un<br>they call us." When<br>results have been re<br>check the order in the<br>administration record<br>lab (laboratory) book | is, LPN #5 stated, "They are<br>it. If there is a critical level,<br>asked how staff verify that<br>aceived, LPN #5 stated, "We   |                       |  |                               |                            |  |
|   | 5/17/17 at 1:28 p.m. obtained for laborate ASM #4 stated, "The fax machine. They a follow up with the do responsible for filing  | nducted with ASM #4 on When asked how results are by tests that are completed, e lab faxed the results to the re distributed to the nurses to actor." When asked who is them in the clinical record, e nurse who they are |                       |  |                               |                            |  |
|   | of nursing, and ASM  | strator, ASM #2, the director<br>#3, the regional director of<br>re made aware of the above<br>.m.  |                       |  |                               |                            |  |
|   | following website:   | was obtained from the ov/understanding-hiv-aids/glo   |                       |  |                               |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPL<br>A. BUILDING  | E CONSTRUCTION      | (X3) DATE SURVEY COMPLETED C  |                 |
|---|---|--|---------------------|---|-----------------|
|   |   | 495407   | B. WING             |   | 05/18/2017      |
|   | ROVIDER OR SUPPLIER   | AB CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406                          | ,               |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETION |
| F 507   | urinalysis (1) results reported on 3/4/17) record.  Resident #10 was a 2/22/17 and readmit #10's diagnoses inciseizures, liver transpinfection. Resident status MDS (minimu an ARD (assessmer coded the resident's decision making as Review of Resident record revealed a phor a urinalysis. Fur clinical record failed urinalysis. There was Resident #10.  On 5/16/17 at 3:50 p staff member) #4 (th nursing) presented Fresults that were colon 3/4/17. The botto the report was preparable.  On 5/17/17 at 7:52 at 2.50 p.m. | emia  ailed to file Resident #10's (collected on 3/3/17 and in the resident's clinical  dmitted to the facility on ted on 3/23/17. Resident uded but were not limited to: blant and urinary tract #10's significant change in im data set) assessment with not reference date) of 3/30/17, cognitive skills for daily severely impaired.  #10's electronic clinical mysician's order dated 3/2/17 ther review of the resident's to reveal the results of the as no paper clinical record for  D.m., ASM (administrative the assistant director of Resident #10's urinalysis lected on 3/3/17 and reported of of the report documented ared by ASM #4 on 5/16/17 at  a.m., an interview was | F 507               | ,   |                 |
|   | medical records employment (administrative staff nursing) wanted to g   | I (other staff member) #4 (the bloyee). OSM #4 stated she in March 2017 and ASM member) #2 (the director of paperless so she went r charts beginning with  |                     |   |                 |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` ′   | PLE CONSTRUCTION  G | , ,  | (X3) DATE SURVEY COMPLETED |                            |  |
|---|--|---|---------------------|--|----------------------------|----------------------------|--|
|   |  | 495407  | B. WING             |  |                            | C<br><b>05/18/2017</b>     |  |
|   | ROVIDER OR SUPPLIER  | 1   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                 |                            | 55/10/2017                 |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE                   | (X5)<br>COMPLETION<br>DATE |  |
| F 507   | she gets a paper charchart and separates into the computer. On o longer had a paper were scanned into the previous week or the stated she tries to se electronic clinical recreceives the docume stated a few employed her with scanning do record.  On 5/17/17 at 8:23 a conducted with ASM and ASM #4. ASM #4 results were obtained website. ASM #2 and results were filed in the stated, "They are in the still scanning things in the still scanning things in the above findings. ASM director of clinical see the above findings. Astill had a paper characcessible on the unit.  No further information (1) "A urinalysis is a done to check for a decrease into the context of the | floor. OSM #4 stated once art, she goes through the it by how it should be logged oSM #4 stated Resident #10 or chart and all documents in ecomputer during the week before. OSM #4 an documents into the ford the same day she onts or the next day. OSM #4 or the same day she of the director of nursing) the confirmed the urinalysis of from the laboratory of ASM #4 were asked if the she clinical record. ASM #2 the process of that. We are not ogo that way."  Important the stated of the same day and the record was not the same day and the same day and the record was not the same day and | F 50                |  |                            |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | 1 ` ′   | LE CONSTRUCTION     | (X3) DATE SURVEY<br>COMPLETED   |                        |       |
|--|---|---|---------------------|---|------------------------|-------|
|  |   | 495407  | B. WING             |   | C<br><b>05/18/2017</b> | 7     |
|  | ROVIDER OR SUPPLIER  JN NURSING AND REF   | AB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406                      | 1 00/10/2017           |       |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE COMPLE          | ETION |
| F 507  | ordered laboratory Resident # 7's clinic Resident # 7 was a 05/01/14 with diagr not limited to: enceyweakness, depress hypertension (4), go disease (5), dyspha vascular disease (7 Resident # 7's mos set), a quarterly ass (assessment refere Resident # 7 as socinterview for menta - 15, 13 being cogn decisions. Resident supervision with set living.  Review of the POS May 2017 documer Panel [8]) 03/13/20 months in the morn on the 13th for 1 (o | website: gov/urinalysis.html  failed to ensure a physician test result was filed in cal record.  dmitted to the facility on loses that included but were chalopathy (1), muscle ion, aphasia (2), dementia (3), astroesophageal reflux logia (6) and peripheral ).  t recent MDS (minimum data sessment with an ARD noce date) of 03/22/17, coded oring a 13 on the brief I status (BIMS) of a score of 0 itively intact for making daily tt # 7 was coded as requiring t up help for activities of daily  (physician order sheet) dated inted, "BMP (Basic Metabolic 17 and Q (every) 6 (six) ing every 6 months(s) starting | F 50                | 7   |                        |       |
|  | director of nursing p   | 50 a.m. ASM # 4, the assistant brovided this surveyor with a coratory test results for n asked where the laboratory   |                     |   |                        |       |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | l ` ′   | PLE CONSTRUCTION  G | , ,   | (X3) DATE SURVEY COMPLETED |                            |  |
|---|--|---|---------------------|---|----------------------------|----------------------------|--|
|   |  | 495407  | B. WING _           |   |                            | C<br>05/18/2017            |  |
|   | PROVIDER OR SUPPLIER   | AB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406                  | <b>I</b>                   | 03/10/2011                 |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD BE                   | (X5)<br>COMPLETION<br>DATE |  |
| F 507   | test results were obta "They were faxed fro were not in the clinic On 05/17/17 at appro (administrative staff administrator, and A) were made aware of No further informatio References:  1. A term for any diffialters brain function was obtained from the http://www.ninds.nih. y/encephalopathy.htm  2. A disorder caused the brain that control hard for you to read, mean to say). This in the website: https://www.nlm.nih.gl.  3. A group of sympto affect the brain. This from the website: https://www.nlm.nih.gl. ml.  4. High blood pressu obtained from the we https://www.nlm.nih.gl. essure.html. | ained from, ASM # 4 stated, on the lab (laboratory); they al record."  Description of p.m. ASM member) # 1 the SM # 2, director of nursing, the findings.  In was provided prior to exit.  Luse disease of the brain that for structure. This information he website:  Igov/disorders/encephalopath m.  By damage to the parts of language. It can make it write, and say what you information was obtained from gov/medlineplus/aphasia.htm  In scaused by disorders that is information was obtained gov/medlineplus/dementia.ht  Tre. This information was | F 5                 | 07  |                            |                            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   |  | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUIDENTIFICATION NUMBER:  A. BUILDING   |                   |         | (X3) DATE SURVEY<br>COMPLETED  |                        |                            |
|---|--|--|-------------------|---------|--|------------------------|----------------------------|
|   |  | 495407   | B. WING           | B. WING |  | C<br><b>05/18/2017</b> |                            |
|   | NAME OF PROVIDER OR SUPPLIER  FALLS RUN NURSING AND REHAB CENTER   |  |                   | 1       | TREET ADDRESS, CITY, STATE, ZIP CODE<br>40 BRIMLEY DRIVE<br>REDERICKSBURG, VA 22406                          | <u>, ou</u>            | 10/2011                    |
|   | ACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |         | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                        | (X5)<br>COMPLETION<br>DATE |
| the esop was obtained https://w 6. A swa obtained https://w sorders. 7. The v blood ve capillarie Arteries called at vessels Weaken bleeding obtained https://w ases.htm 8. The b tests that metaboli the webs https://m F 514 SS=D RECOR LE CFR(s): (i) Medic (1) In ac standard | ained from the www.nlm.nih.gallowing disord from the wearww.nlm.nih.gallowing disord from the wearww.nlm.nih.gallowing disord from the can become therosclerosis and block block block block block block block block from the wearww.nlm.nih.gall.  asic metabol at provides infism. This infosite: nedlineplus.gallow | ritate it. This information e website: pov/medlineplus/gerd.html.  der. This information was bsite: pov/medlineplus/swallowingdi  em is the body's network of ides the arteries, veins and blood to and from the heart. thick and stiff, a problem is. Blood clots can clog bod flow to the heart or brain. sels can burst, causing body.) This information was bsite: pov/medlineplus/vasculardise  ic panel is a group of blood formation about your body's bormation was obtained from bov/ency/article/003462.htm. |                   | 507     |  |                        | 6/22/17                    |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | IDENTIFICATION NUMBER  |                    | CONSTRUCTION | (X3) DATE SURVEY<br>COMPLETED  |                 |                            |
|---|---|--|--------------------|--------------|--|-----------------|----------------------------|
|   |   | 495407   | B. WING            |              |  | C<br>05/18/2017 |                            |
|   | ROVIDER OR SUPPLIER   |  |                    | 1            | TREET ADDRESS, CITY, STATE, ZIP CODE  40 BRIMLEY DRIVE  REDERICKSBURG, VA 22406  | 1 03/           | 10/2017                    |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)      |  | ID<br>PREFI<br>TAG | ×            | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  |                 | (X5)<br>COMPLETION<br>DATE |
| F 514   | Continued From page   | e 162  | F t                | 514          |  |                 |                            |
|   | (ii) Accurately docume  | ented;   |                    |              |  |                 |                            |
|   | (iii) Readily accessible  | e; and   |                    |              |  |                 |                            |
|   | (iv) Systematically org   | ganized  |                    |              |  |                 |                            |
|   | (5) The medical recor   | d must contain-  |                    |              |  |                 |                            |
|   | <ul><li>(i) Sufficient information to identify the resident;</li><li>(ii) A record of the resident's assessments;</li></ul> |  |                    |              |  |                 |                            |
|   |   |  |                    |              |  |                 |                            |
|   | (iii) The comprehension provided;   | ve plan of care and services   |                    |              |  |                 |                            |
|   | (iv) The results of any<br>and resident review e<br>determinations condu  |  |                    |              |  |                 |                            |
|   | (v) Physician's, nurse professional's progres   | s's, and other licensed<br>ss notes; and   |                    |              |  |                 |                            |
|   | services reports as re  | ogy and other diagnostic<br>equired under §483.50.   |                    |              |  |                 |                            |
|   | and clinical record rev<br>the facility staff failed  | iew, facility document review view, it was determined that to maintain a complete and rd for two of 26 residents in esidents #14 and #3. |                    |              | Resident #14 no longer resides in the facility and her record is closed. Resid #3 clinical record has been reviewed an other residents information removed.  | ent             |                            |
|   | The facility staff fail #14's physician's resp warning regarding a c medications ranolazir                                  | led to document Resident   |                    |              | All residents have the potential to be affected by this deficient practice.     DON and or designee(s) will in-serv licensed nurses, medical records clerk HIPPA and required documentation in t medical record. | ice<br>on       |                            |

| AND PLAN OF CORRECTION IDENTIFICATION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | PLE CONSTRUCTION  G   |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---------------------------------------|--|---|---------------------|---|---|-------------------------------|--|
|                                       |  | 495407  | B. WING             |   |   | C<br><b>05/18/2017</b>        |  |
|                                       | ROVIDER OR SUPPLIER  | AB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP COD<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406   |   | 0/10/2017                     |  |
| (X4) ID<br>PREFIX<br>TAG              | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)  | N SHOULD BE   | (X5)<br>COMPLETION<br>DATE    |  |
| F 514                                 |  | Continued From page 163   |                     | F 514   |   |                               |  |
|                                       | The findings include:  1. The facility staff fa #14's physician's reswarning regarding a medications ranolazing Resident #14 was ac 2/7/17 and discharge diagnoses included to cholecystitis (3), high depressive disorder. Medicare assessment reference date) of 2/being cognitively inta Review of Resident a physician's order of 1000 mg (milligrams angina (chest pain) ac 2/7/17 for verapamil for high blood pressure. | drug interaction between the ne (1) and verapamil (2).  dmitted to the facility on e on 2/14/17. Resident #14's but were not limited to: acute n blood pressure and major Resident #14's five day nt with an ARD (assessment 14/17 coded the resident as act.  #14's clinical record revealed lated 2/7/17 for ranolazine by mouth twice a day for and a physician's order dated 120 mg by mouth at bedtime |                     | 4. DON and or designee(s) we resident medical records wee weeks and then monthly for 2 ensure accuracy of the medic Results of audits will be taker committee x3 months for revirevision as needed. | ekly for 4<br>2 months to<br>cal record.<br>n to QAPI |                               |  |
|                                       | Extended Release 1. (milligrams); Give 1 to day for angina; pharic verapamil could not dose of 1000 mgs (ndoctor) notified.  Further review of Refailed to reveal the p  | 2 Hour 1000 MG rablet by mouth two times a macy said ranolazine and be given together in high nilligrams). md (medical sident #14's clinical record hysician's response acy warning documented in   |                     |   |   |                               |  |

| , , ,                    |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|--|---------------------|--|-------------------------------|
|                          |   | 495407   | B. WING             |  | C<br><b>05/18/2017</b>        |
|                          | ROVIDER OR SUPPLIER  N NURSING AND REHA   | 1  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406         | 03/10/2017                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF | D BE COMPLETION               |
| F 514                    | LPN #1 was asked if pharmacy concern s clinical record. LPN document that the pha possible drug intermedications and that LPN #1 stated the nuthe physician said it medications or if not medications that were document the new of the pharmacy "Grid pharmacy and prese staff member) #2 (the 5/17/17 at 3:34 p.m. "ranexa (ranolazine) verapamil02/07/20 s/w (spoke with) (nat documented the abound02/08/2017 1:02 STAT (immediately) nurse) PT (patient) CPLEASE SEND STAT (7:10 p.m.)"  On 5/17/17 at 5:30 producing pharmacy and prese staff member) #2 (the staff member) # | c.m. an interview was (licensed practical nurse) #1. If a physician's response to a should be documented in the #1 stated the nurse should narmacy informed him/her of action, the name of the the physician was notified. The phy | F 514               | 4  |                               |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULT<br>A. BUILDIN   | PLE CONSTRUCTION  G |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|---|---------------------|--|-------------------------------|----------------------------|
|   |   | 495407  | B. WING _           |  |                               | C<br><b>05/18/2017</b>     |
|   | NAME OF PROVIDER OR SUPPLIER  FALLS RUN NURSING AND REHAB CENTER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406             |                               |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE.<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 514   | there is a need to clabecause the order is vague, contraindicat interaction. 6.1 Faci machine(s) for any p 6.2 Pharmacy will he Physician/Prescriber 6.3 Facility should convene staff is notified requiring clarification the issue to the Physical the clarification and received"  No further information (1) "Ranolazine is us medications to treat chest pain or pressue does not get enough was obtained from the https://medlineplus.gtml  (2) "Verapamil is use pressure and to cont This information was https://medlineplus.gtml  (3) "Acute cholecysti irritation of the gallbl pain." This information website: | e pharmacist believes that arify the medication order unclear, incomplete or ed, or has a drug-drug lity staff should check the fax charmacy communication. Old medication orders until is able to clarify the order. Ontact Physician/Prescriber by Pharmacy of an order in 6.4 Facility should explain sician/Prescriber document any new orders.  On was presented prior to exit. Seed alone or with other chronic angina (ongoing re that is felt when the heart a oxygen)." This information | F5                  | 14   |                               |                            |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--------------------------|---|--|-----------------------------|---|-------------------------------|--|--|
|                          |   | 495407   | B. WING                     |   | C<br><b>05/18/2017</b>        |  |  |
|                          | ROVIDER OR SUPPLIER  JN NURSING AND REH   | AB CENTER  |                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>140 BRIMLEY DRIVE<br>FREDERICKSBURG, VA 22406                          | 1 33/10/2011                  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE COMPLETION               |  |  |
| F 514                    | Continued From pag  | ge 166   | F 514                       |   |                               |  |  |
|                          |   | led another resident's clinical<br>ent #3's clinical record.   |                             |   |                               |  |  |
|                          | with diagnoses that   | mitted to the facility on 7/1/16 included but were not limited h blood pressure and  |                             |   |                               |  |  |
|                          | The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 3/14/17 coded the resident as having scored an eight out of 15 on the BIMS (brief interview of mental status) indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance from staff for activities of daily living. |  |                             |   |                               |  |  |
|                          |   | 17 IDT (interdisciplinary team) inical information about   |                             |   |                               |  |  |
|                          | p.m. with LPN (licen resident's nurse. Wh LPN #4 stated, "Oh, When asked if there having the wrong re clinical record, LPN wrong person shoul want what's pertiner want someone read  | nducted on 5/17/17 at 1:05 sed practical nurse) #4, the nen asked to review the note, it's not on the right resident." was any concern about sident's information in the #4 stated, "Yeah, it's the d have been struck out. We not to the resident. We don't ing through too quickly and her when it doesn't. It's a |                             |   |                               |  |  |
|                          | p.m. with RN (regist<br>manager. When ask<br>note on Resident #3  | nducted on 5/17/17 at 1:15 ered nurse) #5, the unit ted to review the 3/30/17 IDT I's record, RN #5 stated, "It's tesides being a privacy issue  |                             |   |                               |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED  |                 |                            |
|--|--|--|---|--|--|-----------------|----------------------------|
|  |  | 495407   | B. WING _                               |  |  | C<br>05/18/2017 |                            |
|  | ROVIDER OR SUPPLIER  | B CENTER   |   | STREET ADDRESS, CITY, STATE, ZIP CODE  140 BRIMLEY DRIVE  FREDERICKSBURG, VA 22406 |  |                 | 2011                       |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                                       |  | ID<br>PREFIX<br>TAG                     | (EACH CORRECTI<br>CROSS-REFERENCI  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                 | (X5)<br>COMPLETION<br>DATE |
| F 514  | employed at the facili interviewed.  On 5/17/17/at 5:15 p. member) #1, the adm director of nursing we findings.  No further information  (1) HIPPA Health In | the note was no longer ty and could not be  m. ASM (administrative staff hinistrator and ASM #2, the ere made aware of the  n was provided prior to exit.  Issurance Portability and PAA) This information was | F                                       | 514  |  |                 |                            |
|  |  |  |   |  |  |                 |                            |