STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 05/16/17 through 05/18/17. Complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 77 at the time of the survey. The survey sample consisted of 21 current resident reviews (Residents #1 through #13 and #19 through #26) and five closed record reviews (Residents #14 through #18).	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 157		6/22/17

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

Electronically Signed | 06/08/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation it was determined that the facility staff failed to notify the physician of a possible need to alter treatment for one of 26 residents in the survey sample, Resident #14. a. The facility staff failed to make Resident #14's physician aware that multiple medications were not administered to the resident as ordered on	F 157	1. Resident #14 no longer resides in the facility. 2. All residents have the potential to be affected by this deficient practice. DON and designee(s) reviewed new residents admitted from 5/18/2017 thru 5/31/2017 for medication availability and MD notification as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 the night of 2/7/17. b. The facility staff failed to make Resident #14's physician aware that zolpidem (sleep medication) was not administered to the resident as ordered on the night of 2/8/17. The findings include: a. Resident #14 was admitted to the facility on 2/7/17 and discharged 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 assessment with an ARD (assessment reference date) of 2/14/17 coded the resident as being cognitively intact. 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. Resident #14's physician's orders dated 2/7/17 documented orders for the following medications including but not limited to: -Atorvastatin (2) 40 mg (milligrams) - one tablet by mouth at bedtime (scheduled at 8:00 p.m.) -Verapamil (3) 120 mg- one capsule by mouth at bedtime (scheduled at 8:00 p.m.) -Zolpidem (4) 5 mg- one tablet by mouth at bedtime (scheduled at 8:00 p.m.) -Candesartan (5) 4 mg- one tablet by mouth two times a day (scheduled at 8:00 a.m. and 8:00 p.m.) -Ranolazine (6) 1000 mg- one tablet by mouth two times a day (scheduled at 8:00 a.m. and 8:00 p.m.)	F 157	3. The DON and or designee(s) will in-service licensed nurses on the policy for medication availability to include use of the stat box and notifying the MD of medication not available. 4. DON and or designee(s) will audit new residents for medication availability 5x a week for 4 weeks and then weekly for 8 weeks. Data collected will be taken to QAPI committee x3 months for review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3	F 157		

-Gabapentin (7) 800 mg- one tablet by mouth three times a day (scheduled at 6:00 a.m., 2:00 p.m. and 10:00 p.m.)
-Metronidazole (8) 500 mg- one tablet by mouth three times a day (scheduled at 6:00 a.m., 2:00 p.m. and 10:00 p.m.)

Review of Resident #14's February 2017 MAR (medication administration record) revealed the resident was not administered the scheduled night dose of any of the above medications on 2/7/17 (as evidenced by an "x" documented on the MAR). Further review of the clinical record (including MAR notes and nurses' notes) failed to reveal Resident #14's physician was made aware that the above medications were not administered.

On 5/17/17 at 2:40 p.m., an interview was conducted with ASM (administrative staff member) #5 (Resident #14's physician). ASM #5 was asked if he could recall being made aware that Resident #14's evening medications were not administered on 2/7/17. ASM #5 stated he thought that had happened before. ASM #5 stated the pharmacy was a long distance from the facility so nurses call him when medications haven't arrived and he tells the nurses the medications can be held that night but have to be delivered the next day. ASM #5 couldn't specifically confirm he was made aware Resident #14's evening medications were not administered on 2/7/17.

On 5/17/17 at 3:05 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (the nurse caring for Resident #14 during the evening shift of 2/7/17). LPN #1 was asked what should be done if a resident is admitted and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 4	F 157		

resident's evening medication is not available for administration. LPN #1 stated nurses can access the facility STAT (Immediate) box (a box containing various medications) and most of the time the STAT box contains the needed medications. LPN #1 stated if the STAT box does not contain the needed medications then nurses notify the physician and he will say to give another medication or to hold the medications until they arrive from the pharmacy. LPN #1 was shown Resident #14's February 2017 MAR. LPN #1 stated she didn't remember if Resident #14's scheduled evening medications were given on 2/7/17 or what was done if the medications were not given. LPN #1 stated she didn't remember if she contacted the physician or not.

On 5/17/17 at 5:30 p.m., ASM #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above findings.

The facility pharmacy policy titled, "Medication Shortages/Unavailable Medications" documented, "4. If an emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain orders or directions..."

No further information was presented prior to exit.

(1) "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

(2) Atorvastatin is used to treat high cholesterol. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 5	F 157		

T0009143/?report=details

(3) "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.html

(4) "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.html

(5) "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.html

(6) "Ranolazine is used alone or with other medications to treat chronic angina (ongoing chest pain or pressure that is felt when the heart does not get enough oxygen)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a606015.html

(7) "Gabapentin is also sometimes used to relieve the pain of diabetic neuropathy (numbness or tingling due to nerve damage in people who have diabetes)..." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694007.html

(8) "Metronidazole eliminates bacteria and other microorganisms that cause infections of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 6	F 157		

reproductive system, gastrointestinal tract, skin, vagina, and other areas of the body..." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a689011.html

COMPLAINT DEFICIENCY

b. Review of Resident #14's clinical record revealed a physician's order dated 2/7/17 for zolpidem (1) 5 mg (milligrams) - one tablet by mouth at bedtime.

Review of Resident #14's February 2017 MAR (medication administration record) and the resident's zolpidem controlled medication utilization record revealed zolpidem, was not administered to the resident on 2/8/17 per physician's order.

A nurse's note dated 2/8/17 documented, "Zolpidem Tartrate 5 MG- Give 1 tablet by mouth at bedtime for Insomnia. Pharmacy needing script for medication." The note failed to document whether or not Resident #14's physician was contacted.

On 5/17/17 at 9:46 a.m., an interview was conducted with LPN (licensed practical nurse) #3 (the nurse who documented the above note.) LPN #3 was shown the above note. LPN #3 confirmed zolpidem was not administered to Resident #14 on 2/8/17 because a hard prescription was needed in order for the pharmacy to deliver the medication. LPN #3 stated if a medication is due and not in the facility then she contacts the pharmacy. LPN #3 stated in this case the pharmacy needed a prescription.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 nursing) and ASM #3 (the regional director of clinical 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.html	F 157		
F 278 SS=D	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.	F 278		6/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 8 (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete MDS (minimum data set) assessment for one of 26 residents in the survey sample, Resident #10. The facility staff failed to attempt Resident #10's mood interview for section D on the resident's admission MDS assessment with an ARD (assessment reference date) of 3/1/17 and the significant change in status MDS assessment with an ARD of 3/30/17. The findings include:	F 278	1. Resident #10's MDS assessment was corrected and submitted. 2. All residents have the potential to be affected by this deficient practice. 3. On 5/17/2017, Regional MDS nurse in-serviced facility MDS nurses and social workers regarding accurate completion of section C and D. 4. DON and or designee(s) will conduct a 10% audit of MDS assessments weekly for 2 weeks and then monthly for 2 months to ensure section C and D are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 9 Resident #10 was admitted to the facility on 2/22/17 and readmitted on 3/23/17. Resident #10's diagnoses included but were not limited to: seizures, liver transplant and urinary tract infection. Review of Resident #10's admission MDS assessment with an ARD of 3/1/17 revealed section B that documented the resident was usually understood and usually understands verbal content. Section C documented a "99" in the BIMS (brief interview for mental status) summary score, indicating the resident was unable to complete the interview. The staff assessment for mental status documented Resident #10's cognitive skills for daily decision making were severely impaired. Section D documented, "Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents." A dash was coded and the resident mood interview was not completed; the staff assessment of resident mood was completed. Review of Resident #10's significant change in status MDS assessment with an ARD of 3/30/17 revealed section B that documented the resident was sometimes understood and sometimes understands verbal content. Section C documented a "99" in the BIMS summary score, indicating the resident was unable to complete the interview. The staff assessment for mental status documented Resident #10's cognitive skills for daily decision making were severely impaired. Section D documented, "Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents." A dash was coded and the resident mood interview was not completed; the staff assessment of resident	F 278	complete and accurate. Data collected will be submitted to the QAPI committee x3 months for review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 10	F 278		

mood was completed.

On 5/16/17 at 3:57 p.m. an interview was conducted with OSM (other staff member) #5 (the social services director and the person responsible for completing sections C and D on Resident #10's MDS assessments). OSM #5 stated she always initially attempts the BIMS interview but if the resident scores five or lower on the BIMS then it is not appropriate to pursue the mood interview with the resident. OSM #5 confirmed she did not attempt Resident #10's mood interviews and completed the staff assessments.

On 5/7/17 at 8:58 a.m., OSM #5 confirmed she did not pursue the mood interview with Resident #10 because the resident scored a 99 on the BIMS interview and the resident would not have been a good historian to give the information related to the mood interview questions. OSM #5 was asked what reference she used for questions related to MDS assessments. OSM #5 stated she coordinates with the MDS department and there is an RAI (resident assessment instrument) manual in their office. OSM #5 was asked to review the RAI manual with the MDS nurses and speak with this surveyor later on during the day.

On 5/7/17 at 4:22 p.m., an interview was conducted with OSM #5, OSM #6 (another social worker), RN (registered nurse) #2 (MDS coordinator) and RN #3 (MDS coordinator). OSM #5 stated she reviewed the policy and Resident #10's mood interviews should have been attempted. RN #3 confirmed the facility staff references the CMS (Centers for Medicare & Medicaid) RAI manual and stated she had an in-service to present. The in-service titled,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 11	F 278		

"INService on Section D (Mood)" dated 5/16/17 documented, "Objectives of the In-Service: All MDS and Social services will verbalize understanding of coding section D MOOD interview in the MDS." A copy of instructions regarding section D from the RAI manual was attached. The in-service was signed by both social workers and both MDS coordinators.

On 5/17/17 at 5:30 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above findings.

The CMS RAI manual documented:
"SECTION D: MOOD
Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable...
D0100: Should Resident Mood Interview Be Conducted?
Item Rationale
This item helps to determine whether or not a resident or staff mood interview should be conducted.
Health-related Quality of Life
Most residents who are capable of communicating can answer questions about how they feel.
Obtaining information about mood directly from the resident, sometimes called 'hearing the resident's voice,' is more reliable and accurate than observation alone for identifying a mood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 12 disorder. D0100: Should Resident Mood Interview Be Conducted? (cont.) Planning for Care Symptom-specific information from direct resident interviews will allow for the incorporation of the resident's voice in the individualized care plan. If a resident cannot communicate, then Staff Mood Interview (D0500 AJ) should be conducted. Steps for Assessment 94. Determine if the resident is rarely/never understood. If rarely/never understood, skip to D0500, Staff Assessment of Resident Mood (PHQ-9-OV©). 95. Review Language item (A1100) to determine if the resident needs or wants an interpreter to communicate with doctors or health care staff (A1100 = 1). If the resident needs or wants an interpreter, complete the interview with an interpreter. Coding Instructions Code 0, no: if the interview should not be conducted. This option should be selected for residents who are rarely/never understood, or who need an interpreter (A1100 = 1) but one was not available. Skip to item D0500, Staff Assessment of Resident Mood (PHQ-9-OV©). Code 1, yes: if the resident interview should be conducted. This option should be selected for residents who are able to be understood, and for whom an interpreter is not needed or is present. Continue to item D0200, Resident Mood Interview (PHQ-9©)..." No further information was presented prior to exit.	F 278		
F 281 SS=E	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i)	F 281		6/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 13 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to follow professional standards of care for four of 26 residents in the survey sample, Resident #12, Resident #14, Resident #2 and Resident #7. 1. The facility staff failed to clarify a physician's order for Tylenol to be given every four hours for breakthrough pain for Resident #12. 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. 3. The facility staff failed to clarify the parameters for administration of PRN (as needed) pain medication for Resident # 2. 4. The facility staff failed to clarify the parameters for administration of PRN (as needed) pain medication for Resident # 7. The findings include: 1. The facility staff failed to clarify a physician's	F 281	1. Resident #12's Tylenol order was clarified, resident #14 no longer resides in the facility, resident #2, and #7's PRN pain medication/parameters were clarified. 2. All residents have the potential to be affected by this deficient practice. Current residents receiving PRN pain medication have been reviewed and parameters if indicated clarified. Current resident's will be reviewed for accuracy. 3. DON and or designee(s) will in-service licensed nurses on following MD orders, to include parameters if indicated for PRN medications and on accurate transcription of diet orders. 4. DON and or designee(s) will audit 10 residents with PRN pain medication orders 5x a week for 4 weeks and then weekly for 8 weeks. DON and or designee(s) will audit 5 residents a week for 4 weeks and then weekly for 8 weeks to ensure orders/parameters are followed as indicated. DON and or designee(s) will audit 10 residents" diets weekly for 4 weeks and then monthly for 2 months for accuracy. Results of audits will be taken to the QAPI committee x3 months for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 14 order for Tylenol to be given every four hours for breakthrough pain for Resident #12. Resident #12 was admitted to the facility on 4/4/13 and readmitted on 8/6/15 with diagnoses that included but were not limited to: muscle weakness, dementia, chronic pain, heart disease ad high blood pressure. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/4/17 coded the resident as having a BIMS (brief interview for mental status) of 12 out of 15 indicating the resident was cognitively intact to make daily decisions. Review of the care plan initiated on 7/25/15; and revised on 1/26/17 documented, "Focus At risk for pain...Interventions meds (medications) as ordered, prn (as needed) medications as needed. contact md [sic] (medical doctor) if ineffective." Review of the physician's orders dated May 2017 documented, "Tylenol Tablet 325 MG (milligrams) (Acetaminophen) Give 325 mg by mouth every four hours for Breakthrough pain. Order Date 7/14/2016." Review of the May 2017 MAR (medication administration record) documented, "Tylenol Tablet 325 MG (milligrams) (Acetaminophen) Give 325 mg by mouth every four hours for Breakthrough pain. -Start Date- 7/14/2016." Further review of the May 2017 MAR documented that the Tylenol had been given every four hours each day of the month. Resident #12's pain was rated as "0" (indicating no pain) 54 times out of 68 opportunities. The Tylenol was	F 281	review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 15	F 281		

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, LPN #4 stated, "Well, let me put it to you this way. She complains to her daughter that she has pain but she doesn't complain to us." When asked if the resident was assessed for pain, LPN #4 stated she was. When asked if the resident exhibited signs of pain, LPN #4 stated, "No." When asked if the Tylenol order was followed as ordered, LPN #4 stated, "No." When asked what staff would do in this case, LPN #4 stated, "We should probably get rid of it and make it prn if she needs it."

An interview was conducted on 5/17/17 at 1:15 p.m. with RN (registered nurse) #5. When asked to review Resident #12's Tylenol order, RN #5 stated, "It's for breakthrough pain so it's technically a prn (medication). I'm going to first find out number one if she's having pain. I'm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 16	F 281		

going to assess the pain level..." When asked if the Tylenol would be given if the resident stated her pain level was zero, RN #5 stated, "Absolutely not. No need. I'd probably make a note in the nurse's notes that (the resident) stated she had no pain."

An interview was conducted on 5/17/17 at 2:43 p.m. with OSM (other staff member) #5, Resident #12's physician. When asked when he expected the Tylenol for breakthrough pain would be given, OSM #5 stated, "Pain of one to ten." When asked if the Tylenol should be given if the resident did not have pain, OSM #5 stated, "No I don't expect to it be." When made aware of the concern, OSM #5 stated, "We'll take care of it."

On 5/17/17 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "New Orders for Non-Controlled Substances" documented, "Procedure: 1.2 Facility should ensure all resident information is complete and accurate has been reconciled and is verified by Physician/Prescriber before faxing or transmitting orders to the pharmacy. 2.1.2 Facility should ensure mediation orders include medication name, strength, dose, route, frequency, indication for use, stop orders, and parameters for administration, if any. 3.2 One the drug is chosen, staff should carry on with the order process by completing the directions, administration schedule, reason for use, and any other information required to complete the order." No further information was provided prior to exit.

In "Fundamentals of Nursing" 6th edition, 2005;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 17	F 281		

Patricia A. Potter and Anne Griffin Perry; Mosby, Inc.; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

(1) Tramadol (Ultram®) is a commonly prescribed analgesic because of its relatively lower risk of addiction and better safety profile in comparison with other opiates. However, two significant adverse reactions are known to potentially occur with tramadol-seizures and serotonin syndrome. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2714818/

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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 18	F 281		

Resident #14's comprehensive care plan initiated on 2/8/17 failed to document information regarding the resident's diet.

On 5/17/17 at 8:30 a.m., an interview was conducted with OSM (other staff member) #2 (the director of dietary services). OSM #2 was asked what process was in place to ensure the correct physician ordered diet was served to residents. OSM #2 stated, "We get a dietary communication slip." OSM #2 was asked if she could provide Resident #14's dietary communication slip.

On 5/17/17 at 9:40 a.m., OSM #2 presented a dietary communication form dated 2/7/17 that documented Resident #14's name and a check mark beside a regular diet order and a thin texture. The words, "No Red meats. No fried foods." were handwritten on the form. The renal diet was not checked off.

The nurse who completed the dietary communication form was no longer employed at the facility.

On 5/17/17 at 3:05 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what process was in place to ensure physician ordered diets are accurately communicated to the dietary department when a resident is admitted. LPN #1 stated, "We have a form we fill out that goes to the kitchen and we put the order in the computer." LPN #1 was asked if the information documented on the form that is given to the dietary department should match the physician's order. LPN #1 stated, "Yes."

On 5/17/17 at 5:30 p.m., ASM (administrative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 19	F 281		

staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above findings.

The facility policy titled, "INTERDEPARTMENTAL NOTIFICATION OF DIET" documented, "Policy: Nursing Services shall notify the Dietary Department of a resident's diet orders, including any changes in the resident's diet, meal service, and food preferences. Procedure: 1. When a new resident is admitted, or diet has been changed, the Nurse Supervisor shall ensure that the Food Services Department receives a written notice of the diet order..."

On 5/18/17 at 8:18 a.m., ASM #2 stated the above policy was the standard of practice that is followed when transcribing physician ordered diets onto the dietary communication forms.

No further information was presented prior to exit.

(1) "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

3. The facility staff failed to clarify the parameters for administration of PRN (as needed) pain medication for Resident # 2.

Resident # 2 was readmitted to the facility on 07/02/14 with diagnoses that included but were not limited to: cerebral vascular disease (1),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 20	F 281		

muscle weakness, pain, low iron, depression, benign prostatic hyperplasia (2), gastroesophageal reflux disease (3), dysphagia (4) and hypertension (5).

Resident # 2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/07/17, coded Resident # 2 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for making daily decisions. Resident # 2 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician's Order Sheet) for Resident # 2 dated May 2017 documented, "Pain assessment every shift. Please assess and document the resident's pain on a scale of 0 (zero) - (to) 10. 10 being the worst pain and 0 (zero) being no pain. If pain is indicated, document on pain flow log as well as what you did to address pain. First intervention being non-pharmacological, second intervention being pharmacological if needed." "Hydrocodone-Acetaminophen (6) Tablet 5 (five)-325 MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 07/21/2016." "Ultram Tablet 50 MG [Tramadol] (7) Give 2 tablet [sic] by mouth every 06 (six) hours as needed for severe pain. Order Date 06/30/2016."

The eMAR (electronic medication administration record) for Resident # 2 dated "March 2017 documented, "Hydrocodone-Acetaminophen (6) Tablet 5 (five)-325 MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 07/21/2016." "Ultram Tablet 50

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 21 MG [Tramadol] Give 2 tablet [sic] by mouth every 06 hours as needed for severe pain. Order Date 06/30/2016." Further review of the eMAR dated March 2017 revealed Ultram Tablet 50 MG was not administered during the month of March 2017 and Hydrocodone-Acetaminophen Tablet 5-325 MG was administered on the following dates and times: 03/03/17 at 1:05 a.m., 03/04/17 at 5:00 a.m., 03/05/17 at 5:00 a.m., and 03/31/17 at 1:30 a.m. The "eMAR Note" for each date Hydrocodone-Acetaminophen Tablet 5-325 MG was administered documented, "Hydrocodone-Acetaminophen Tablet 5-325 MG. Give 1 tablet by mouth every 6 hours as needed for pain." The eMAR (electronic medication administration record) for Resident # 2 dated "April 2017" documented, "Hydrocodone-Acetaminophen (6) Tablet 5 (five)-325 MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 07/21/2016." "Ultram Tablet 50 MG [Tramadol] (7) Give 2 tablet [sic] by mouth every 06 (six) hours as needed for severe pain. Order Date 06/30/2016." Further review of the eMAR dated April2017 revealed Ultram Tablet 50 MG was not administered during the month of April 2017 and Hydrocodone-Acetaminophen Tablet 5-325 MG was administered on the following dates: 04/16/17 at 3:03 a.m., 04/31/17 at 10:00 a.m. The "eMAR Note" for each date the Hydrocodone-Acetaminophen Tablet 5-325 MG was administered documented, "Hydrocodone-Acetaminophen Tablet 5-325 MG. Give 1 tablet by mouth every 6 hours as needed	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 22	F 281		

for pain."

The eMAR (electronic medication administration record) for Resident # 2 dated "May 2017" documented, "Hydrocodone-Acetaminophen (6) Tablet 5 (five)-325 MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 07/21/2016." "Ultram Tablet 50 MG [Tramadol] (7) Give 2 tablet [sic] by mouth every 06 (six) hours as needed for severe pain. Order Date 06/30/2016."

The eMAR dated May 2017 revealed Hydrocodone-Acetaminophen Tablet 5-325 MG was administered on the following dates and times: 05/01/17 at 2:23 a.m., 05/02/17 at 3:40 a.m., 05/04/17 at 5:30 a.m., 05/09/19 at 5:25 a.m., and 05/10/17 at 5:11 a.m. The "eMAR Note" for each date the Hydrocodone-Acetaminophen Tablet 5-325 MG was administered documented, "Hydrocodone-Acetaminophen Tablet 5-325 MG. Give 1 tablet by mouth every 6 hours as needed for pain."

The eMAR dated May 2017 revealed Ultram Tablet 50 MG was administered on the following dates and times: 05/11/17 at 5:10 a.m. and 05/12/17 at 5:40 a.m. The "eMAR Note" for each date above documented, "Ultram Tablet 50 MG. Give 2 tablet [sic] by mouth every 06 hours as needed for severe pain."

Further review of the eMARs for Resident # 2 dated March 2017 through May 2017 failed to evidence parameters for the administration of Resident # 2's PRN pain medication of Hydrocodone-Acetaminophen and Ultram.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 23	F 281		

The "Progress Notes" for Resident # 2 dated 03/02/2017 through 05/16/2017 were reviewed and failed to evidence Resident # 2's PRN pain medications were clarified.

The care plan for Resident # 2 with an initiation date of initiated: 07/18/2014 and a revision date of 03/16/2017 failed to evidence parameters for the administration of Resident # 2's PRN pain medication of Hydrocodone-Acetaminophen and Ultram.

On 05/17/17 at 1:40 p.m. an interview was conducted with LPN (licensed practical nurse) # 5. When asked how it is determined what PRN pain medication should be administered when there is more than one prescribed LPN # 5 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." When asked to describe parameters LPN # 5 stated, "You would give one pain medication for mild pain another pain medication for moderate pain. It would depend on the resident's pain level." After reviewing the eMARs dated March, April and May 2017 and physician's orders for Resident # 2's PRN pain medications LPN # 5 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 # 5 stated, "I don't know what number it would be on the pain scale." When asked if there was documentation of parameters. LPN # 5 stated, "There are no parameters."

On 05/17/17 at 2:00 p.m. an interview was conducted with LPN # 2. When asked how it is determined what PRN pain medication should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 24	F 281		

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."

On 05/17/17 at 2:30 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing and ASM # 4, the assistant 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." After reviewing the eMARs dated March, April and May 2017 and physician's orders for Resident # 2's PRN pain medications ASM # 2 was asked if there was documentation of parameters. ASM # 2 stated, "There are no parameters."

On 05/17/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 25	F 281		

1. A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.

2. An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

3. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

4. A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

5. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

6. Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve moderate-to-severe pain. Other hydrocodone combination products are used to relieve cough. Hydrocodone is in a class of medications called opiate (narcotic) analgesics and in a class of medications called antitussives.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 26	F 281		

Hydrocodone relieves pain by changing the way the brain and nervous system respond to pain. Hydrocodone relieves cough by decreasing activity in the part of the brain that causes coughing. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601006.html.

7. Used to relieve moderate to moderately severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html.

4. The facility staff failed to clarify the parameters for administration of PRN (as needed) pain medication for Resident # 7.

Resident # 7 was admitted to the facility on 05/01/14 with diagnoses that included but were not limited to: encephalopathy (1), muscle weakness, depression, aphasia (2), dementia (3), hypertension (4), gastroesophageal reflux disease (5), dysphagia (6) and peripheral vascular disease (7).

Resident # 7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/22/17, coded Resident # 7 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 being cognitively intact for making daily decisions. Resident # 7 was coded as requiring supervision with set up help for activities of daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 27	F 281		

The POS (Physician's Order Sheet) For Resident # 7 dated May 2017 documented,

"Acetaminophen (8) 325 MG (milligram) Tablet. Give 650 MG orally (by mouth) every 6 (six) hours as needed for pain. As needed for pain or fever > (greater than) 109. Date Ordered: 09/10/2014."

"Ibuprofen Tablet 200 MG. Give 2 (two) tablet [sic] by mouth every 6 (six) hours as needed for pain. Date Ordered: 07/21/2016."

The eMAR (electronic medication administration record) for Resident # 7 dated "January 2017 documented the above medication orders. Review of the eMAR dated January 2017 revealed Acetaminophen 325 MG was administered on: 01/07/17 at 2:49 a.m., 01/22/17 at 1:40 a.m., 01/26/17 at 9:263 p.m., 01/29/17 at 7:58 a.m., 01/30/17 at 2:09 a.m., and 01/30/17 at 11:01 p.m. The "eMAR Note" for each date and time Acetaminophen 325 MG was administered as documented, "Acetaminophen 325 MG Tablet. Give 650 MG orally every 6 hours as needed for pain. As needed for pain or fever > (greater than) 109."

The eMAR dated January 2017 revealed Ibuprofen 200 MG was administered on: 01/04/17 at 2:15 a.m., 01/05/17 at 11:50 p.m., 01/07/17 at 5:50 a.m., 01/16/17 at 10:07 p.m., 01/19/17 at 12:01 a.m., 01/26/17 at 12:02 a.m., 01/28/17 at 12:55 a.m. and 01/29/17 at 12:12 a.m. The "eMAR Note" for each date and time Ibuprofen 200 MG was administered documented, "Ibuprofen 200 MG. Give 2 tablets by mouth every 6 hours as needed for pain."

The eMAR (electronic medication administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 28	F 281		

record) for Resident # 7 dated "February 2017 documented the above physician orders on the physician order sheet. Review of the eMAR dated February 2017 revealed Acetaminophen 325 MG was administered on: 02/04/17 at 12:09 a.m., 02/07/17 at 11:52 p.m., 02/08/17 at 7:30 p.m., 02/11/17 at 12:44 a.m. and at 6:09 p.m., 02/12/17 at 7:31 a.m., 02/13/17 at 8:13 p.m., 02/14/17 at 11"00 p.m., 02/15/17 at 6:08 a.m. and at 10:32 p.m., 02/17/17 at 10:48 a.m., 02/22/17 at 1:09 a.m. The "eMAR Note" for each date and time Acetaminophen 325 MG was administered as documented, "Acetaminophen 325 MG Tablet. Give 650 MG orally every 6 hours as needed for pain. As needed for pain or fever > (greater than) 109."

The eMAR dated February 2017 revealed Ibuprofen 200 MG was administered on: 02/21/17 at 11:43 p.m., 02/22/17 at 3:41 p.m. and at 11:44 p.m., 02/23/17 at 11:31 p.m., and 02/26/17 1:00 a.m. The "eMAR Note" for each date and time Ibuprofen 200 MG was administered documented, "Ibuprofen 200 MG. Give 2 tablets by mouth every 6 hours as needed for pain."

The eMAR (electronic medication administration record) for Resident # 7 dated "March 2017 documented the physician order for Acetaminophen 325 MG and Ibuprofen 200 MG to be administered as documented on the physician order sheet above. The eMAR dated March 2017 revealed Acetaminophen 325 MG was not administered during the month of March 2017. The eMAR dated March 2017 revealed Ibuprofen 200 MG was administered on: 03/01/17 at 12:06 p.m., 03/02/17 at 12:50 a.m., 03/12/17 at 1:26 a.m. and at 11:05 p.m., 03/14/17 at 7:22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 29	F 281		

a.m., 03/16/17 at 6:59 a.m. and at 2:08 p.m., 03/17/17 at 1:42 p.m., 03/18/17 at 12:34 a.m., 03/22/17 at 4:38 p.m., 03/24/17 at 11:36 a.m., and 03/29/17 at 3:20 a.m. The "eMAR Note" for each time Ibuprofen 200 MG was administered documented: "Ibuprofen 200 MG. Give 2 tablets by mouth every 6 hours as needed for pain."

The eMAR (electronic medication administration record) for Resident # 7 dated "April 2017 documented, documented the physician order for Acetaminophen 325 MG and Ibuprofen 200 MG to be administered as documented on the physician order sheet above. The eMAR dated April 2017 revealed Acetaminophen 325 MG was not administered during the month of April 2017. The eMAR dated April 2017 revealed Ibuprofen 200 MG was administered on: 04/05/17 at 6:49 p.m., 04/07/17 at 8:32 a.m.,04/08/17 at 6:46 a.m., 04/12/17 at 4:05 a.m., 04/18/17 at 8:38 p.m., 04/23/17 at 11:43 a.m., and 04/25/17 at 9:38 p.m. The "eMAR Note" for each time Ibuprofen 200 MG was administered documented: "Ibuprofen 200 MG. Give 2 tablets by mouth every 6 hours as needed for pain."

The eMAR (electronic medication administration record) for Resident # 7 dated "May 2017 documented the physician order for Acetaminophen 325 MG and Ibuprofen 200 MG to be administered as documented on the physician order sheet above. The eMAR dated May 2017 revealed Acetaminophen 325 MG was not administered during the month of May 2017. The eMAR dated May 2017 revealed Ibuprofen 200 MG was administered on: 05/06/17 at 2:54 a.m. and at 3:52 p.m., 05/07/17 at 12:30 a.m., 05/10/17 at 12:30 a.m.,05/11/17 at 11:54 a.m., and 05/12/17 at 7:55 a.m. The "eMAR Note" for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 30	F 281		

each time Ibuprofen 200 MG was administered documented: "Ibuprofen 200 MG. Give 2 tablets by mouth every 6 hours as needed for pain."

The eMARs for Resident # 7 dated "January 2017, February 2017, March 2017, April 2017 and May 2017 were reviewed and failed to evidence Resident # 7's PRN pain medications of Acetaminophen and Ibuprofen were clarified.

The "Progress Notes" for Resident # 7 dated 01/02/2017 through 05/13/2017 were reviewed and failed to evidence that Resident # 7's PRN pain medications of Acetaminophen and Ibuprofen were clarified.

The care plan for Resident # 7 with an initiation date of 06/26/14 and a revision date of 04/25/2017 failed to evidence parameters for the administration of Resident # 7's PRN pain medication of Acetaminophen and Ibuprofen.

On 05/17/17 at 1:40 p.m. an interview was conducted with LPN (licensed practical nurse) # 5. When asked how it is determined what PRN pain medication should be administered when there is more than one prescribed LPN # 5 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 January, February, March, April and May 2017 and physician's orders for Resident # 7's PRN pain medications, LPN # 5 was asked if there was documentation of parameters. LPN # 5 stated, "There are no parameters."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 31	F 281		

On 05/17/17 at 2:00 p.m. an interview was conducted with LPN # 2. When asked how it is determined what PRN pain medication should be 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 January, February, March, April and May 2017 and physician's orders for Resident # 7's PRN pain medications LPN # 2 was asked if there was documentation of parameters. LPN # 2 stated, "There are no parameters."

On 05/17/17 at 2:30 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing and ASM # 4, the assistant director of nursing regarding multiple PRN pain medications. When asked how it is determined what PRN pain medication should be administered when there is more than one prescribed, ASM # 2 stated, "It should be clarified." After reviewing the eMARs dated January, February, March, April and May 2017 and physician's orders for Resident # 7's PRN pain medications ASM # 2 was asked if there was documentation of parameters. ASM # 2 stated, "There are no parameters."

On 05/17/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 32	F 281		

1. A term for any diffuse disease of the brain that alters brain function or structure. This information was obtained from the website: http://www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm.

2. A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html

3. A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html.

4. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

5. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

6. A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

7. The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 33 Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.	F 281		
F 282 SS=E	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow the written plan of care for five of 26 residents in the survey sample, Resident #12, Resident #9, Resident #1, Resident #2 and Resident #7. 1. The facility staff failed to follow the written plan of care for the administration of prn (as needed) Tylenol to Resident #12. 2. The facility staff failed to follow the care plan for offering non-pharmacological interventions to Resident #9 prior to the administration of PRN (as needed) Tylenol [1] and Xanax [2].	F 282	1. Resident #12, 1, 2 and 7's care plan has been reviewed for accuracy. Resident #9 no longer reside in the facility. Resident #1 MD was notified concerning not obtaining vital signs prior to medication administration. 2. All residents have the potential to be affected by this deficient practice. 3. DON and or designee(s) will in-service licensed nurses on following MD orders to include obtaining parameters as ordered and on following care plans to include use of no-pharmacological interventions for pain and anti-anxiety medications.	6/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 34 3. The facility staff failed to follow the written plan of care for obtaining vital signs per the physician orders for Resident #1. 4. The facility staff failed to follow the written plan of care to provide non-pharmacological interventions for pain to Resident #2 before administering pain medications. 5. The facility staff failed to follow the comprehensive plan of care to offer non-pharmacological intervention for pain to Resident #7 prior to administering pain medications. The findings include: 1. The facility staff failed to follow the comprehensive care plan for prn (as needed) medications for Resident #12. Resident #12 was admitted to the facility on 4/4/13 and readmitted on 8/6/15 with diagnoses that included but were not limited to: muscle weakness, dementia, chronic pain, heart disease ad high blood pressure. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/4/17 coded the resident as having scored 12 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. Review of the care plan initiated on 7/25/15 and	F 282	4. DON and or designee(s) will audit residents receiving PRN pain medication and or anti-anxiety for use of non-pharmacological interventions prior to medication administration 5x a week for 4 weeks and then weekly for 8 weeks. DON and or designee(s) will also audit 5 residents with medication parameters weekly for 4 weeks and then monthly for 2 months to ensure MD orders are followed. Results of audits will be taken to the QAPI committee x3 months for review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 35	F 282		

revised on 1/26/17 documented, "Focus At risk for pain...Interventions meds (medications) as ordered, prn (as needed) medications as needed. contact md (medical doctor) if ineffective."

Review of the physician's orders dated May 2017 documented, "Tylenol Tablet 325 MG (milligrams) (Acetaminophen) Give 325 mg by mouth every four hours for Breakthrough pain. Order Date 7/14/2016."

Review of the May 2017 MAR (medication administration record) documented, "Tylenol Tablet 325 MG (milligrams) (Acetaminophen) Give 325 mg by mouth every four hours for Breakthrough pain. -Start Date- 7/14/2016." Further review of the May 2017 MAR documented that the Tylenol had been given every four hours each day of the month. Resident #12's pain was rated as "0" (indicating no pain) 54 times out of 68 opportunities. The Tylenol was documented as being given even though the resident did not report pain.

An interview was conducted with LPN (licensed practical nurse) #5 on 5/17/17 at 11:16 a.m. When asked the purpose of the care plan, LPN #5 stated, "It's to ensure the best possible care to achieve the resident's goals." When asked if the care plan should be followed, LPN #5 stated, "Yes. If a goal is not achievable, then we have to rethink that and adjust the care plan." When asked if the care plan stated to give medications as ordered, should the nurse follow that, LPN #5 stated, "Yes."

An interview was conducted with administrative staff member (ASM) #4, on 5/17/17 at 1:28 p.m. When asked the purpose of the care plan, ASM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 36	F 282		

#4 stated, "It's to provide individualized care to each resident." When asked if the care plan should be followed, ASM #4 stated, "We should."

On 5/17/17 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

2. The facility staff failed to follow the care plan for offering non-pharmacological interventions to Resident #9 prior to the administration of PRN (as needed) Tylenol [1] and Xanax [2].

Resident #9 was admitted to the facility on 4/10/17 with the diagnoses of but not limited to diabetes, high blood pressure, anxiety, depression, leg fracture, stroke, and cerebrovascular disease. The most recent MDS (Minimum Data Set) was the admission/5-day assessment with an ARD (Assessment Reference Date) of 4/17/17. The resident was coded as being moderately cognitively impaired in ability to make daily life decisions, scoring an 8 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, and hygiene; independent for eating after set-up help; and as incontinent of bowel and bladder.

A review of the clinical record revealed a physician's order dated 4/14/17 for "Tylenol 325 mg (milligrams)....Give 2 tablet by mouth every 4 hours as needed for pain."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 37	F 282		

A review of the April 2017 MAR (Medication Administration Record), in conjunction with the nurses notes revealed Resident #9 was administered the Tylenol on the following dates: 4/15/17, 4/18/17, 4/19/17, 4/20/17, 4/26/17, 4/27/17, and 4/28/17. There were no non-pharmacological interventions documented as having been offered for any of the above identified administrations.

A review of the May 2017 MAR in conjunction with the nurses notes revealed Resident #9 was administered the Tylenol on the following dates: 5/1/17, 5/2/17, and 5/15/17. There were no non-pharmacological interventions documented as having been offered for any of the above identified administrations.

A review of the care plan revealed one for "Pain-At risk for r/t (related to) pain to CVA (stroke)." This care plan was initiated on 4/10/17. This care plan included the intervention, "Staff to attempt non-pharmacological interventions." This intervention was initiated on 4/11/17.

A review of the clinical record revealed a physician's order dated 4/10/17 for "Alprazolam (Xanax)...0.25 mg (milligrams). Give 1 tablet by mouth every 6 hours as needed for anxiety."

A review of the April 2017 MAR (Medication Administration Record), in conjunction with the nurses notes revealed Resident #9 was administered the Xanax on the following dates: 4/10/17, 4/13/17, 4/16/17, 4/18/17, 4/22/17, 4/25/17, 4/27/17, and 4/29/17. There were no non-pharmacological interventions documented as having been offered for the administrations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 38	F 282		

that occurred on 4/10/17, 4/1/17, 4/18/17, and 4/22/17.

A review of the May 2017 MAR in conjunction with the nurses notes revealed Resident #9 was administered the Xanax on the following dates: 5/1/17, 5/3/17, 5/6/17, 5/7/17 (twice), 5/10/17, 5/11/17, and 5/16/17. There were no non-pharmacological interventions documented as having been offered for administrations on 5/3/17 and 5/10/17.

A review of the care plan for Resident #9 revealed one for "Use of psychotropic drugs having an altering effect on the mind characterized by problems with cardiac, neuromuscular, gastrointestinal systems AEB (as evidenced by): anxiety, restlessness, crying." This care plan was initiated on 4/11/17. This care plan included an intervention for "Non pharm interventions such as redirection, rest periods, encourage to express feelings." This intervention was dated 4/11/17.

On 5/17/17 at approximately 2:00 p.m., in an interview with LPN #4 (Licensed Practical Nurse), she stated that if the care plan says to attempt non-pharmacological interventions, and it wasn't documented that any were done, then the care plan was not followed.

A review of the facility policy "Care Plan" documented, "D. All staff must be familiar with each resident's Care Plan and all approaches must be implemented."

On 5/17/17 at 5:13 p.m., ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3 the regional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 39	F 282		

director of clinical services were made aware of the findings. No further information was provided by the end of the survey.

References:

[1] Tylenol is used to relieve mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html

[2] Xanax is used to treat anxiety and panic disorders. Information obtained from https://medlineplus.gov/druginfo/meds/a684001.html

3. The facility staff failed to follow the written plan of care for obtaining vital signs per the physician orders for Resident #1.

Resident #1 was admitted to the facility on 12/23/10 with a recent readmission on 3/28/17 with diagnoses that included but were not limited to: osteoporosis, pain, anemia, psychosis, congestive heart failure (CHF), seizure disorder, anxiety disorder, insomnia, diabetes and high blood pressure.

The most recent MDS (minimum data set) assessment, with an assessment reference date of 2/27/17, coded the resident as scoring a 14 on the BIMS (brief interview for mental) status score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for transfers, dressing, toileting and personal hygiene. The resident was coded as requiring supervision of one staff member for moving on and off the unit and eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 40 The care plan dated, 10/14/16 and revised on 2/22/17, documented in part, "Focus: The resident has hypertension (high blood pressure) and CAD (coronary artery disease), CHF." The "Interventions" documented in part, "Give medications as ordered. Call MD (medical doctor) with any side effects." The physician order dated, 3/28/17, documented, "Atenolol Tablet (used to treat high blood pressure (1)) 50 MG (milligrams); Give 1 tablet by mouth one time a day related to Hypertension; Hold for systolic BP (blood pressure) < (less than) 100 HR (heartrate) < 60 (beats per minute)." The April 2017 MAR (medication administration record) documented, "Atenolol Tablet 50 MG; Give 1 tablet by mouth one time a day related to Hypertension; Hold for systolic BP < 100 HR < 60." The medication was scheduled for 6:00 a.m. above where the nurse documented her initials of administration; the resident's blood pressures were documented. There was no documentation of pulse or heartrate. The May 2017 MAR documented, Atenolol Tablet 50 MG; Give 1 tablet by mouth one time a day related to Hypertension; Hold for systolic BP < 100 HR < 60." The medication was scheduled for 6:00 a.m. above where the nurse documented her initials of administration; the resident's blood pressures were documented. There was no documentation of pulse or heartrate. The vital signs tab in the electronic medical record, did not document any heartrates in April and May 2017. The last documented heartrate was taken on 3/29/17 at 10:29 p.m.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 41	F 282		

Review of the nurse's notes from 3/28/17 through 5/16/17, did not evidence any documentation of a heartrate measurement.

An interview was conducted with LPN (licensed practical nurse) #5 on 5/17/17 at 11:16 a.m. When asked the purpose of the care plan, LPN #5 stated, "It's to ensure the best possible care to achieve the resident's goals." When asked if the care plan should be followed, LPN #5 stated, "Yes. If a goal is not achievable, then we have to rethink that and adjust the care plan." When asked if the care plan stated to give medications as ordered, should the nurse follow that, LPN #5 stated, "Yes."

An interview was conducted with administrative staff member (ASM) #4, on 5/17/17 at 1:28 p.m. When asked the purpose of the care plan, ASM #4 stated, "It's to provide individualized care to each resident." When asked if the care plan should be followed, ASM #4 stated, "We should."

The facility policy, "Care Plan" documented in part, "All direct care staff must always know, understand and follow their Resident's Care Plan. IF unable to implement any part of the plan, notify your Charge Nurse or MDS coordinator, so that this can be documented or the Care Plan changed if necessary."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 42	F 282		

and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care."

ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concern on 5/17/17 at 5:25 p.m.

No further information was provided prior to exit.

4. The facility staff failed to follow the written plan of care to provide non-pharmacological interventions for pain to Resident #2 before administering pain medications.

Resident # 2 was readmitted to the facility on 07/02/14 with diagnoses that included but were not limited to: cerebral vascular disease (1), muscle weakness, pain, low iron, depression, benign prostatic hyperplasia (2), gastroesophageal reflux disease (3), dysphagia (4) and hypertension (5).

Resident # 2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/07/17, coded Resident # 2 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for making daily decisions. Resident # 2 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician's Order Sheet) for Resident # 2 dated May 2017 documented, "Pain assessment every shift. Please assess and document the resident's pain on a scale of 0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 43	F 282		

(zero) - (to) 10. 10 being the worst pain and 0 (zero) being no pain. If pain is indicated, document on pain flow log as well as what you did to address pain. First intervention being non-pharmacological, second intervention being pharmacological if needed."
"Hydrocodone-Acetaminophen (6) Tablet 5 (five)-325 MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 07/21/2016." "Ultram Tablet 50 MG [Tramadol] (7) Give 2 tablet [sic] by mouth every 06 (six) hours as needed for severe pain. Order Date 06/30/2016."

The eMAR (electronic medication administration record) for Resident # 2 dated "March 2017 documented, "Hydrocodone-Acetaminophen (6) Tablet 5 (five)-325 MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 07/21/2016." "Ultram Tablet 50 MG [Tramadol] Give 2 tablet [sic] by mouth every 06 hours as needed for severe pain. Order Date 06/30/2016."

Further review of the eMAR dated March 2017 revealed Ultram Tablet 50 MG was not administered during the month of March 2017 and Hydrocodone-Acetaminophen Tablet 5-325 MG was administered on the following dates and times: 03/03/17 at 1:05 a.m., 03/04/17 at 5:00 a.m., 03/05/17 at 5:00 a.m., and 03/31/17 at 1:30 a.m. The "eMAR Note" for each date Hydrocodone-Acetaminophen Tablet 5-325 MG was administered documented, "Hydrocodone-Acetaminophen Tablet 5-325 MG. Give 1 tablet by mouth every 6 hours as needed for pain."

The eMAR (electronic medication administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 44	F 282		

record) for Resident # 2 dated "April 2017" documented, "Hydrocodone-Acetaminophen (6) Tablet 5 (five)-325 MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 07/21/2016." "Ultram Tablet 50 MG [Tramadol] (7) Give 2 tablet [sic] by mouth every 06 (six) hours as needed for severe pain. Order Date 06/30/2016."

Further review of the eMAR dated April2017 revealed Ultram Tablet 50 MG was not administered during the month of April 2017 and Hydrocodone-Acetaminophen Tablet 5-325 MG was administered on the following dates: 04/16/17 at 3:03 a.m., 04/31/17 at 10:00 a.m. The "eMAR Note" for each date the Hydrocodone-Acetaminophen Tablet 5-325 MG was administered documented, "Hydrocodone-Acetaminophen Tablet 5-325 MG. Give 1 tablet by mouth every 6 hours as needed for pain."

The eMAR (electronic medication administration record) for Resident # 2 dated "May 2017" documented, "Hydrocodone-Acetaminophen (6) Tablet 5 (five)-325 MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 07/21/2016." "Ultram Tablet 50 MG [Tramadol] (7) Give 2 tablet [sic] by mouth every 06 (six) hours as needed for severe pain. Order Date 06/30/2016."

The eMAR dated May 2017 revealed Hydrocodone-Acetaminophen Tablet 5-325 MG was administered on the following dates and times: 05/01/17 at 2:23 a.m., 05/02/17 at 3:40 a.m., 05/04/17 at 5:30 a.m., 05/09/19 at 5:25 a.m., and 05/10/17 at 5:11 a.m. The "eMAR Note" for each date the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 45	F 282		

Hydrocodone-Acetaminophen Tablet 5-325 MG was administered documented, "Hydrocodone-Acetaminophen Tablet 5-325 MG. Give 1 tablet by mouth every 6 hours as needed for pain."

The eMAR dated May 2017 revealed Ultram Tablet 50 MG was administered on the following dates and times: 05/11/17 at 5:10 a.m. and 05/12/17 at 5:40 a.m. The "eMAR Note" for each date above documented, "Ultram Tablet 50 MG. Give 2 tablet [sic] by mouth every 06 hours as needed for severe pain."

Further review of the eMARs for Resident # 2 dated March 2017 through May 2017 failed to evidence documentation of non-pharmacological interventions prior to the administration of Hydrocodone-Acetaminophen and Ultram.

The "Progress Notes" for Resident # 2 dated 03/02/2017 through 05/16/2017 were reviewed and failed to evidence documentation of non-pharmacological interventions prior to the administration of Hydrocodone-Acetaminophen and Ultram.

The care plan for Resident # 2 with a revision date of 03/16/2017 documented, "Focus: Resident has risk for pain r/t (related to) CVA (cerebral vascular disease), Osteoporosis and Osteoarthritis. Receives routine and prn (as needed) pain medications. Date initiated: 07/18/2014. Revision on: 03/16/2017." Under "Interventions" it documented, "Assess/document for probable cause of each pain episode. Remove/limit causes where possible. Date initiated: 07/18/2014."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 46	F 282		

On 05/17/17 at 1:40 p.m. an interview was conducted with LPN (licensed practical nurse) # 5. When asked to describe the purpose of the care plan LPN # 5 stated, "To reach goals. You have different interventions for the resident's care. You should follow the interventions." After reviewing the May 2017 physician order sheet (POS), care plan with a revision date of 03/16/2017, the March, April, and May 2017 MARs and progress notes dated 03/02/2017 through 05/16/2017 for Resident # 2, LPN # 5 was asked if the written plan of care was followed for the use of non-pharmacological interventions prior to the administration of PRN pain medication. LPN # 5 stated, "No it wasn't followed."

On 05/17/17 at 2:00 p.m. an interview was conducted with LPN # 2. When asked to describe the purpose of the care plan LPN # 2 stated, "It's specific to each patient, what their goals and interventions are and how we are going to take care of them. If it's on the care plan I would follow it." After reviewing May 2017 POS, care plan with a revision date of 03/16/2017, the March, April, and May 2017 MARs and progress notes dated 03/02/2017 through 05/16/2017 for Resident # 2, LPN # 2 was asked if the written plan of care was followed for the use of non-pharmacological interventions prior to the administration of PRN pain medication. LPN # 2 stated, "No it wasn't followed."

On 05/17/17 at 2:30 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing and ASM # 4, the assistant director of nursing regarding the written plan of care for Resident # 2. When asked to describe the purpose of the care plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 47	F 282		

ASM # 2 stated, "To know how to take care of the resident." After reviewing the May 2017 POS, care plan with a revision date of 03/16/2017, March, April, and May 2017 MARs and progress notes dated 03/02/2017 through 05/16/2017 for Resident # 2, ASM # 2 was asked if the written plan of care was followed for the use of non-pharmacological interventions prior to the administration of PRN pain medication. ASM # 2 stated, "No it wasn't followed."

The facility's policy, "Care Plan" documented in part, "All direct care staff must always know, understand and follow their Resident's Care Plan. IF unable to implement any part of the plan, notify your Charge Nurse or MDS coordinator, so that this can be documented or the Care Plan changed if necessary." The policy further documented, "D. All staff must be familiar with each resident's Care Plan and all approaches must be implemented."

On 05/17/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:

1. A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 48	F 282		

2. An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

3. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

4. A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

5. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

6. Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve moderate-to-severe pain. Other hydrocodone combination products are used to relieve cough. Hydrocodone is in a class of medications called opiate (narcotic) analgesics and in a class of medications called antitussives. Hydrocodone relieves pain by changing the way the brain and nervous system respond to pain. Hydrocodone relieves cough by decreasing activity in the part of the brain that causes coughing. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601006.html.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 49	F 282		

7. Used to relieve moderate to moderately severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html.

5. The facility staff failed to follow the comprehensive plan of care to offer non-pharmacological intervention for pain to Resident #7 prior to administering pain medications.

Resident # 7 was admitted to the facility on 05/01/14 with diagnoses that included but were not limited to: encephalopathy (1), muscle weakness, depression, aphasia (2), dementia (3), hypertension (4), gastroesophageal reflux disease (5), dysphagia (6) and peripheral vascular disease (7).

Resident # 7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/22/17, coded Resident # 7 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 being cognitively intact for making daily decisions. Resident # 7 was coded as requiring supervision with set up help for activities of daily living.

The POS (Physician's Order Sheet) For Resident # 7 dated May 2017 documented, "Acetaminophen (8) 325 MG (milligram) Tablet. Give 650 MG orally (by mouth) every 6 (six) hours as needed for pain. As needed for pain or fever > (greater than) 109. Date Ordered: 09/10/2014." "Ibuprofen Tablet 200 MG. Give 2 (two) tablet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 50	F 282		

[sic] by mouth every 6 (six) hours as needed for pain. Date Ordered: 07/21/2016."

The eMAR (electronic medication administration record) for Resident # 7 dated "January 2017 documented the above medication orders. Review of the eMAR dated January 2017 revealed Acetaminophen 325 MG was administered on: 01/07/17 at 2:49 a.m., 01/22/17 at 1:40 a.m., 01/26/17 at 9:263 p.m., 01/29/17 at 7:58 a.m., 01/30/17 at 2:09 a.m., and 01/30/17 at 11:01 p.m. The "eMAR Note" for each date and time Acetaminophen 325 MG was administered as documented, "Acetaminophen 325 MG Tablet. Give 650 MG orally every 6 hours as needed for pain. As needed for pain or fever > (greater than) 109."

The eMAR dated January 2017 revealed Ibuprofen 200 MG was administered on: 01/04/17 at 2:15 a.m., 01/05/17 at 11:50 p.m., 01/07/17 at 5:50 a.m., 01/16/17 at 10:07 p.m., 01/19/17 at 12:01 a.m., 01/26/17 at 12:02 a.m., 01/28/17 at 12:55 a.m. and 01/29/17 at 12:12 a.m. The "eMAR Note" for each date and time Ibuprofen 200 MG was administered documented, "Ibuprofen 200 MG. Give 2 tablets by mouth every 6 hours as needed for pain."

The eMAR (electronic medication administration record) for Resident # 7 dated "February 2017 documented the above physician orders on the physician order sheet. Review of the eMAR dated February 2017 revealed Acetaminophen 325 MG was administered on: 02/04/17 at 12:09 a.m., 02/07/17 at 11:52 p.m., 02/08/17 at 7:30 p.m., 02/11/17 at 12:44 a.m. and at 6:09 p.m., 02/12/17 at 7:31 a.m., 02/13/17 at 8:13 p.m., 02/14/17 at 11"00 p.m., 02/15/17 at 6:08 a.m. and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 51	F 282		

at 10:32 p.m., 02/17/17 at 10:48 a.m., 02/22/17 at 1:09 a.m. The "eMAR Note" for each date and time Acetaminophen 325 MG was administered as documented, "Acetaminophen 325 MG Tablet. Give 650 MG orally every 6 hours as needed for pain. As needed for pain or fever > (greater than) 109."

The eMAR dated February 2017 revealed Ibuprofen 200 MG was administered on: 02/21/17 at 11:43 p.m., 02/22/17 at 3:41 p.m. and at 11:44 p.m., 02/23/17 at 11:31 p.m., and 02/26/17 1:00 a.m. The "eMAR Note" for each date and time Ibuprofen 200 MG was administered documented, "Ibuprofen 200 MG. Give 2 tablets by mouth every 6 hours as needed for pain."

The eMAR (electronic medication administration record) for Resident # 7 dated "March 2017 documented the physician order for Acetaminophen 325 MG and Ibuprofen 200 MG to be administered as documented on the physician order sheet above. The eMAR dated March 2017 revealed Acetaminophen 325 MG was not administered during the month of March 2017. The eMAR dated March 2017 revealed Ibuprofen 200 MG was administered on: 03/01/17 at 12:06 p.m., 03/02/17 at 12:50 a.m., 03/12/17 at 1:26 a.m. and at 11:05 p.m., 03/14/17 at 7:22 a.m., 03/16/17 at 6:59 a.m. and at 2:08 p.m., 03/17/17 at 1:42 p.m., 03/18/17 at 12:34 a.m., 03/22/17 at 4:38 p.m., 03/24/17 at 11:36 a.m., and 03/29/17 at 3:20 a.m. The "eMAR Note" for each time Ibuprofen 200 MG was administered documented: "Ibuprofen 200 MG. Give 2 tablets by mouth every 6 hours as needed for pain."

The eMAR (electronic medication administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 52	F 282		

record) for Resident # 7 dated "April 2017 documented, documented the physician order for Acetaminophen 325 MG and Ibuprofen 200 MG to be administered as documented on the physician order sheet above. The eMAR dated April 2017 revealed Acetaminophen 325 MG was not administered during the month of April 2017. The eMAR dated April 2017 revealed Ibuprofen 200 MG was administered on: 04/05/17 at 6:49 p.m., 04/07/17 at 8:32 a.m.,04/08/17 at 6:46 a.m., 04/12/17 at 4:05 a.m., 04/18/17 at 8:38 p.m., 04/23/17 at 11:43 a.m., and 04/25/17 at 9:38 p.m. The "eMAR Note" for each time Ibuprofen 200 MG was administered documented: "Ibuprofen 200 MG. Give 2 tablets by mouth every 6 hours as needed for pain."

The eMAR (electronic medication administration record) for Resident # 7 dated "May 2017 documented the physician order for Acetaminophen 325 MG and Ibuprofen 200 MG to be administered as documented on the physician order sheet above. The eMAR dated May 2017 revealed Acetaminophen 325 MG was not administered during the month of May 2017. The eMAR dated May 2017 revealed Ibuprofen 200 MG was administered on: 05/06/17 at 2:54 a.m. and at 3:52 p.m., 05/07/17 at 12:30 a.m., 05/10/17 at 12:30 a.m.,05/11/17 at 11:54 a.m., and 05/12/17 at 7:55 a.m. The "eMAR Note" for each time Ibuprofen 200 MG was administered documented: "Ibuprofen 200 MG. Give 2 tablets by mouth every 6 hours as needed for pain."

The eMARs for Resident # 7 dated "January 2017, February 2017, March 2017, April 2017 and May 2017 were reviewed and failed to evidence documentation of non-pharmacological

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 53	F 282		

interventions prior to the administration of Acetaminophen and Ibuprofen.

The "Progress Notes" for Resident # 7 dated 01/02/2017 through 05/13/2017 were reviewed and failed to evidence documentation of non-pharmacological interventions prior to the administration of Acetaminophen and Ibuprofen.

The care plan for Resident # 7 dated 06/26/14 documented, "Focus: At risk for pain. Resident has dx (diagnosis) CVA (cerebral vascular disease) with hemiparesis and GERD (gastroesophageal reflux disease). Date Initiated: 06/26/14. Revision on 04/25/2017." Under "Interventions" it documented, "Non pharm (pharmacological) interventions such as assist with positioning for comfort. Date Initiated: 06/26/14."

On 05/17/17 at 1:40 p.m. an interview was conducted with LPN (licensed practical nurse) # 5. When asked to describe the purpose of the care plan, LPN # 5 stated, "To reach goals. You have different interventions for the resident's care. You should follow the interventions." After reviewing the care plan with a revision date of 03/16/2017, the MARs dated March 2017, April 2017, and May 2017 and the progress notes dated 03/02/2017 through 05/16/2017 for Resident # 7, LPN # 5 was asked if the care plan was followed for the use of non-pharmacological interventions prior to the administration of PRN pain medication. LPN # 5 stated, "No it wasn't followed."

On 05/17/17 at 2:00 p.m. an interview was conducted with LPN # 2. When asked to describe the purpose of the care plan, LPN # 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 54	F 282		

stated, "It's specific to each patient, what their goals and interventions are and how we are going to take care of them. If it's on the care plan I would follow it." After reviewing the care plan with a revision date of 03/16/2017, the MARs dated March 2017, April 2017, and May 2017 and the progress notes dated 03/02/2017 through 05/16/2017 for Resident # 7, LPN # 2 was asked if the care plan was followed for the use of non-pharmacological interventions prior to the administration of PRN pain medication. LPN # 2 stated, "No it wasn't followed."

On 05/17/17 at 2:30 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing and ASM # 4, the assistant director of nursing regarding the care plan for Resident # 2. When asked to describe the purpose of the care plan ASM # 2 stated, "To know how to take care of the resident." After reviewing the care plan with a revision date of 03/16/2017, the MARs dated March 2017, April 2017, and May 2017 and the progress notes dated 03/02/2017 through 05/16/2017 for Resident # 7, ASM # 2 was asked if the care plan was followed for the use of non-pharmacological interventions prior to the administration of PRN pain medication. ASM # 2 stated, "No it wasn't followed."

On 05/17/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 55	F 282		

1. A term for any diffuse disease of the brain that alters brain function or structure. This information was obtained from the website: http://www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm.

2. A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html

3. A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html.

4. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

5. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

6. A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

7. The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 56 called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.	F 282		
F 309 SS=E	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		6/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 57 (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review and in the course of a complaint investigation it was determined that the facility staff failed to provide the necessary care and services to attain or maintain the highest level of physical well-being for five of 26 residents in the survey sample, Residents #14, #6, #9, #2 and #7. 1.a. The facility staff failed to administer Resident #14's physician ordered scheduled blood pressure medications on 2/7/17 at 8:00 p.m. On 2/8/17 at 1:04 a.m., the resident's blood pressure was documented as 161/93 and the nurse failed to administer as needed blood pressure medication per physician's orders. b. The facility staff failed to administer physician ordered gabapentin (used to treat neuropathy), metronidazole (an antibiotic) and zolpidem (sleep medication) to Resident #14 during the night of 2/7/17 and failed to administer physician ordered zolpidem to the resident during the night of 2/8/17. All the medications were present in the facility STAT (Immediate) box (a box in the facility that contains various medications). 2. The facility staff failed to follow the specialist recommendations for Resident #6.	F 309	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 plans 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-service licensed nurses on the policy for medication availability, including MD notification. DON and or designee(s) will 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 medication for use of non-pharmacological interventions prior to medication administration. 5x a week for 4 weeks and then weekly for 8 weeks. DON and or designee(s) will also audit 5 residents with medication parameters weekly for 4 weeks and then monthly for 2 months to ensure MD orders are followed. Results of audits will be taken to QAPI committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 58 3. The facility staff failed to offer non-pharmacological interventions prior to the administration of PRN (as needed) Tylenol for Resident #9. 4. The facility staff failed to implement non-pharmacological interventions prior to the administration of PRN (as needed) pain medication for Resident # 2 as ordered by the physician. 5. The facility staff failed to implement non-pharmacological interventions prior to the administration of PRN (as needed) pain medication for Resident # 7. The findings include: 1.a. The facility staff failed to administer Resident #14's physician ordered scheduled blood pressure medications on 2/7/17 at 8:00 p.m. On 2/8/17 at 1:04 a.m., the resident's blood pressure was documented as 161/93 and the nurse failed to administer as needed blood pressure medication per physician's orders. Resident #14 was admitted to the facility on 2/7/17 and discharged 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 assessment with an ARD (assessment reference date) of 2/14/17 coded the resident as being cognitively intact. 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.	F 309	x3 months for review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 59	F 309		

Resident #14's physician's orders dated 2/7/17 documented orders for the following medications including but not limited to:
- Verapamil (1) 120 mg- one capsule by mouth at bedtime (scheduled at 8:00 p.m.) for high blood pressure
- Candesartan (2) 4 mg- one tablet by mouth two times a day (scheduled at 8:00 a.m. and 8:00 p.m.) for high blood pressure
- Clonidine (3) 0.1 mg- one tablet by mouth every 24 hours as needed for high blood pressure. Give one daily for a systolic blood pressure greater than 160

Review of Resident #14's February 2017 MAR (medication administration record) revealed the resident was not administered the scheduled 8:00 p.m. dose of Verapamil or Candesartan on 2/7/17 (as evidenced by an "x" documented on the MAR).

On 2/8/17 at 1:04 a.m. Resident #14's blood pressure was documented as 161/93. Further review of Resident #14's February 2017 MAR revealed the nurse did not administer as needed clonidine.

Resident #14's comprehensive care plan initiated on 2/8/17 failed to document information regarding medication administration or high blood pressure.

On 5/17/17 at 3:05 p.m.an interview was conducted with LPN (licensed practical nurse) #1 (the nurse responsible for administering Verapamil and Candesartan to Resident #14 on 2/7/17 at 8:00 p.m.). LPN #1 stated the moment residents are admitted she takes paperwork from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 60	F 309		

the transportation people, faxes the physician's orders to the pharmacy and writes a request for the pharmacy to send the medications STAT (immediately) on the fax. LPN #1 stated the pharmacy usually does not send the medications STAT so if a resident is prescribed a narcotic pain medication then she calls the pharmacy to see if they received the fax. LPN #1 stated most other times, she does not call the pharmacy because the orders are placed in the computer and should automatically go to the pharmacy. LPN #1 was shown Resident #14's clonidine physician's order and asked what should be done if the resident's systolic blood pressure is greater than 160. LPN #1 stated she would check the computer to see if the resident had received clonidine within the last 24 hours and if not she would administer clonidine. LPN #1 stated she would call the physician if she could not administer clonidine. (Note- review of Resident #14's February 2017 MAR failed to reveal the resident was administered clonidine on 2/7/17).

The nurse who documented Resident #14's blood pressure as 161/93 was not available for interview.

On 5/17/17 at 5:30 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above findings. A policy for following physician's orders was requested. ASM #3 stated the facility did not have the requested policy.

No further information was presented prior to exit.

(1) "Verapamil is used to treat high blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 61	F 309		

pressure and to control angina (chest pain)."
This information was obtained from the website:
https://medlineplus.gov/druginfo/meds/a684030.html

(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.html

(3) Clonidine is used to treat high blood pressure.
This information was obtained from the website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009680/?report=details

COMPLAINT DEFICIENCY

b. The facility staff failed to administer physician ordered gabapentin (1), metronidazole (2) and zolpidem (3) to Resident #14 during the night of 2/7/17 and failed to administer physician ordered zolpidem to the resident during the night of 2/8/17. All the medications were present in the facility STAT box (a box in the facility that contains various medications).

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.

Resident #14's physician's orders dated 2/7/17 documented orders for the following medications including but not limited to:
- Gabapentin 800 mg- one tablet by mouth three times a day (scheduled at 6:00 a.m., 2:00 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 62	F 309		

and 10:00 p.m.)
- Metronidazole 500 mg- one tablet by mouth three times a day (scheduled at 6:00 a.m., 2:00 p.m. and 10:00 p.m.)
- Zolpidem 5 mg- one tablet by mouth at bedtime (scheduled at 8:00 p.m.)

Review of Resident #14's February 2017 MAR (medication administration record) revealed the resident was not administered the scheduled night dose of any of the above medications on 2/7/17 (as evidenced by an "x" documented on the MAR). Further review of the MAR revealed zolpidem was also not administered on 2/8/17. A nurse's note dated 2/8/17 documented, "Zolpidem Tartrate 5 MG- Give 1 tablet by mouth at bedtime for Insomnia. Pharmacy needing script for medication." The note failed to document whether Resident #14's physician was contacted.

Review of the facility STAT box lists revealed the prescribed doses of gabapentin metronidazole and zolpidem were available in the STAT box.

Resident #14's comprehensive care plan initiated on 2/8/17 failed to document information regarding medication administration.

On 5/17/17 at 9:19 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated if medications for a newly admitted resident haven't arrived then the medications should be obtained from the STAT box if in stock. RN #1 stated the facility STAT box also contained controlled substances (such as zolpidem).

On 5/17/17 at 9:46 a.m., an interview was conducted with LPN (licensed practical nurse) #3 (the nurse who documented the 2/8/17 note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 63	F 309		

regarding the zolpidem). LPN #3 was shown the above note. LPN #3 confirmed zolpidem was not administered to Resident #14 on 2/8/17 because a hard prescription was needed in order for the pharmacy to deliver the medication. LPN #3 stated if a medication is due and not in the facility then she contacts the pharmacy. LPN #3 stated in this case the pharmacy needed a prescription. 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 3:05 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (the nurse caring for Resident #14 during the evening shift of 2/7/17). LPN #1 was asked what should be done if a resident is admitted and the resident's bedtime medication is not available for administration. LPN #1 stated nurses can access the facility STAT box and most of the time the STAT box contains the needed medications. LPN #1 stated if the STAT box does not contain the needed medications then nurses notify the physician and he will say to give another medication or to hold the medications until they arrive from the pharmacy. LPN #1 was shown Resident #14's February 2017 MAR. LPN #1 stated she didn't remember if Resident #14's scheduled bedtime medications were given on 2/7/17 or what was done if the medications were not given. LPN #1 stated she didn't remember if she contacted the physician or not.

On 5/17/17 at 5:30 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 64	F 309		

(the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above findings.

The facility pharmacy policy titled, "Medication Shortages/Unavailable Medications" documented, "2. If a medication shortage is discovered during normal pharmacy hours: 2.1. Facility nurse should call Pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply (STAT box) to administer the dose...3. If a medication shortage is discovered after normal Pharmacy hours: 3.1 a licensed Facility nurse should obtain the ordered medication from the Emergency Medication Supply..."

No further information was presented prior to exit.

(1) "Gabapentin is also sometimes used to relieve the pain of diabetic neuropathy (numbness or tingling due to nerve damage in people who have diabetes)..." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694007.html

(2) "Metronidazole eliminates bacteria and other microorganisms that cause infections of the reproductive system, gastrointestinal tract, skin, vagina, and other areas of the body..." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a689011.html

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 65	F 309		

Complaint Deficiency
2. The facility staff failed to follow the specialist recommendations for Resident #6 to receive a KUB (kidney ureters and bladder x-ray).

Resident #6 was admitted to the facility on 1/1/11 with a recent readmission on 1/10/17 with diagnoses that included but were not limited to: quadriplegia (paralysis affecting all four limbs and the trunk of the body below the level of spinal cord injury (1)), cystitis (inflammation of the urinary bladder and ureters (2)), neurogenic bladder, pain, high blood pressure, depression, anxiety disorder and urinary tract infections.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 4/17/17, coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living except eating in which she was coded as requiring supervision after set up assistance was provided. In Section H - Bladder and Bowel, the resident was coded as requiring an indwelling catheter for urinary drainage.

Observation was made of Resident #6 on 5/16/17 at 2:47 p.m. She was resting in her bed. The catheter bag was hanging off the bottom of the bed with a privacy cover in place. She was then observed on 5/17/17 at 8:02 a.m. in bed, asleep. The catheter bag was hanging off the bottom of the bed with a privacy cover in place. Resident #6 was observed on 5/18/17 at 8:02 a.m. in bed, asleep, the catheter bag was not visible from the doorway to the room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 66	F 309		

The clinical record was reviewed. A "Report of Consultation" dated 4/14/17 documented, "Recommendations/New Orders: Empty Foley Q (every) 2-3 hours. Flush Foley BID (twice a day) (a C with a line over it indicating 'with'), 60 ML (milliliters) NSS (normal saline solution). (A check mark) KUB (kidney ureters and bladder x-ray)."

The physician orders dated, 4/14/17 documented, "Flush Foley BID (a C with a line over it indicating 'with'), 60 ML NSS.

Review of the April 2017 TAR (treatment administration record) documented, "Flush Foley BID (a C with a line over it indicating 'with'), 60 ML NSS.

Review of the clinical record failed to evidence a result of the KUB x-ray. The review did not reveal a physician's order for the KUB x-ray.

The nurse's note dated 4/14/17 at 2:11 p.m. documented, "Resident out for appointment at 12 p.m. for a urology appointment. Returned with new orders. Resident and RP (responsible party) aware of the new orders." This note was written by LPN (licensed practical nurse) #5.

The comprehensive care plan dated, 4/25/17, and revised on 5/9/17, documented in part, "Focus: The resident has suprapubic catheter r/t (related to) neuromuscular bladder dysfunction secondary to spinal stenosis. She is at increased risk for UTI (urinary tract infection) r/t indwelling S/P (suprapubic) catheter." The "Interventions" documented in part, "F/U (follow up) with urology per orders."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 67	F 309		

A request for the x-ray results was made to the director of nursing, ASM #2 on 5/17/17 at approximately 9:30 a.m.

An interview was conducted with LPN (licensed practical nurse) #4 on 5/17/17 at 10:30 a.m. LPN #4 was asked how specialist recommendations for residents are processed after an appointment, LPN #4 stated, "We are supposed to run it by the doctor here and they either approve or disapprove the recommendations." When asked where that conversation is documented, LPN #4 stated, "It should be in the nurse's notes."

An interview was conducted with LPN #5 on 5/17/17 at 11:16 a.m. When asked how staff process recommendations made by a specialist after a resident returns from a consultation with a specialist, LPN #5 stated, "We verify them with our physician to agree or disagree with the orders." When asked where that conversation is documented, LPN #5 stated, "In the nurse's notes." The Urologist recommendations of 4/14/17 were reviewed with LPN #5. When asked if she could recall this, LPN #5 stated, "I remember the order for the flushes but I don't recall the order for the KUB."

An interview was conducted with ASM #4, the assistant director of nursing, on 5/17/17 at 1:28 p.m. The recommendations from the specialist of 4/14/17 were reviewed. When asked what is supposed to happen with the recommendations from a specialist, ASM #4 stated, "The nurse that receives these orders should verify the orders with the attending physician and he will decide if to follow the recommendations or not." When asked where that conversation with the doctor is documented, ASM #4 stated, "In the nurse's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 68	F 309		

notes."

On 5/17/17 at 2:55 p.m. RN (registered nurse) #4, presented a physician order dated, 5/17/17 at 2:27 p.m. that documented, "KUB." A nurse's note was attached, dated, 5/17/17 at 2:49 p.m. that documented, "KUB ordered and scheduled. RP (responsible party) notified."

An interview was conducted with RN #4 on 5/17/17 at 3:12 p.m. When asked where this information was obtained from, RN #4 stated, (the names of ASM [administrative staff member] #2, the director of nursing, and ASM #4, the assistant director of nursing) called (ASM #5, the medical director) and obtained the order." When asked why it was obtained, RN #4 stated, "It got missed off the recommendations when they were transcribed."

ASM #1, the administrator, ASM #2, and ASM #3, the regional director of clinical services, were made aware of the above findings on 5/17/17 at 5:25 p.m. A policy on specialist recommendations was requested.

On 5/18/17 at 8:20 a.m. ASM #2 and ASM 4 informed this surveyor that the facility did not have a policy on specialist recommendations.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, by Rothenberg and Chapman, page 489.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, by Rothenberg and Chapman, page 151.
(3) "Zolpidem is used to treat insomnia (difficulty

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 69	F 309		

falling asleep or staying asleep)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a693025.html

3. The facility staff failed to offer non-pharmacological interventions prior to the administration of PRN (as needed) Tylenol [1] for Resident #9.

Resident #9 was admitted to the facility on 4/10/17 with the diagnoses of but not limited to diabetes, high blood pressure, anxiety, depression, leg fracture, stroke, and cerebrovascular disease. The most recent MDS (Minimum Data Set) was the admission/5-day assessment with an ARD (Assessment Reference Date) of 4/17/17. The resident was coded as being moderately cognitively impaired in ability to make daily life decisions, scoring an 8 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, and hygiene; independent for eating after set-up help; and as incontinent of bowel and bladder.

A review of the clinical record revealed a physician's order dated 4/14/17 for "Tylenol 325 mg (milligrams)....Give 2 tablet by mouth every 4 hours as needed for pain."

A review of the April 2017 MAR (Medication Administration Record), in conjunction with the nurses notes revealed the resident was administered the Tylenol on the following dates:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 70	F 309		

4/15/17, 4/18/17, 4/19/17, 4/20/17, 4/26/17, 4/27/17, and 4/28/17. There were no non-pharmacological interventions documented as having been offered for any of the above identified administrations.

A review of the May 2017 MAR in conjunction with the nurses notes revealed the resident was administered the Tylenol on the following dates: 5/1/17, 5/2/17, and 5/15/17. There were no non-pharmacological interventions documented as having been offered for any of the above identified administrations.

On 5/17/17 at approximately 2:00 p.m., in an interview with LPN #4 (Licensed Practical Nurse), she stated that when a resident complains of pain, the nurse should assess where the pain is located, the level of pain, and attempt non-pharmacological interventions. She stated the assessment and interventions should be documented in the clinical record.

A review of the resident's care plan revealed one for "Pain: At risk for r/t (related to) pain to CVA (stroke)." This care plan was initiated on 4/10/17. The interventions included one for "Staff to attempt non-pharmacological interventions." This intervention was dated 4/11/17.

A review of the facility policy "Pain Management and Pain Protocol" documented, "3. Non-pharmacological intervention will be attempted prior to the administration of PRN pain medications..."

On 5/17/17 at 5:13 p.m., ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3 the regional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 71	F 309		

director of clinical services were made aware of the findings. No further information was provided by the end of the survey.

References:

[1] Tylenol is used to relieve mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html

4. The facility staff failed to implement non-pharmacological interventions prior to the administration pf PRN (as needed) pain medication for Resident # 2.

Resident # 2 was readmitted to the facility on 07/02/14 with diagnoses that included but were not limited to: cerebral vascular disease (1), muscle weakness, pain, low iron, depression, benign prostatic hyperplasia (2), gastroesophageal reflux disease (3), dysphagia (4) and hypertension (5).

Resident # 2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/07/17, coded Resident # 2 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for making daily decisions. Resident # 2 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician's Order Sheet) for Resident # 2 dated May 2017 documented, "Pain assessment every shift. Please assess and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 72	F 309		

document the resident's pain on a scale of 0 (zero) - (to) 10. 10 being the worst pain and 0 (zero) being no pain. If pain is indicated, document on pain flow log as well as what you did to address pain. First intervention being non-pharmacological, second intervention being pharmacological if needed."
"Hydrocodone-Acetaminophen (6) Tablet 5 (five)-325 MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 07/21/2016." "Ultram Tablet 50 MG [Tramadol] (7) Give 2 tablet [sic] by mouth every 06 (six) hours as needed for severe pain. Order Date 06/30/2016."

The eMAR (electronic medication administration record) for Resident # 2 dated "March 2017 documented, "Hydrocodone-Acetaminophen (6) Tablet 5 (five)-325 MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 07/21/2016." "Ultram Tablet 50 MG [Tramadol] Give 2 tablet [sic] by mouth every 06 hours as needed for severe pain. Order Date 06/30/2016."

Further review of the eMAR dated March 2017 revealed Ultram Tablet 50 MG was not administered during the month of March 2017 and Hydrocodone-Acetaminophen Tablet 5-325 MG was administered on the following dates and times: 03/03/17 at 1:05 a.m., 03/04/17 at 5:00 a.m., 03/05/17 at 5:00 a.m., and 03/31/17 at 1:30 a.m. The "eMAR Note" for each date Hydrocodone-Acetaminophen Tablet 5-325 MG was administered documented, "Hydrocodone-Acetaminophen Tablet 5-325 MG. Give 1 tablet by mouth every 6 hours as needed for pain."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 73	F 309		

The eMAR (electronic medication administration record) for Resident # 2 dated "April 2017" documented, "Hydrocodone-Acetaminophen (6) Tablet 5 (five)-325 MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 07/21/2016." "Ultram Tablet 50 MG [Tramadol] (7) Give 2 tablet [sic] by mouth every 06 (six) hours as needed for severe pain. Order Date 06/30/2016."

Further review of the eMAR dated April2017 revealed Ultram Tablet 50 MG was not administered during the month of April 2017 and Hydrocodone-Acetaminophen Tablet 5-325 MG was administered on the following dates: 04/16/17 at 3:03 a.m., 04/31/17 at 10:00 a.m. The "eMAR Note" for each date the Hydrocodone-Acetaminophen Tablet 5-325 MG was administered documented, "Hydrocodone-Acetaminophen Tablet 5-325 MG. Give 1 tablet by mouth every 6 hours as needed for pain."

The eMAR (electronic medication administration record) for Resident # 2 dated "May 2017" documented, "Hydrocodone-Acetaminophen (6) Tablet 5 (five)-325 MG (milligram). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 07/21/2016." "Ultram Tablet 50 MG [Tramadol] (7) Give 2 tablet [sic] by mouth every 06 (six) hours as needed for severe pain. Order Date 06/30/2016."

The eMAR dated May 2017 revealed Hydrocodone-Acetaminophen Tablet 5-325 MG was administered on the following dates and times: 05/01/17 at 2:23 a.m., 05/02/17 at 3:40 a.m., 05/04/17 at 5:30 a.m., 05/09/19 at 5:25 a.m., and 05/10/17 at 5:11 a.m. The "eMAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 74	F 309		

Note" for each date the Hydrocodone-Acetaminophen Tablet 5-325 MG was administered documented, "Hydrocodone-Acetaminophen Tablet 5-325 MG. Give 1 tablet by mouth every 6 hours as needed for pain."

The eMAR dated May 2017 revealed Ultram Tablet 50 MG was administered on the following dates and times: 05/11/17 at 5:10 a.m. and 05/12/17 at 5:40 a.m. The "eMAR Note" for each date above documented, "Ultram Tablet 50 MG. Give 2 tablet [sic] by mouth every 06 hours as needed for severe pain."

Further review of the eMARs for Resident # 2 dated March 2017 through May 2017 failed to evidence documentation of non-pharmacological interventions prior to the administration of Hydrocodone-Acetaminophen and Ultram.

The "Progress Notes" for Resident # 2 dated 03/02/2017 through 05/16/2017 were reviewed and failed to evidence documentation of non-pharmacological interventions prior to the administration of Hydrocodone-Acetaminophen and Ultram.

The care plan for Resident # 2 with a revision date of 03/16/2017 documented, "Focus: Resident has risk for pain r/t (related to) CVA (cerebral vascular disease), Osteoporosis and Osteoarthritis. Receives routine and prn (as needed) pain medications. Date initiated: 07/18/2014. Revision on: 03/16/2017." Under "Interventions" it documented, "Assess/document for probable cause of each pain episode. Remove/limit causes where possible. Date initiated: 07/18/2014."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 75 On 05/17/17 at 1:40 p.m. an interview was conducted with LPN (licensed practical nurse) # 5. When asked to describe the procedure of administering PRN pain medication, LPN # 5 stated, "Try to reposition to alleviate pain or other interventions. If that doesn't work do a pain assessment, location, use pain scale one to ten, ten being most severe. Administer the pain medication according to the physician's order, follow-up approximately 30 to 40 minutes after giving the medication to determine if it was effective using the pain scale. If it wasn't effective call the physician for further orders." When asked how often the non-pharmacological interventions should be attempted, LPN # 5 stated, "Every time." When asked where they would document the use of non-pharmacological interventions, LPN # 5 stated, "It's documented on the MAR and in the nurse's notes." After reviewing the MARs dated March 2017, April 2017, and May 2017 and the progress notes dated 03/02/2017 through 05/16/2017 for Resident # 2, LPN # 5 was asked if there was documentation of non-pharmacological interventions attempted prior to the administration of PRN pain medication. LPN # 5 stated, "No, it wasn't documented it wasn't done." On 05/17/17 at 2:00 p.m. an interview was conducted with LPN # 2. When asked to describe the procedure of administering PRN pain medication, LPN # 2 stated, "Rate the resident's pain on a scale of one to ten after attempting other methods to help alleviate pain. Ask where the pain is and to describe it. The pain medication should be administered according to the pain level." Administer the pain medication according to the physician's order,	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 76	F 309		

follow-up approximately 30 to 45 minutes after giving the medication to determine if it was effective using the pain scale." When asked where staff would document the use of non-pharmacological interventions, LPN # 2 stated, "It's documented on the MAR and in the nurse's notes." After reviewing the MARs dated March 2017, April 2017, and May 2017 and the progress notes dated 03/02/2017 through 05/16/2017 for Resident # 2, LPN # 2 was asked if there was documentation of non-pharmacological interventions attempted prior to the administration of PRN pain medication. LPN # 2 stated, "No, it wasn't documented it wasn't done."

On 05/17/17 at 2:30 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing and ASM # 4, the assistant director of nursing regarding the administration of PRN pain medication to Resident # 2. When asked to describe the procedure of administering PRN pain medication, ASM # 2 stated, "Ask the resident to rate the pain using pain scale one to ten, ten being most severe. Try interventions before administering pain meds (medications). If that doesn't work administer the pain medication according to the physician's order, follow-up approximately 60 minutes after giving the medication to determine if it was effective. If not effective call the physician." When asked how often the non-pharmacological interventions should be attempted, ASM # 2 stated, "Every time." When asked where they would document the use of non-pharmacological interventions, ASM # 2 stated, "It's documented on the MAR and in the nurse's notes." After reviewing the MARs dated March 2017, April 2017, and May 2017 and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 77	F 309		

progress notes dated 03/02/2017 through 05/16/2017 for Resident # 2, ASM # 2 was asked if there was documentation of non-pharmacological interventions attempted prior to the administration of PRN pain medication. ASM # 2 stated, "No, it wasn't documented it wasn't done."

The facility's policy "Pain Management and Pain Protocol" documented, "Policy: It is the policy of this facility to ensure any resident that is admitted to the facility is assessed for pain and/or the potential for pain in order for the resident to obtain or maintain his/her highest practicable level of physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Procedure: 5g. Non pharmacological interventions will be attempted prior to the administration of PRN pain medications."

On 05/17/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:

1. A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 78	F 309		

2. An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

3. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

4. A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

5. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

6. Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve moderate-to-severe pain. Other hydrocodone combination products are used to relieve cough. Hydrocodone is in a class of medications called opiate (narcotic) analgesics and in a class of medications called antitussives. Hydrocodone relieves pain by changing the way the brain and nervous system respond to pain. Hydrocodone relieves cough by decreasing activity in the part of the brain that causes coughing. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601006.html.

7. Used to relieve moderate to moderately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 79	F 309		

severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html.

5. The facility staff failed to implement non-pharmacological interventions prior to the administration of PRN (as needed) pain medication for Resident # 7.

Resident # 7 was admitted to the facility on 05/01/14 with diagnoses that included but were not limited to: encephalopathy (1), muscle weakness, depression, aphasia (2), dementia (3), hypertension (4), gastroesophageal reflux disease (5), dysphagia (6) and peripheral vascular disease (7).

Resident # 7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/22/17, coded Resident # 7 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 being cognitively intact for making daily decisions. Resident # 7 was coded as requiring supervision with set up help for activities of daily living.

The POS (Physician's Order Sheet) For Resident # 7 dated May 2017 documented, "Acetaminophen (8) 325 MG (milligram) Tablet. Give 650 MG orally (by mouth) every 6 (six) hours as needed for pain. As needed for pain or fever > (greater than) 109. Date Ordered: 09/10/2014." "Ibuprofen Tablet 200 MG. Give 2 (two) tablet [sic] by mouth every 6 (six) hours as needed for pain. Date Ordered: 07/21/2016."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 80	F 309		

The eMAR (electronic medication administration record) for Resident # 7 dated "January 2017 documented the above medication orders. Review of the eMAR dated January 2017 revealed Acetaminophen 325 MG was administered on: 01/07/17 at 2:49 a.m., 01/22/17 at 1:40 a.m., 01/26/17 at 9:263 p.m., 01/29/17 at 7:58 a.m., 01/30/17 at 2:09 a.m., and 01/30/17 at 11:01 p.m. The "eMAR Note" for each date and time Acetaminophen 325 MG was administered as documented, "Acetaminophen 325 MG Tablet. Give 650 MG orally every 6 hours as needed for pain. As needed for pain or fever > (greater than) 109."

The eMAR dated January 2017 revealed Ibuprofen 200 MG was administered on: 01/04/17 at 2:15 a.m., 01/05/17 at 11:50 p.m., 01/07/17 at 5:50 a.m., 01/16/17 at 10:07 p.m., 01/19/17 at 12:01 a.m., 01/26/17 at 12:02 a.m., 01/28/17 at 12:55 a.m. and 01/29/17 at 12:12 a.m. The "eMAR Note" for each date and time Ibuprofen 200 MG was administered documented, "Ibuprofen 200 MG. Give 2 tablets by mouth every 6 hours as needed for pain."

The eMAR (electronic medication administration record) for Resident # 7 dated "February 2017 documented the above physician orders on the physician order sheet. Review of the eMAR dated February 2017 revealed Acetaminophen 325 MG was administered on: 02/04/17 at 12:09 a.m., 02/07/17 at 11:52 p.m., 02/08/17 at 7:30 p.m., 02/11/17 at 12:44 a.m. and at 6:09 p.m., 02/12/17 at 7:31 a.m., 02/13/17 at 8:13 p.m., 02/14/17 at 11"00 p.m., 02/15/17 at 6:08 a.m. and at 10:32 p.m., 02/17/17 at 10:48 a.m., 02/22/17 at 1:09 a.m. The "eMAR Note" for each date and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 81	F 309		

time Acetaminophen 325 MG was administered as documented, "Acetaminophen 325 MG Tablet. Give 650 MG orally every 6 hours as needed for pain. As needed for pain or fever > (greater than) 109."

The eMAR dated February 2017 revealed Ibuprofen 200 MG was administered on: 02/21/17 at 11:43 p.m., 02/22/17 at 3:41 p.m. and at 11:44 p.m., 02/23/17 at 11:31 p.m., and 02/26/17 1:00 a.m. The "eMAR Note" for each date and time Ibuprofen 200 MG was administered documented, "Ibuprofen 200 MG. Give 2 tablets by mouth every 6 hours as needed for pain."

The eMAR (electronic medication administration record) for Resident # 7 dated "March 2017 documented the physician order for Acetaminophen 325 MG and Ibuprofen 200 MG to be administered as documented on the physician order sheet above. The eMAR dated March 2017 revealed Acetaminophen 325 MG was not administered during the month of March 2017. The eMAR dated March 2017 revealed Ibuprofen 200 MG was administered on: 03/01/17 at 12:06 p.m., 03/02/17 at 12:50 a.m., 03/12/17 at 1:26 a.m. and at 11:05 p.m., 03/14/17 at 7:22 a.m., 03/16/17 at 6:59 a.m. and at 2:08 p.m., 03/17/17 at 1:42 p.m., 03/18/17 at 12:34 a.m., 03/22/17 at 4:38 p.m., 03/24/17 at 11:36 a.m., and 03/29/17 at 3:20 a.m. The "eMAR Note" for each time Ibuprofen 200 MG was administered documented: "Ibuprofen 200 MG. Give 2 tablets by mouth every 6 hours as needed for pain."

The eMAR (electronic medication administration record) for Resident # 7 dated "April 2017 documented, documented the physician order for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 82	F 309		

Acetaminophen 325 MG and Ibuprofen 200 MG to be administered as documented on the physician order sheet above. The eMAR dated April 2017 revealed Acetaminophen 325 MG was not administered during the month of April 2017. The eMAR dated April 2017 revealed Ibuprofen 200 MG was administered on: 04/05/17 at 6:49 p.m., 04/07/17 at 8:32 a.m.,04/08/17 at 6:46 a.m., 04/12/17 at 4:05 a.m., 04/18/17 at 8:38 p.m., 04/23/17 at 11:43 a.m., and 04/25/17 at 9:38 p.m. The "eMAR Note" for each time Ibuprofen 200 MG was administered documented: "Ibuprofen 200 MG. Give 2 tablets by mouth every 6 hours as needed for pain."

The eMAR (electronic medication administration record) for Resident # 7 dated "May 2017 documented the physician order for Acetaminophen 325 MG and Ibuprofen 200 MG to be administered as documented on the physician order sheet above. The eMAR dated May 2017 revealed Acetaminophen 325 MG was not administered during the month of May 2017. The eMAR dated May 2017 revealed Ibuprofen 200 MG was administered on: 05/06/17 at 2:54 a.m. and at 3:52 p.m., 05/07/17 at 12:30 a.m., 05/10/17 at 12:30 a.m.,05/11/17 at 11:54 a.m., and 05/12/17 at 7:55 a.m. The "eMAR Note" for each time Ibuprofen 200 MG was administered documented: "Ibuprofen 200 MG. Give 2 tablets by mouth every 6 hours as needed for pain."

The eMARs for Resident # 7 dated "January 2017, February 2017, March 2017, April 2017 and May 2017 were reviewed and failed to evidence documentation of non-pharmacological interventions prior to the administration of Acetaminophen and Ibuprofen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 83	F 309		

The "Progress Notes" for Resident # 7 dated 01/02/2017 through 05/13/2017 were reviewed and failed to evidence documentation of non-pharmacological interventions prior to the administration of Acetaminophen and Ibuprofen.

The care plan for Resident # 7 dated 06/26/14 documented, "Focus: At risk for pain. Resident has dx (diagnosis) CVA (cerebral vascular disease) with hemiparesis and GERD (gastroesophageal reflux disease). Date Initiated: 06/26/14. Revision on 04/25/2017." Under "Interventions" it documented, "Non pharm (pharmacological) interventions such as assist with positioning for comfort. Date Initiated: 06/26/14."

On 05/17/17 at 1:40 p.m. an interview was conducted with LPN (licensed practical nurse) # 5. When asked to describe the procedure of administering PRN pain medication, LPN # 5 stated, "Try to reposition to alleviate pain or other interventions. If that doesn't work do a pain assessment, location, use pain scale one to ten, ten being most severe. Administer the pain medication according to the physician's order, follow-up approximately 30 to 40 minutes after giving the medication to determine if it was effective using the pain scale. If it wasn't effective call the physician for further orders." When asked how often the non-pharmacological interventions should be attempted, LPN # 5 stated, "Every time." When asked where they would document the use of non-pharmacological interventions, LPN # 5 stated, "It's documented on the MAR and in the nurse's notes." After reviewing the MARs dated January 2017, February 2017, March 2017, April 2017, and May 2017 and the progress notes dated 01/02/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 84	F 309		

through 05/13/2017 for Resident # 7, LPN # 5 was asked if there was documentation of non-pharmacological interventions attempted prior to the administration of PRN pain medication. LPN # 5 stated, "No, it wasn't documented it wasn't done."

On 05/17/17 at 2:00 p.m. an interview was conducted with LPN # 2. When asked to describe the procedure of administering PRN pain medication, LPN # 2 stated, "Rate the resident's pain on a scale of one to ten after attempting other methods to help alleviate pain. Ask where the pain is and to describe it. The pain medication should be administered according to the pain level." Administer the pain medication according to the physician's order, follow-up approximately 30 to 45 minutes after giving the medication to determine if it was effective using the pain scale." When asked where they would document the use of non-pharmacological interventions, LPN # 2 stated, "It's documented on the MAR and in the nurse's notes." After reviewing the MARs dated January 2017, February 2017, March 2017, April 2017, and May 2017 and the progress notes dated 01/02/2017 through 05/13/2017 for Resident # 7, LPN # 2 was asked if there was documentation of non-pharmacological interventions attempted prior to the administration of PRN pain medication. LPN # 2 stated, "No, it wasn't documented it wasn't done."

On 05/17/17 at 2:30 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing and ASM # 4, the assistant director of nursing regarding the administration of PRN pain medication to Resident # 7. When asked to describe the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 85	F 309		

procedure of administering PRN pain medication, ASM # 2 stated, "Ask the resident to rate the pain using pain scale one to ten, ten being most severe. Try interventions before administering pain meds. If that doesn't work administer the pain medication according to the physician's order, follow-up approximately 60 minutes after giving the medication to determine if it was effective. If not effective call the physician." When asked how often the non-pharmacological interventions should be attempted, ASM # 2 stated, "Every time." When asked where they would document the use of non-pharmacological interventions, ASM # 2 stated, "It's documented on the MAR and in the nurse's notes." After reviewing the MARs dated January 2017, February 2017, March 2017, April 2017, and May 2017 and the progress notes dated 01/02/2017 through 05/13/2017 for Resident # 7, ASM # 2 was asked if there was documentation of non-pharmacological interventions attempted prior to the administration of PRN pain medication to Resident #7. ASM # 2 stated, "No, it wasn't documented it wasn't done."

On 05/17/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:

1. A term for any diffuse disease of the brain that alters brain function or structure. This information was obtained from the website: http://www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 86 2. A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html 3. A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html. 4. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 5. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. 6. A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. 7. The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website:	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 87 https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.	F 309		
F 329 SS=E	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329		6/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 88 (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a drug regimen free from unnecessary drugs for four of 26 residents in the survey sample, Resident #12, Resident #8, Resident #1 and Resident #9. 1. The facility staff failed to administer needed (PRN) Tylenol as ordered by the physician. The staff administered the as needed Tylenol to Resident #12 every four hours when the resident had no complaints of pain. The physician ordered the medication to be administered every four hours for breakthrough pain. 2. The facility staff failed to monitor Resident #8's behaviors for the administration of Risperdal (1). 3. The facility staff failed to monitor the resident's heartrate (pulse) per the physician ordered parameters for a high blood pressure medication for Resident #1. 4. The facility staff failed to offer non-pharmacological interventions prior to the administration of PRN (as needed) Xanax [1] and failed to document the symptoms of anxiety for Resident #9. The findings include:	F 329	1. Resident #12's medication order was clarified. Resident #8's behavior monitoring sheet is in place. Resident #1's MD was notified of not obtaining vital signs prior to medication administration. Resident #9 non longer resides in the facility. 2. All residents have the potential to be affected by this deficient practice. 3. DON and or designee(s) will in-service licensed nurses on following MD orders to include parameters, following care plans to include us of non-pharmacological interventions prior to administration of PRN pain and/or anti-anxiety medications, and on behavior monitoring 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 prior to medication administration 5x a week for 4 weeks, then monthly for 8 weeks. DON and or designee(s) will audit 5 residents with medication parameters weekly for 4 weeks and then monthly for 2 months to ensure orders are followed. Results from the audits will be taken to QAPI committee x3 months for review and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 89 1. The facility staff failed to administer needed (PRN) Tylenol as ordered by the physician. The staff administered the as needed Tylenol to Resident #12 every four hours when the resident had no complaints of pain. The physician ordered the medication to be administered every four hours for breakthrough pain. Resident #12 was admitted to the facility on 4/4/13 and readmitted on 8/6/15 with diagnoses that included but were not limited to: muscle weakness, dementia, chronic pain, heart disease ad high blood pressure. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/4/17 coded the resident as having a BIMS (brief interview for mental status) of 12 out of 15 indicating the resident was cognitively intact to make daily decisions. Review of the care plan initiated on 7/25/15 and revised on 1/26/17 documented, "Focus At risk for pain...Interventions meds (medications) as ordered, prn (as needed) medications as needed. contact md (medical doctor) if ineffective." Review of the physician's orders dated May 2017 documented, "Tylenol Tablet 325 MG (milligrams) (Acetaminophen) Give 325 mg by mouth every four hours for Breakthrough pain. Order Date 7/14/2016." Review of the May 2017 MAR (medication administration record) documented, "Tylenol Tablet 325 MG (milligrams) (Acetaminophen) Give 325 mg by mouth every four hours for Breakthrough pain. -Start Date- 7/14/2016." Further review of the May 2017 MAR	F 329	revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 90	F 329		

documented that the Tylenol had been given every four hours each day of the month. Resident #12's pain was rated as "0" (indicating no pain) 54 times out of 68 opportunities. The Tylenol was documented as being given even though the resident did not report pain.

On 5/16/17 at 4:08 p.m. the medication administration observation was conducted with LPN (licensed practical nurse) #1. LPN #1 put a Tylenol 325 mg tablet into a medicine cup and took it into Resident #12's room. She asked Resident #12 if she had pain and Resident #12 stated she did not. She gave the medicine cup to Resident #12 and then gave Resident #12 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 they did not have reports of pain, LPN #4 stated, "Well, let me put it to you this way. She complains to her daughter that she has pain but she doesn't complain to us." When asked if the resident was assessed for pain, LPN #4 stated she was. When asked if the resident exhibited signs of pain, LPN #4 stated, "No." When asked if the Tylenol order was followed as ordered, LPN #4 stated, "No." When asked what staff would do in this case, LPN #4 stated, "We should probably get rid of it and make it prn if she needs it."

An interview was conducted on 5/17/17 at 1:15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 91	F 329		

p.m. with RN (registered nurse) #5, the unit manager. When asked to review Resident #12's Tylenol order, RN #5 stated, "It's for breakthrough pain so it's technically a prn (medication). I'm going to first find out number one if she's having pain. I'm going to assess the pain level..." When asked if the Tylenol would be given if the resident stated her pain level was zero, RN #5 stated, "Absolutely not. No need. I'd probably make a note in the nurse's notes that (the resident) stated she had no pain."

An interview was conducted on 5/17/17 at 2:43 p.m. with OSM (other staff member) #5, Resident #12's physician. OSM #12 was asked when he expected the Tylenol for breakthrough pain to be administered, OSM #5 stated, "Pain of one to ten." When asked if the Tylenol should be given if the resident did not have pain, OSM #5 stated, "No I don't." When made aware of the concern, OSM #5 stated, "We'll take care of it."

On 5/17/17 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

(1) Tramadol (Ultram®) is a commonly prescribed analgesic because of its relatively lower risk of addiction and better safety profile in comparison with other opiates. However, two significant adverse reactions are known to potentially occur with tramadol-seizures and serotonin syndrome. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2714818/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 92	F 329		

2. The facility staff failed to monitor Resident #8's behaviors for the administration of Risperdal (1).

Resident #8 was admitted to the facility on 5/31/16 with diagnoses that included but were not limited to: psychosis (1), depression, high blood pressure, anxiety, diabetes and kidney disease.

Resident #8's most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/24/17 coded the resident as having scored 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring supervision from staff for activities of daily living. The resident was coded as not having any behavioral symptoms.

Review of the care plan initiated on 6/13/16 and revised on 9/15/16 documented, "Focus Resident at risk for experiencing complications related to the use of psychotropic drugs (2). Interventions/Tasks Administer medications as ordered. Monitor/document for side effects and effectiveness."

Review of the psychiatrist's note dated 10/21/16 documented, "Risperdal 1 mg (milligram) PO (by mouth) BID (twice a day)."

Review of the November 2016 MAR documented, ""RisperDAL (3) Table 1 MG (milligram) by mouth two times a day for delusional disorder. Start Date 10/18/16." The medication was documented as being given twice a day for each day of the month.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 93	F 329		

Review of the November 2016 behavior monitoring record documented that the resident did not have behaviors 14 times and that the resident had behaviors that required redirection one time. The remainder of the monitoring record was left blank.

Review of the December 2016 MAR documented, ""RisperDAL (3) Table 1 MG (milligram) by mouth two times a day for delusional disorder. Start Date 10/18/16." The medication was documented as being given twice a day for each day of the month.

Review of the December 2016 behavior monitoring record did not evidence documentation of behaviors for the 3:00 p.m. to 11:00 p.m. shift. All spaces were left blank.

Review of the nurse's notes for November 2016 through December 2016 did not evidence documentation regarding the resident's behaviors.

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 November 2016 and December 2016 behavior monitoring records and what the blank spaces meant, LPN #4 stated, "That it wasn't documented." When asked why behaviors were monitored for Resident #8, LPN #4 stated, "Because we need to know if we need to reduce the medication she's on. Try to do a gradual dose reduction."

A telephone interview was conducted on 5/17/17 at 4:16 p.m. with LPN #6, the resident's night nurse. When asked if behaviors were monitored,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 94	F 329		

LPN #4 stated, "Yes." When asked where that would be documented, LPN #6 stated, "Definitely on the behavior sheet if they're on a psychotropic (medications)." When asked what it meant when the sheet was blank, LPN #6 stated, "Somebody dropped the ball I would think." When asked why staff monitored and documented resident's behaviors, LPN #6 stated, "A lot of these medications have side effects. For (residents with) behaviors we want to make sure they get the appropriate care and treatment. If it's not working the doctor can go back and look (at the medication) for appropriate dosing."

An interview was conducted on 5/18/17 at 9:32 a.m. with LPN #2, the resident's evening nurse. When asked why staff monitored the resident's behaviors, LPN #2 stated, "So you want to document the behaviors they are exhibiting and document your interventions. Depending on what they are doing could cause harm to themselves or cause harm to other patients." When asked to review the November and December 2016 behavior monitoring sheets and asked what the blank spaces indicated, LPN #2 stated, "I didn't document any behaviors. It meant I didn't assess them."

On 5/17/17 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Psychotropic Medication Documentation and Review" documented, "POLICY: All resident (sic) receiving psychotropic medication will have their behaviors, effectiveness of interventions (pharmacological and non-pharmacological) and potential for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 95	F 329		

gradual dose reduction of psychotropic medication monitored and documented. PROCEDURES: A. Resident receiving psychotropic medication will have a Behavior/Intervention Monthly Flow Record (BFR)...initiated on admission or whenever psychotropic meds (medications) are ordered. B. Nurses will document on the following every shift: a. Number of behavior episodes. C. The Behavior/Intervention Monthly Flow Record will be updated with any changes in psychotropic medication, dosage, new behaviors and/or side effects by the nurse on duty at the time of the change. a. The Physician will be notified of any significant change in behaviors, side effects or med changes recommended by another physician other than resident's primary physician..."

No further information was provided prior to exit.

(3) Risperdal -- RISPERDAL® (risperidone) is indicated for the acute and maintenance treatment of schizophrenia. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=01859e07-1262-4 cc 6-b7ed-5a273cbf0c36
3. The facility staff failed to monitor Resident #1's heartrate (pulse) per the physician ordered parameters for the administration of Atenolol (a high blood pressure medication).

Resident #1 was admitted to the facility on 12/23/10 with a recent readmission on 3/28/17 with diagnoses that included but were not limited to: osteoporosis, pain, anemia, psychosis, congestive heart failure (CHF), seizure disorder, anxiety disorder, insomnia, diabetes and high

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 96	F 329		

blood pressure.

The most recent MDS (minimum data set) assessment, with an assessment reference date of 2/27/17, coded the resident as scoring a 14 on the BIMS (brief interview for mental) status score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for transfers, dressing, toileting and personal hygiene.

The physician order dated, 3/28/17, documented, "Atenolol Tablet (used to treat high blood pressure (1)) 50 MG (milligrams); Give 1 tablet by mouth one time a day related to Hypertension; Hold for systolic BP (blood pressure) < (less than) 100 HR (heartrate) < 60 (beats per minute)."

The April 2017 MAR (medication administration record) documented, "Atenolol Tablet 50 MG; Give 1 tablet by mouth one time a day related to Hypertension; Hold for systolic BP < 100 HR < 60." The medication was scheduled for 6:00 a.m. above where the nurse documented her initials of administration; the resident's blood pressure was documented. There was no documentation of the residents pulse or heartrate.

The May 2017 MAR documented, Atenolol Tablet 50 MG; Give 1 tablet by mouth one time a day related to Hypertension; Hold for systolic BP < 100 HR < 60." The medication was scheduled for 6:00 a.m. above where the nurse documented her initials of administration; the resident's blood pressure was documented. There was no documentation of the residents pulse or heartrate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 97	F 329		

The care plan dated, 10/14/16, with a revised on date of 2/22/17, documented in part, "Focus: The resident has hypertension (high blood pressure) and CAD (coronary artery disease), CHF." The "Interventions" documented in part, "Give medications as ordered. Call MD (medical doctor) with any side effects."

The vital signs tab in the electronic medical record, did not document any heartrates in April and May 2017. The last documented heartrate was taken on 3/29/17 at 10:29 p.m.

Review of the nurse's notes from 3/28/17 through 5/16/17, did not evidence any documentation of a heartrate measurement.

An interview was conducted with LPN (licensed practical nurse) #4 on 5/17/17 at 10:30 a.m. LPN #4 was asked what is expected of staff, when the physician has ordered a medication with parameters to hold the medication if the blood pressure is less than 100 and the heartrate (pulse) is less than 60. LPN (licensed practical nurse) #4 stated, "The nurse has to take the blood pressure and pulse and hold the medication if it is below the prescribed parameters." When asked if both the blood pressure and the pulse should be obtained, LPN #4 stated, "If that's what the parameters are, pulse and blood pressure, then the nurse has to take both." When asked where this would be documented, LPN #4 stated, "The MAR should have a place to document the blood pressure and pulse." When asked who puts the orders into the computer so that the blood pressure and pulse would be recorded, LPN #4 stated, "All nurses except maybe the MDS nurses, they don't put in orders into the computer."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 98	F 329		

An interview was conducted with administrative staff member (ASM) #4, the assistant director of nursing, on 5/17/17 at 10:45 a.m. ASM #4 was asked what is expected of staff, when the physician has ordered a medication with parameters to hold the medication if the blood pressure is less than 100 and the heartrate (pulse) is less than 60. ASM #4 stated, "They have to take whatever vital signs are ordered prior to giving the medication." When asked if they had to take both the heartrate and blood pressure, ASM #4 stated, "Yes, if the order says to hold for the blood pressure or pulse, then we have to take both." When asked where the blood pressure and pulse would be documented, ASM #4 stated, "The MAR." When asked who enters the physician orders into the MAR to show the blood pressure and pulse, ASM #4 stated, "The nurse who takes off the order."

ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above concern on 5/17/17 at 5:25 p.m.

According to "Fundamentals of Nursing- Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished.

No further information was provided prior to exit.

(1) This information was obtained from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 99	F 329		

following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=9aacaa30-04b7-47d4-9ebf-b801cacf3ab4

4. The facility staff failed to offer non-pharmacological interventions prior to the administration of PRN (as needed) Xanax [1] and failed to document the symptoms of anxiety for Resident #9.

Resident #9 was admitted to the facility on 4/10/17 with the diagnoses of but not limited to diabetes, high blood pressure, anxiety, depression, leg fracture, stroke, and cerebrovascular disease. The most recent MDS (Minimum Data Set) was the admission/5-day assessment with an ARD (Assessment Reference Date) of 4/17/17. The resident was coded as being moderately cognitively impaired in ability to make daily life decisions, scoring an 8 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, and hygiene; independent for eating after set-up help; and as incontinent of bowel and bladder.

A review of the clinical record revealed a physician's order dated 4/10/17 for "Alprazolam (Xanax)...0.25 mg (milligrams). Give 1 tablet by mouth every 6 hours as needed for anxiety."

A review of the April 2017 MAR (Medication Administration Record), in conjunction with the nurses notes revealed the resident was administered the Xanax on the following dates: 4/10/17, 4/13/17, 4/16/17, 4/18/17, 4/22/17,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 100	F 329		

4/25/17, 4/27/17, and 4/29/17. There were no non-pharmacological interventions documented as having been offered for the administrations that occurred on 4/10/17, 4/13/17, 4/18/17, and 4/22/17. In addition, for the dates of 4/10/17, 4/13/17, 4/16/17, 4/18/17, 4/22/17, 4/25/17, and 4/29/17, non-pharmacological interventions were attempted, however the facility did not document the resident's signs/symptoms of anxiety.

A review of the May 2017 MAR in conjunction with the nurses notes revealed the resident was administered the Xanax on the following dates: 5/1/17, 5/3/17, 5/6/17, 5/7/17 (twice), 5/10/17, 5/11/17, and 5/16/17. There were no non-pharmacological interventions documented as having been offered for administrations on 5/3/17 and 5/10/17 In addition, for the dates of 5/1/17, 5/2/17, 5/6/17, 5/7/17 (second dose), and 5/10/17, non-pharmacological interventions were attempted, however the facility did not document the resident's signs/symptoms of anxiety.

On 5/17/17 at approximately 2:00 p.m., in an interview with LPN #4 (Licensed Practical Nurse), she stated that when a resident complains of anxiety, the nurse should assess the resident's symptoms of anxiety, and attempt non-pharmacological interventions. She stated the assessment and interventions should be documented in the clinical record. She stated that if it was not documented, then it wasn't done.

A review of the resident's care plan revealed one for "Use of psychotropic drugs having altering affect (sic) on the mind characterized by problems with cardiac, neuromuscular, gastrointestinal systems AEB (as evidenced by) anxiety, restlessness, crying." This care plan was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 101 initiated on 4/11/17. The interventions included one for "Non-pharm (pharmacological) interventions such as redirection, rest periods, encourage to express feelings." This intervention was dated 4/11/17. A review of the facility policy "Behavior Management" documented, "2. In the event that pain has been identified as the contributing to the behavior, the resident will be referred to the Pain Management Program. 3. Once the resident has been evaluated and it is determined that pain is not the issue, refer to the "Immediate Plan of Correction for Exhibited Behaviors" for non-pharmacological interventions...." The facility did not have a policy specific to the use of an antianxiety medication. On 5/17/17 at 5:13 p.m., ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3 the regional director of clinical services were made aware of the findings. No further information was provided by the end of the survey. References: [1] Xanax is used to treat anxiety and panic disorders. Information obtained from https://medlineplus.gov/druginfo/meds/a684001.html	F 329		
F 364 SS=B	NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP CFR(s): 483.60(d)(1)(2) (d) Food and drink Each resident receives and the facility provides-	F 364		6/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 102 (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, resident group interview, staff interview, and facility document review, it was determined that the facility staff failed to serve food at palatable temperatures for one of 2 facility dining rooms and one of 2 facility nursing units (both on the second floor). The findings include: On 5/16/17 at 2:00 p.m., a group interview was conducted with 6 current facility residents. During this group interview, residents stated that the food, especially breakfast, was served cold in the second floor dining room and nursing unit. On 5/17/17 at 7:57 a.m., an observation of the breakfast meal service was conducted. A. On the steam table in the main kitchen the following temperatures were recorded: Oatmeal - 183 degrees Grits - 170 degrees Cheese and sausage quiche - 172 degrees Cheese and broccoli quiche - 164 degrees Cheese quiche - 172 degrees Scrambled eggs - 142 degrees Sausage patties - 175 degrees On 5/17/17 at 9:05 a.m., a test tray was	F 364	1. Food on steam table was re-checked for appropriate temperature. 2. All residents have the potential to be affected by this deficient practice. 3. DM and or designee(s) will in-service dietary staff on appropriate temperatures for hot foods and how to monitor holding temperatures to point of service. Plate warmer has been purchased for 2nd floor dining room. 4. DM and or designee(s) will take temperatures of hot foods at point of service 5x a week for 4 weeks and then weekly for 8 weeks to ensure food is at the appropriate temperature. Results of audits will be taken to QAPI committee for review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 103	F 364		

conducted of the menu items from the main kitchen that was used to serve the residents on the nursing unit of the second floor. The temperatures were as follows:

Cheese and broccoli quiche - 133.5 degrees
Sausage patties - 106.9 degrees
Oatmeal - 145.6 degrees

Two surveyors taste tested the food and found it to be not warm enough for palatability for meal enjoyment. OSM (other staff member) # 2, dietary manager also taste tested the food and stated that she thought it was warm enough for meal enjoyment.

B. On 5/17/17 at 8:06 a.m., the temperatures on the steam table in the second floor dining room were obtained, and were as follows:

Oatmeal - 142.7 degrees
Scrambled eggs - 146.3 degrees
Cheese and broccoli quiche - 165 degrees
Cheese and sausage quiche - 167.2 degrees
Sausage patties - 149.3 degrees

On 5/17/17 at 8:41 a.m., a test tray of the meal from the second floor dining room steam table was conducted. At this time the temperatures were as follows:

Oatmeal - 130 degrees
Sausage patties - 100 degrees
Cheese and broccoli quiche - 122 degrees

Two surveyors taste tested the food and found it to be not warm enough for palatability for meal enjoyment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 104 During an interview conducted with OSM #2 (other staff member) the dietary manager on 5/17/17 at 9:10 a.m., it was revealed that the meal from the second floor dining room steam table were served on plates that were stored on a table at room temperature; whereas the plates in the kitchen were stored in a plate warmer, and that this may account for some of the concerns with food being served at low temperatures. A review of the facility policy, "Food Temperatures" documented, "3. Hot food items may not fall below 135 (degrees) while holding after cooking.....Hot food should be at least 135 degrees when plated, which is defined as point of service." On 5/17/17 at 5:13 p.m., ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3 the regional director of clinical services were made aware of the findings. No further information was provided by the end of the survey.	F 364		
F 367 SS=D	THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN CFR(s): 483.60(e)(1)(2) (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced	F 367		6/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 367	Continued From page 105 by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to provide a physician prescribed therapeutic diet for one of 26 residents in the survey sample, Resident #14. The facility staff failed to provide Resident #14's physician prescribed renal diet. The findings include: Resident #14 was admitted to the facility on 2/7/17 and discharged 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 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. Resident #14's comprehensive care plan initiated on 2/8/17 failed to document information regarding the resident's diet. On 5/17/17 at 8:30 a.m., an interview was conducted with OSM (other staff member) #2 (the director of dietary services). OSM #2 was asked what process was in place to ensure the correct physician ordered diet was served to residents. OSM #2 stated, "We get a dietary communication slip (from nursing)." OSM #2 stated dietary staff manually writes the diet on the tray card served	F 367	1. Resident #14 no longer resides in the facility. 2. All residents have the potential to be affected by this deficient practice. Current residents' diets have been audited for accuracy. 3. DON and or designee(s) will in-service licensed nurses on transcribing diet orders to the dietary communication form. 4. DON and or designee(s) will audit 10 resident diets weekly for 4 weeks for accuracy to ensure they are as prescribed and then monthly for 2 months. Results of audits will be taken to QAPI committee for review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 367	Continued From page 106	F 367		

with the meal until she puts the diet into the tray card system on the computer. OSM #2 was asked how she ensures the diet served matches the physician order. OSM #2 stated she ensures the physician prescribed diet is provided by attending the daily risk meetings and talking to unit managers or reviewing the resident's clinical record. OSM #2 was asked if she could provide Resident #14's dietary communication slip.

On 5/17/17 at 9:40 a.m., OSM #2 presented a dietary communication form dated 2/7/17 that documented Resident #14's name and a check mark beside a regular diet order and a thin texture. The words, "No Red meats. No fried foods." were handwritten on the form. The renal diet was not checked off. OSM #2 confirmed the diet documented on the dietary communication form is the diet that would have been entered into the tray card system and the diet that would have been served to Resident #14.

The nurse who completed the dietary communication form was no longer employed at the facility.

On 5/17/17 at 3:05 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what process was in place to ensure physician ordered diets are accurately communicated to the dietary department when a resident is admitted. LPN #1 stated, "We have a form we fill out that goes to the kitchen and we put the order in the computer." LPN #1 was asked if the information documented on the form that is given to the dietary department, should match the physician's order and stated, "Yes."

On 5/17/17 at 5:30 p.m., ASM (administrative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 367	Continued From page 107	F 367		

staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above findings.

The facility policy titled, "INTERDEPARTMENTAL NOTIFICATION OF DIET" documented, "Policy: Nursing Services shall notify the Dietary Department of a resident's diet orders, including any changes in the resident's diet, meal service, and food preferences. Procedure: 1. When a new resident is admitted, or diet has been changed, the Nurse Supervisor shall ensure that the Food Services Department receives a written notice of the diet order..."

The facility dietary description of a renal diet documented:
"RENAL DIET
(80 gram protein, 3 gram sodium, Limited Potassium and Phosphorus)
The liberal renal diet is for patients with acute, chronic, or end stage renal disease and is appropriate for both pre-dialysis and hemodialysis patients. This diet may not be appropriate for patients requiring strict limits on protein or the micronutrients sodium, potassium, or phosphorus. This diet reduces the intake of protein, potassium, sodium, and phosphorus. Fluid intake should be individually determined. The liberal renal diet provides approximately 80 grams of protein, 3,000 mg (milligrams) of sodium, 3,000 mg of potassium, and 1,500 mg of phosphorus. Although a good source of high biological value protein, milk is limited to 1 cup per day due to phosphorus and potassium restrictions..."

No further information was presented prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 367	Continued From page 108 (1) "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	F 367		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that facility	F 371	1. Dietary employees hair was immediately tucked underneath her	6/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 109 staff failed to prepare food in a sanitary manner. The facility staff failed to ensure hair restraints covered the entire head and contained all hair, while preparing breakfast on 5/17/17. The findings include: On 5/17/17 at 8:30 a.m., observation of tray line was conducted in the kitchen. On 5/17/17 at 8:35 a.m., OSM (other staff member) #1, the dietary aide was observed plating breakfast and placing the plates onto the food cart. OSM #1's hair net was halfway around her head. Her hair net covered the front of her head to the back of her ponytail. The bottom part of her hair was uncovered. Wisps of hair were also hanging out of the side of her hair net. On 5/17/17 at 9:22 a.m., an interview was conducted with OSM #1, the dietary aide. When asked the purpose of the hair net, OSM #1 stated that the purpose of the hair net was to prevent food from getting into the food. OSM #1 stated that the hair net should be worn by all staff that enters the kitchen area. When asked if her hair net was on properly, OSM #1 fixed her hair net by pulling the back of net down covering the bottom of her hair. OSM #1 also tucked in the wisps of hair on the side of her head. OSM #1 confirmed that she was not wearing the hair net properly. On 5/17/17 at 9:48 a.m., an interview was conducted with OSM #2, the Dietary Manager. When asked the purpose of the hair net, OSM #2 stated that the purpose of the hair net was to prevent hair from contaminating the food. When	F 371	hairnet. 2. All residents have the potential to be affected by this deficient practice. 3. DM and or designee(s) will in-service dietary staff on the proper wearing of hairnets to ensure all hair is covered. 4. DM and or designee(s) will audit dietary employees daily for proper hairnet placement daily for 4 weeks and then weekly for 8 weeks. Results of audits will be taken to QAPI committee for review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 110 asked how the hair net should be worn, OSM #2 stated that the hair net should be covering the entire head. OSM #2 stated that all staff working in the food service area should be wearing a hair net. On 5/17/17 at 11:07 a.m., ASM (administrative staff member) #1, the administrator and ASM #3, regional director of clinical services, were made aware of the above findings. Facility policy titled, "Employee Sanitary Practices," documents in part, the following: "Procedure: 1. Wear hair restraints and clean clothes..." No further information was presented prior to exit.	F 371		
F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.45(a)(b)(1) (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to ensure medications were	F 425	1. Resident #14 no longer resides in the facility. 2. All residents have the potential to be	6/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 111 available for administration in a timely manner for one of 26 residents in the survey sample, Resident #14. a. The facility staff failed to acquire Resident #14's Verapamil and Candesartan (blood pressure medications) for administration on 2/7/17 at 8:00 p.m. 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. The findings include: a. The facility staff failed to acquire Resident #14's Verapamil (1) and Candesartan (2) for administration on 2/7/17 at 8:00 p.m. Resident #14 was admitted to the facility on 2/7/17 and discharged on 2/14/17. Resident #14's diagnoses included but were not limited to: acute cholecystitis (3), high blood pressure and major depressive disorder. Resident #14's five day Medicare assessment with an ARD (assessment reference date) of 2/14/17 coded the resident as being cognitively intact. 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. Resident #14's physician's orders dated 2/7/17	F 425	affected by this deficient practice. DON and or designee(s) reviewed new residents admitted from 5/18/2017 thru 5/31/2017 for medication availability and notification. 3. The DON and or designee(s) will in-service licensed nurses on the policy for medication availability, including MD notification when medication is not available. 4. DON and or designee(s) will audit new residents for medication availability 5x each week for 4 weeks and then weekly for 8 weeks. Results of audits will be taken to the QAPI committee x3 months for review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 112	F 425		

documented orders for the following medications including but not limited to:
- Verapamil 120 mg- one capsule by mouth at bedtime (scheduled at 8:00 p.m.)
- Candesartan 4 mg- one tablet by mouth two times a day (scheduled at 8:00 a.m. and 8:00 p.m.)

Review of Resident #14's February 2017 MAR (medication administration record) revealed the resident was not administered the scheduled 8:00 p.m. dose of the above medications on 2/7/17 (as evidenced by an "x" documented on the MAR). Further review of the clinical record (including MAR notes and nurses' notes) failed to reveal Resident #14's physician was made aware that the above medications were not administered.

Review of the facility STAT (Immediate) box lists revealed the prescribed doses of Verapamil and Candesartan were not available in the STAT box.

Resident #14's comprehensive care plan initiated on 2/8/17 failed to document information regarding medication administration.

On 5/17/17 at 9:19 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated if medications for a newly admitted resident haven't arrived then the medications should be obtained from the STAT box if in stock. RN #1 stated if the medication was an unusual medication then nurses can make a STAT order and the pharmacy will send the medication faster.

On 5/17/17 at 1:30 p.m., an interview was conducted with OSM (other staff member) #3 (the consulting pharmacist). OSM #3 was asked to explain the process that was in place to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 113	F 425		

newly admitted residents received their prescribed medications. OSM #3 stated the pharmacy has set delivery times and set cut off times (a time when the medication order has to be sent to the pharmacy in order to receive the medication on the next delivery). OSM #3 stated if medication is needed right away or at another time (other than the delivery times) then the nurse has to call the pharmacy. OSM #3 stated if the medication is needed right away and is not in the facility STAT box (a box containing various medications) then the medication can be sent from a local pharmacy. OSM #3 stated there are some specialty drugs that have to come from a specialty pharmacy and the facility is made aware of those drugs and the processes for obtaining those drugs. OSM #3 confirmed Verapamil and Candesartan were not in the STAT box but were not considered specialty drugs.

On 5/17/17 at 3:05 p.m.an interview was conducted with LPN (licensed practical nurse) #1 (the nurse responsible for administering Verapamil and Candesartan to Resident #14 on 2/7/17 at 8:00 p.m.). LPN #1 stated the moment residents are admitted she takes paperwork from the transportation people, faxes the physician's orders to the pharmacy and writes a request for the pharmacy to send the medications STAT (immediately) on the fax. LPN #1 stated the pharmacy usually does not send the medications STAT so if a resident is prescribed a narcotic pain medication then she calls the pharmacy to see if they received the fax. LPN #1 stated most other times, she does not call the pharmacy because the orders are placed in the computer and should automatically go to the pharmacy. LPN #1 was asked what should occur when the medication is due and not available for administration. LPN #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 114	F 425		

stated nurses can access the facility STAT box and most of the time the STAT box contains the needed medications. LPN #1 stated if the STAT box does not contain the needed medications then nurses notify the physician and he will say to give another medication or to hold the medications until they arrive from the pharmacy. LPN #1 was shown Resident #14's February 2017 MAR. LPN #1 stated she didn't remember if Resident #14's scheduled evening medications were given on 2/7/17 or what was done if the medications were not given. LPN #1 stated she didn't remember if she contacted the physician or not.

On 5/17/17 at 5:30 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above findings.

The pharmacy delivery schedule documented orders received by 9:00 a.m. depart the pharmacy by 10:00 a.m. and orders received by 11:00 p.m. depart the pharmacy by 1:00 a.m. The schedule documented, "NOTE: All new orders needed after 6:30 pm must be accompanied by a phone call..."

The facility pharmacy policy titled, "New Orders for Non-Controlled Substances" documented, "5. If the medication is needed before the next scheduled delivery and is not available in the Emergency Medication Supply (STAT box), Facility staff should:
5.1.1 Fax or transmit the order to the pharmacy.
5.1.2 Notify the Pharmacy and include the exact time by which the medication is needed..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 115	F 425		

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.html

(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.html

(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.

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)-one tablet by mouth two times a day for angina

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 116	F 425		

(chest pain).

Review of Resident #14's February 2017 MAR (medication administration record) revealed the resident was not administered ranolazine on 2/7/17 at 8:00 p.m. or on 2/8/17 at 8:00 a.m.

Review of the facility STAT (immediate) box (a box containing various medications) list revealed ranolazine was not available in the STAT box.

A nurse's note dated 2/8/17 at 1:03 p.m. documented, "Ranolazine ER (Extended Release) Tablet Extended Release 12 Hour 1000 MG- Give 1 tablet by mouth two times a day for angina; pharmacy said ranolazine and verapamil (4) (another medication prescribed to Resident #14) could not be given together in high dose of 1000 mgs (milligrams). md (medical doctor) notified." The clinical record failed to document the date/time the physician responded to the above note and what the physician's response was.

A nurse's note dated 2/8/17 at 6:38 p.m. documented Resident #14 was administered nitroglycerin at that time for a complaint of chest pain. A nurse's note dated 2/8/17 at 7:03 p.m. documented the nitroglycerin was effective.

Further review of Resident #14's February 2017 MAR revealed the resident was administered ranolazine on 2/8/17 at 8:00 p.m.

Resident #14's comprehensive care plan initiated on 2/8/17 failed to document information regarding medication administration or angina.

On 5/17/17 at 9:19 a.m., an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 117	F 425		

conducted with RN (registered nurse) #1 (the nurse responsible for administering ranolazine to Resident #14 on 2/8/17 at 8:00 a.m.) RN #1 stated she didn't remember Resident #14. RN #1 was shown the above nurse's note that she documented on 2/8/17 at 1:03 p.m. RN #1 stated the physician doesn't always okay pharmacy recommendations so she notified the physician regarding the pharmacy concern about the interaction of administering a high dose of ranolazine with verapamil. RN #1 could not verify the physician's response to the pharmacy concern. RN #1 stated, "He probably said continue." RN #1 stated she usually calls the physician or contacts the physician via computer messaging but sometimes the physician doesn't respond right away. RN #1 stated sometimes the physician responds within two to three hours so Resident #14 probably missed the scheduled 8:00 a.m. dose of ranolazine on 2/8/17. RN #1 was asked to provide computer messenger documentation regarding her conversation with the physician. On 5/17/17 at 10:04 a.m. ASM (administrative staff member) #4 (the assistant director of nursing) stated computer messenger conversations can't be viewed once the conversations have ended.

On 5/17/17 at 3:05 p.m.an interview was conducted with LPN (licensed practical nurse) #1 (the nurse responsible for administering ranolazine to Resident #14 on 2/7/17 at 8:00 p.m.). LPN #1 stated the moment residents are admitted she takes paperwork from the transportation people, faxes the physician's orders to the pharmacy and writes a request for the pharmacy to send the medications STAT (immediately) on the fax. LPN #1 stated the pharmacy usually does not send the medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 118	F 425		

STAT so if a resident is prescribed a narcotic pain medication then she calls the pharmacy to see if they received the fax. LPN #1 stated most other times, she does not call the pharmacy because the orders are placed in the computer and should automatically go to the pharmacy.

The pharmacy "Grid Notes" obtained from the pharmacy and presented by ASM (administrative staff member) #2 (the director of nursing) on 5/17/17 at 3:34 p.m. documented that on 2/7/17 at 9:44 p.m. the pharmacy identified an interaction between ranolazine and verapamil. On 2/8/17 at 1:02 p.m. an employee from the pharmacy spoke with a facility nurse who stated she would clarify the interaction with the physician. On 2/8/17 at 7:10 p.m. another nurse told the pharmacy the physician stated it was okay to administer the ranolazine to Resident #14 and the nurse requested the medication be sent STAT. The pharmacy manifest documented Resident #14's ranolazine was delivered to the facility on 2/8/17 at 9:52 p.m.

On 5/17/17 at 5:30 p.m., ASM #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above findings. A policy for following physician's orders was requested. ASM #3 stated the facility did not have the requested policy.

The facility pharmacy policy titled, "Physician/Prescriber Authorization and Communication of Orders to Pharmacy" documented, "6. Pharmacy may contact Facility staff via fax or telephone before dispensing a medication when the pharmacist believes that there is a need to clarify the medication order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 119	F 425		

because the order is unclear, incomplete or vague, contraindicated, or has a drug-drug interaction. 6.1 Facility staff should check the fax machine(s) for any pharmacy communication. 6.2 Pharmacy will hold medication orders until Physician/Prescriber is able to clarify the order. 6.3 Facility should contact Physician/Prescriber when staff is notified by Pharmacy of an order requiring clarification. 6.4 Facility should explain the issue to the Physician/Prescriber, document the clarification and document any new orders received. 6.5 Facility staff should then communicate the result and any new orders or directions to the Pharmacy..."

No further information was presented prior to exit.

(1) "Ranolazine is used alone or with other medications to treat chronic angina (ongoing chest pain or pressure that is felt when the heart does not get enough oxygen)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a606015.html

(2) Nitroglycerin is used to treat angina (chest pain). This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0001281/

(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

(4) "Verapamil is used to treat high blood pressure and to control angina (chest pain)."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 120 This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684030.html	F 425		
F 428 SS=E	COMPLAINT DEFICIENCY DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 428		6/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 121 director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to ensure medication regimen reviews (MRRs) were completed and readily available for review and or filed in the clinical record for four of 26 residents in the survey sample, Residents #7, #1, #5 and #10. 1. The facility staff failed to have monthly medication regimen reviews readily available for review and or filed in the clinical record for Resident # 7, and failed to provide evidence the monthly medication reviews for June and July 2016 were completed. 2. The facility staff failed to have Resident #1's pharmacy medication regimen reviews in the	F 428	1. MRR of residents #7, 1, 5, and 10 are now with the residents medical record. 2. All residents have the potential to be affected by this deficient practice. Records of current residents have been audited to ensure MRR's are contained within the resident record. 3. DON and or designee has in-serviced unit managers and medical records clerk on the process for maintaining an accurate medical record and the process for filing pharmacy review/recommendation into the residents medical record, this also includes pharmacist ability to document into PCC pharmacy reviews.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 122 clinical record or readily available for review and failed to provide evidence the medication regimen reviews were completed in November and December 2016. 3. The facility staff failed to have the monthly medication regimen reviews and pharmacy recommendations for Resident #5, readily available for review or filed in the clinical record. 4. The facility staff failed to have Resident #10's March 2017 and April 2017 pharmacy reviews readily available for review and or filed in the clinical record. The findings include: Resident # 7 was admitted to the facility on 05/01/14 with diagnoses that included but were not limited to: encephalopathy (1), muscle weakness, depression, aphasia (2), dementia (3), hypertension (4), gastroesophageal reflux disease (5), dysphagia (6) and peripheral vascular disease (7). Resident # 7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/22/17, coded Resident # 7 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 being cognitively intact for making daily decisions. Resident # 7 was coded as requiring supervision with set up help for activities of daily living. Review of the clinical record revealed that Resident 7's monthly medication regimen reviews for May 2016 through April 2017 could not be	F 428	4. The MRR's and pharmacy recommendations will be audited against the pharmacists list by the medical records clerk weekly for 2 weeks and then monthly for 2 months. Results of audits will be taken to QAPI x3 months for review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 123	F 428		

located.

On 05/17/17 at 4:50 p.m. an interview was conducted ASM (administrative staff member) # 2, the director of nursing regarding the medication regimen reviews (MRRs) dating May 2016 through April 2017 for Resident # 7. When asked to describe the process regarding a resident's MRRs, ASM # 2 stated, "The pharmacist comes into the facility during the first seven days of each month and completes the MRRs for each resident and leaves me the recommendations. I review the recommendations by the pharmacist, sign them and go over them with the physician, follow up with the recommendations. The MRRs are then filed in a binder in my office." ASM # 2 was then asked to provide the MRRs for Resident # 7 dated May 2016 through April 2017.

On 05/18/17 at 10:15 a.m. ASM # 4, assistant director of nursing stated that they were unable to locate the MRRs for Resident # 7 dated May 2016 through April 2017.

On 05/18/17 at approximately 11:00 a.m. a phone interview was conducted with OSM # 3, pharmacist. When asked to describe the process for completing and filing the MRRs OSM # 3 stated, "I review the residents each month when I come in, document in my computer and on the MRR form in the resident's clinical record, the recommendations are printed and given to the DON (director of nursing) before I go." When asked about the missing MRRs for Resident # 7 dated May 2016 through April 2017, OSM # 3 stated she would check her computer and fax them to the facility.

On 05/18/17 at approximately 11:45 a.m. ASM #

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 124	F 428		

2 provided copies of the MRRs that were faxed to the facility from the pharmacist on 05/18/17 for Resident #7 dated May 2016, August 2016 through April 2017. The facility was unable to evidence that the MRRs for June and July 2016 were completed.

No further information was provided.

The facility's policy "Medication Regimen Review" documented, "7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the recommendations contained in the MRR. For those issues that require Physician/Prescriber intervention, Facility should encourage Physician/Prescriber to either (a) accept or act upon the recommendations contained within the MRR, or (b) reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected. 9. Facility should maintain copies of MRRs on the file in Facility, either as part of the resident's permanent medical record or in a special file, in accordance with Applicable Law."

On 05/17/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings.

References:

1. A term for any diffuse disease of the brain that alters brain function or structure. This information was obtained from the website: http://www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 125	F 428		

2. A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html

3. A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html.

4. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

5. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

6. A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

7. The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 126	F 428		

https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.

2. The facility staff failed to have Resident #1's pharmacy medication regimen reviews in the clinical record or readily available for review and failed to provide evidence the medication regimen reviews were completed in November and December 2016.

Resident #1 was admitted to the facility on 12/23/10 with a recent readmission on 3/28/17 with diagnoses that included but were not limited to: osteoporosis, pain, anemia, psychosis, congestive heart failure (CHF), seizure disorder, anxiety disorder, insomnia, diabetes and high blood pressure.

The most recent MDS (minimum data set) assessment, with an assessment reference date of 2/27/17, coded the resident as scoring a 14 on the BIMS (brief interview for mental) status score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for transfers, dressing, toileting and personal hygiene.

The clinical record was reviewed. Resident #1 had a complete electronic record. She did not have a paper record.

Review of the clinical record did not reveal any documentation that the monthly Medication Regimen Review was completed for Resident #1. There were no pharmacist recommendations in the electronic medical record.

On 5/16/17 at approximately 3:00 p.m. ASM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 127	F 428		

(administrative staff member) #2, the director of nursing, presented a binder with the "Consultant Reports" for July 2016, September 2016 and October 2016, from the pharmacist for Resident #1.

The clinical record still lacked documentation of the monthly pharmacy medication regimen reviews.

On 5/17/17 at 4:50 p.m. another interview was conducted with ASM #2. ASM #2 was asked the process for the pharmacy medication regimen reviews, ASM #2 stated, "She (the pharmacist) comes in the first seven days of the month. She reviews the charts, leaves me the recommendations. I review them. I sign that I have reviewed them. As soon as (ASM #5 - the medical director) has a minute I go over them with him." When asked then what happens, ASM #2 stated, "We follow through with the recommendations and file them in a binder." ASM #2 stated, "They are in a binder in my office listed by month." When asked if she has any part of the medication regimen review process by the pharmacist in the clinical record, ASM #2 stated, "They are using the sign off sheets in the record but in May, this year, she has started documenting directly in the electronic clinical record."

ASM #1, the administrator, ASM #2, and ASM #3, the regional director of clinical services, were made aware of the above findings on 5/17/17 at 5:25 p.m.

On 5/18/17 at 8:00 a.m. the facility presented a "Medication Regimen Review" logs for February, March and April 2017 and April through August

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 128	F 428		

2016. Still missing were November and December 2016 and January 2017.

On 5/18/17 at 8:07 a.m. an interview was conducted with ASM #2 and ASM #4, the assistant director of nursing. ASM #2 explained that a stack of medication regimen logs had been found in medical records in a drawer and marked, "Done," indicating these records had already been scanned in to the electronic medical record. She verified that these records were not scanned in to the computer and were not part of the clinical record.

On 5/18/17 at 10:15 a.m., the administrator was made aware that the months of November and December of 2016 and January 2017 were still missing.

On 5/18/17 at 10:32 a.m. ASM #2 informed this surveyor that they could not locate documentation of the medication regimen reviews for Resident #1 in November and December 2016 and January 2017.

On 5/18/17 at 10:55 a.m. a telephone interview was conducted with other staff member (OSM) #3, the pharmacist. OSM #3 was asked to explain the process for completing the medication regimen reviews, OSM #3 stated, "I do a medication review on each resident when I come to the building." When asked where it is documented in the clinical record, OSM #3 stated, "My clinical notes are in my computer." When asked the process for recommendations, OSM #3 stated, "I print the recommendations before I leave the facility and give them to (ASM #2)." When asked if she saw Resident #1 in November, December of 2016 and January 2017,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 129	F 428		

OSM #3 checked her computer. She stated, "I saw Resident #1 on 11/14/16. In December she was in the hospital at the time of my visit. I saw her on 1/19/17 and made recommendations, but she went to the hospital after I had made them." She stated the recommendations were for a dose reduction and the use of many PRN (as needed) medications.

There was no documentation in the clinical record or provided by the facility of the November, December 2016 and January 2017 medication regimen reviews.

No further information was provided prior to exit.

3. The facility staff failed to have the monthly medication regimen reviews and pharmacy recommendations for Resident #5, readily available for review or filed in the 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, 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 clinical record was reviewed. Resident #5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 130	F 428		

had a complete electronic record. She did not have a paper record.

Review of the clinical record did not reveal any documentation that the monthly Medication Regimen Review was completed for Resident #5. There were no pharmacist recommendations in the electronic medical record.

On 5/17/17 at approximately 11:56 a.m. ASM (administrative staff member) #2, the director of nursing, presented a binder with the "Consultant Reports" for July and December 2016 from the pharmacist for Resident #5.

The documentation of the monthly pharmacy medication regimen reviews was still not provided.

On 5/17/17 at 4:50 p.m. another interview was conducted with ASM #2. ASM #2 was asked the process for the pharmacy medication regimen reviews, ASM #2 stated, "She (the pharmacist) comes in the first seven days of the month. She reviews the charts, leaves me the recommendations. I review them. I sign that I have reviewed them. As soon as (ASM #5 - the medical director) has a minute I go over them with him." When asked then what happens, ASM #2 stated, "We follow through with the recommendations and file them in a binder." ASM #2 stated, "They are in a binder in my office listed by month." ASM #2 stated, "We are keeping them in a binder that is not part of the medical record." When asked if she has any part of the medication regimen review process by the pharmacist in the clinical record, ASM #2 stated, "They are using the sign off sheets in the record but in May, this year, she has started

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 131	F 428		

documenting directly in the electronic clinical record."

ASM #1, the administrator, ASM #2, and ASM #3, the regional director of clinical services, were made aware of the above findings on 5/17/17 at 5:25 p.m.

On 5/18/17 at 8:00 a.m. the facility presented a "Medication Regimen Review" logs for June 2016 through April 2017 that documented the reviews were completed.

On 5/18/17 at 8:07 a.m. an interview was conducted with ASM #2 and ASM #4, the assistant director of nursing. ASM #2 explained that a stack of medication regimen logs had been found in medical records in a drawer and marked, "Done." Indicating these records had already been scanned in to the electronic medical record. She verified that these records were not scanned in to the computer and were not part of the clinical record.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/785/hyperlipidemia

4. The facility staff failed to have Resident #10's March 2017 and April 2017 pharmacy reviews readily available for review and or filed in the clinical record.

Resident #10 was admitted to the facility on 2/22/17 and readmitted on 3/23/17. Resident #10's diagnoses included but were not limited to:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 132	F 428		

seizures, liver transplant and urinary tract infection. Resident #10's significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 3/30/17, coded the resident's cognitive skills for daily decision making as severely impaired.

Review of Resident #10's electronic clinical record failed to reveal a March 2017 pharmacy review and an April 2017 pharmacy review. There was no paper clinical record for Resident #10.

On 5/17/17 at 7:52 a.m., an interview was conducted with OSM (other staff member) #4 (the medical records employee). OSM #4 stated she began employment in March 2017 and ASM (administrative staff member) #2 (the director of nursing) wanted to go paperless so she went through all the paper charts beginning with residents on the first floor. OSM #4 stated once she gets a paper chart, she goes through the chart and separates it by how it should be logged into the computer. OSM #4 stated Resident #10 no longer had a paper chart and all documents were scanned into the computer during the previous week or the week before. OSM #4 stated a few employees at the front desk assist her with scanning documents into the computer. OSM #4 was asked if Resident #4's pharmacy reviews should be scanned into the electronic clinical record. OSM #4 stated, "Yeah. It would have been something that if it was part of her chart, we would have scanned it in." OSM #4 stated she tries to scan documents into the electronic clinical record the same day she receives the documents or the next day.

On 5/17/17 at 5:30 p.m. ASM #1 (the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 133 administrator), ASM #2 and ASM #3 (the regional director of clinical services) were made aware of the above findings. On 5/18/17 at 8:07 a.m., ASM #2 and ASM #4 (the assistant director of clinical services) presented Resident #10's March 2017 and April 2017 pharmacy reviews in addition to a stack of other residents' pharmacy reviews. ASM #2 stated most residents' pharmacy reviews were in the paper chart on the unit under the physician order tab. ASM #2 confirmed Resident #10 had no paper chart on the unit and stated the pharmacy reviews were in a stack of pharmacy reviews for multiple residents that were in a drawer in the medical records department with a note that documented, "Done." No further information was presented prior to exit.	F 428		
F 441 SS=E	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441		6/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 134 (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 135 actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain infection control practices during the medication administration observation for 11 of 14 residents in the medication administration observation, Residents # 19, #20, #21, #22, #23, #24, #25, #26, #12, #13 and #1. The facility staff failed to sanitize their hands during the medication administration observation conducted on 5/16/17 after administering medications and failed to sanitize equipment used in the resident's rooms before returning it to the medication cart. The findings include: The medication administration observation was conducted on 5/16/16 at 4:08 p.m. with LPN (licensed practical nurse) #1. LPN #1 put two Tylenol 350 mg tablets into a medicine cup and took them into Resident #19's room. LPN #1 handed the resident the medicine cup, the resident took the pills and gave the medicine cup back to LPN #1. LPN #1 discarded the medicine cup, returned to the medication cart and charted	F 441	1. Residents #19, 20, 21, 22, 23, 24, 25, 26, 12, 13, and 1 display no adverse effects from infection control issue on 5/16/2017. 2. All residents have the potential to be affected by this deficient practice. 3. DON and or designee(s) will in-service licensed nurses on proper hand washing and sanitizing techniques. 4. DON and or designee(s) will conduct random medication administration observations weekly for 4 weeks and then 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 and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 136	F 441		

the medications. LPN #1 did not wash her hands.

LPN #1 then put the Carbidopa-Levodopa Tablet 25-250 MG for Resident #20 into a medicine cup and went into the resident's room. The resident took the medicine and gave the cup back to LPN #1. LPN #1 discarded the cup. LPN #1 then washed her hands put on a pair of gloves and checked Resident #20's accuchek (blood sugar). LPN #1 removed the gloves and left the room without washing her hands. LPN #1 went to the nurse's station and called the physician for an insulin order. She then entered the order into the computer and returned to the medication cart. LPN #1 picked a piece of paper up off the floor and discarded it. LPN #1 took the insulin out of the resident's medication drawer and returned to Resident #20's room. She put on a pair of gloves, gave the resident the insulin removed her gloves and washed her hands. She then cleaned the accuchek monitor with an alcohol wipe.

LPN #1 then took the accuchek monitor into Resident #1's room, put on a pair of gloves, obtained the resident's blood sugar with the accuchek monitor and removed the gloves. She did not wash her hands or clean the accuchek monitor. LPN #1 then went to the medication cart took the insulin out of the resident's medication drawer and returned to the resident's rooms, she put on a pair of gloves and administered the insulin. She took off the gloves and washed her hands. LPN #1 returned to the medication cart and documented that the medication had been given.

LPN #1 then put 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 137	F 441		

the resident stated she did not. She gave the medicine cup to the resident and then gave Resident #12 water from the water pitcher. LPN #1 left the room without washing her hands.

LPN #1 returned to the medication cart and took the accuchek monitor and the vial of test strips and put them into her pocket. She then went into Resident #21's room, placed the accuchek monitor and test strips on the resident's bedside table. She put on a pair of gloves, checked the resident's blood sugar with the monitor. LPN #1 removed the gloves, washed her hands and put the accuchek monitor and test strips into her pocket without sanitizing the items. LPN #1 returned to the medication cart, took out the resident's insulin and returned to the resident's room. LPN #1 washed her hands, put on a pair of gloves, administered the insulin and removed the gloves. LPN #1 washed her hands and returned to the cart and placed the accuchek monitor on top of the cart without cleaning the monitor.

LPN #1 then put two Divalproex 250 mg tablets into a medication cup and took them into Resident #22's room. She placed her hands on the resident's bedside table and gave her the medication. LPN #1 did not wash her hands. LPN #1 then went back to the medication cart and took the thermometer out of the cart and returned to the resident's room and checked her temperature. LPN #1 then put the thermometer into her pocket and left the room. LPN #1 did not wash her hands or sanitize the thermometer.

Resident #23 was waiting outside Resident #22's door with a cup in her hand. LPN #1 took the cup and went to the medication room and filled the cup with wine and handed it to Resident #23. LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 138	F 441		

#1 did not wash her hands.

LPN #1 then returned to the medication cart and went into Resident #24's room. She put the accuchek monitor and test strips on the resident's bedside table and then washed her hands and put on a pair of gloves. After checking the blood sugar, LPN #1 removed her gloves, put the test strips back into her pocket and put the accuchek monitor on top of the medication cart. She did not wash her hands or sanitize the equipment.

LPN #1 then put Resident #25's Xarelto 20 mg into a medication cup. LPN #1 then moved Resident #24's wheelchair out of Resident #25's doorway, patted Resident #24's shoulder and then took the medication to Resident #25. She gave the resident the medication cup and handed her a glass of water. She took the medication cup to the bathroom, discarded it and washed her hands.

LPN #1 then went into Resident #26's room. The resident had his right leg hanging off the bed; LPN #1 put his leg back into bed and covered him up with a sheet. She then checked the water flush bag and left the room. LPN #1 did not wash or sanitize her hands when she left the room.

LPN #1 then went back to the nurse's station, wrote a note in the computer and scratched her faced. Resident #13 was sitting at the nurse's station in a wheelchair and was crying and asking staff to "Get the dogs in." LPN #1 got up and pushed Resident #13 in her wheelchair to her room. LPN #1 picked up the phone receiver and dialed a number (resident's daughter) and gave the phone to Resident #13. LPN #1 spoke on the phone with the resident's daughter, patted the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 139	F 441		

resident on the shoulder and left the room without washing her hands. LPN #1 returned to the medication cart. LPN #1 took Ativan 0.5 mg out of the cart and put it into a medication cup. LPN #1 took the medication to Resident #13 who refused the medications and demanded to be taken outside to let the dogs in. LPN #1 pushed the resident into the day room and asked for help.

An interview was conducted on 5/17/17 at 9:40 a.m. with LPN #5. When asked when staff washed their hands, LPN #5 stated, "Before and after contact with the residents, when you take off gloves. Touching anything that's soiled even if you have gloves on because stuff can still get underneath it (the gloves) and you're sweating too."

An interview was conducted on 5/17/17 at 1:30 p.m. with ASM (administrative staff member) #4, the assistant director of nursing. When asked when staff washed their hands, ASM #4 stated, "Before and after care of the residents. When you enter and leave the room. Between residents." When asked the process followed by staff during medication administration, ASM #4 stated, "Before each resident and after (giving the medications). They can use hand sanitizer up to three times and then they need to wash their hands." When asked why staff washed their hands, ASM #4 stated, "Infection control." When asked about the process staff follows after using equipment in a resident's room, ASM #4 stated, "Use sanitizing wipes to clean it." When asked if it was acceptable to put equipment used with a resident into your pocket, ASM #4 stated, "No, its infection control. Always wash equipment between residents and before you leave the resident's room." ASM #4 was made aware of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 140	F 441		

findings at that time. A request for the manufacturer's cleaning instructions for the accuchek and thermometer were requested.

An interview was conducted on 5/17/17 at 2:55 p.m. with LPN #1. When asked when staff washed their hands, LPN #1 stated, "We wash almost all the time, before and after wound treatment, after we eat, after the bathroom. Before and after we interact with the patient and anytime we take off gloves." When asked why staff washed their hands, LPN #1 stated, "For infection control." When asked what process staff followed after they used equipment on a resident, LPN #1 stated, "Wipe it off." When asked what was to be used use wipe off equipment, LPN #1 stated, "The wipes with the red top on them." When asked about the medication administration observation of 5/16/17, LPN #1 stated, "I know I didn't have the wipes to wipe them down so I wiped the accuchek with an alcohol wipe but I don't think that cleans it. I think I forgot to wash my hands in between a couple of the residents." When asked if resident equipment could be stored in staff pockets, LPN #1 stated, "I put them in my pocket?" When asked if that was appropriate, LPN #1 stated, "No."

On 5/17/17 at 5:15 p.m. ASM #1, the administrator and ASM #2 the director of nursing were made aware of the findings.

Review of the manufacturer's instructions for cleaning the accuchek monitor documented, "Cleaning the Meter. The GLUCOCARD (trademark) Vital blood glucose meter is a precise instrument. Please handle with care. Clean the outside of the meter with a damp cloth only." Manufacturer's instructions on cleaning the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 141	F 441		

thermometer was not obtained.

Review of the facility's policy titled, "General Dose Preparation and Medication Administration" documented, "Procedure: 2. Prior to preparing or administering medications, authorized and competent Facility staff should follow Facility's infection control policy (e.g. handwashing)."

Review of the facility's policy titled, "Hand Washing" documented, "POLICY: Hand washing is the most important component for preventing the spread of infection. Use of gloves does not replace the need for hand cleaning by either hand rubbing or hand washing. 3. Perform hand hygiene: a. Before and after having direct contact with residents. b. After removing gloves. c. Before handling an invasive device (regardless of whether or not gloves are used) for resident care...f. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident..."

Review of the facility's policy titled, "Infection Control" documented, "PURPOSE: To protect and work areas shall be cleaned according to manufacturer's specifications..."

Resident #19 was admitted to the facility on 7/13/11 with diagnoses that included but were not limited to: irregular heartbeat, weakness, urinary tract infection, anemia and pain. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 5/2/17 coded the resident as having a BIMS (brief interview for mental status) of 9 out of 15 indicating the resident was moderately impaired cognitively. Review of the May 2017 physician's orders documented, "Acetaminophen (Tylenol)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 142	F 441		

325 MG (milligrams) Give 2 tablet (sic) by mouth two times a day for pain."

Resident #20 was admitted to the facility on 9/11/15 and readmitted on 12/1/15 with diagnoses that included but were not limited to: Parkinson's disease (1), high blood pressure, diabetes and cancer. The most recent MDS, a quarterly assessment, with an ARD of 6/4/17 coded the resident as having a BIMS of 14 out of 15 indicating the resident was cognitively intact to make daily decisions. Review of the May 2017 physician's orders documented, "Carbidopa-Levodopa (2) Tablet 25-250 MG Give 1 tablet six times per day for parkinson's [sic]. NovoLOG (3)FlexPen Solution Pen-injector 100 UNIT/ML...inject per sliding scale..."

Resident #21 was admitted to the facility on 2/16/17 with diagnoses that included but were not limited to: dementia, high blood pressure and edema (swelling). The most recent MDS, a quarterly assessment, with an ARD of 4/24/17 coded the resident as having a BIMS of 10 indicating the resident was moderately impaired cognitively. Review of the May 2017 physician's orders documented, "HumaLOG (4) KwikPen Solution Pen-injector 100 UNIT/ML (milliliter) inject as per sliding scale..."

Resident #22 was admitted to the facility on 7/8/16 and readmitted on 5/10/17 with diagnoses that included but were not limited to: muscle weakness, anemia, high blood pressure, stroke and lung disease. The most recent MDS, a quarterly assessment, with an ARD of 2/5/17 coded the resident as having a BIMS of 15 out of 15 indicating the resident was cognitively intact to make daily decisions. Review of the May 2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 143	F 441		

physician's order documented, "Divalproex Sodium (5) Tablet Delayed Release 250 MG Give 2 tablet (sic) by mouth in the evening for Bipolar Disorder."

Resident #23 was admitted to the facility on 3/22/12 and readmitted on 3/2/17 with diagnoses that included but were not limited to: anxiety, dementia with behavioral disorders and difficulty walking. The most recent MDS, a quarterly assessment, with an ARD of 3/3/17 coded the resident as having a BIMS of 14 out of 15 indicating the resident was cognitively intact to make daily decisions. Review of the May 2017 physician orders documented, "May have one glass of wine with dinner..."

Resident #24 as admitted to the facility on 3/26/13 and readmitted on 7/2/16 with diagnoses that included but were not limited to: high blood pressure, heart disease, arthritis and diabetes. The most recent MDS, a quarterly assessment, with an ARD of 2/2/17 coded the resident as having a BIMS of 15 out of 15 indicating the resident was cognitively intact to make daily decisions. Review of the May 2017 physician's orders documented, "NovoLOG Solution (Insulin ASpart) ...before meals and at bedtime for insulin coverage."

Resident #25 was admitted to the facility on 3/13/12 with diagnoses that included but were not limited to: stroke, shoulder pain, kidney disease and high blood pressure. The most recent MDS, a quarterly assessment, with an ARD of 4/12/17 coded the resident as having a BIMS of 13 out of 15 indicating the resident was cognitively intact to make daily decisions. Review of the May 2017 physician's orders documented, "Xarelto Tablet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 144	F 441		

(6) 20 MG...Give 1 tablet by mouth in the afternoon..."

Resident #26 was admitted to the facility on 8/22/16 with diagnoses that included but were not limited to: brain damage due to lack of oxygen, difficulty swallowing and muscle weakness. The most recent MDS, a quarterly assessment, with an ARD of 4/10/17 coded the resident as having short and long term memory problems and was severely impaired cognitively. Review of the May 2017 physician's orders documented, "Flush 300 ml H2O (water) via G (gastrostomy) tube q (every) 4 hours..."

Resident #12 was admitted to the facility on 4/4/13 and readmitted on 8/6/15 with diagnoses that included but were not limited to: muscle weakness, dementia, chronic pain, heart disease ad high blood pressure. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/4/17 coded the resident as having a BIMS (brief interview for mental status) as a 12 out of 15 indicating the resident was cognitively intact to make daily decisions. Review of the physician's orders dated May 2017 documented, "Tylenol Tablet 325 MG (milligrams) (Acetaminophen) Give 325 mg by mouth every four hours for Breakthrough pain. Order Date 7/14/2016."

Resident #13 was admitted to the facility on 9/16/13 and readmitted on 10/21/16 with diagnoses that included but were not limited to: high blood pressure, depression, pain and arthritis. The most recent MDS, a quarterly assessment, with an ARD of 4/30/17 coded the resident as having a BIMS of 6 out of 15 indicating the resident was severely impaired

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 145	F 441		

cognitively. Review of the May 2017 physician orders documented, "Ativan (7) 0.5 MG...Give 1 tablet by mouth every 12 hours as needed for increased anxiety."

Resident #1 was admitted to the facility on 12/23/10 with a recent readmission on 3/28/17 with diagnoses that included but were not limited to: osteoporosis, pain, anemia, psychosis, congestive heart failure, seizure disorder, anxiety disorder, insomnia, diabetes and high blood pressure. The most recent MDS (minimum data set) assessment, with an assessment reference date of 2/27/17, coded the resident as scoring a 14 on the BIMS (brief interview for mental) status score, indicating the resident was cognitively intact to make daily decisions. Review of the May 2017 physician's orders documented, "NovoLOG Solution (Insulin ASpart) ...before meals and at bedtime for insulin coverage."

No further information was provided prior to exit.

According to Fundamentals of Nursing, 5th edition, Lippincott, Williams & Wilkins, page 568, "Administering Oral Medications: Procedure - 1. Wash hands. Rationale - Reduces transfer of microorganisms from hands to medication...Prepare selected medications ...c. Medications from a bingo card: Snap the bubble containing the correct medication directly over the medication cup. Do not touch the medication."

In Fundamentals of Nursing, Lippincott Williams and Wilkins, page 140-143, concerning hand washing and the use of hand sanitizer: "The hands are conduits for almost every transfer of potential pathogens from one patient to another, from a contaminated object to the patient, or from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 146	F 441		

a staff member to the patient. Hand hygiene is the single most important procedure in preventing infection....typically hands are washed with soap before coming on duty; before and after direct or indirect patient contact;...before preparing or administering medications...always wash your hands with soap after removing gloves...when using hand sanitizer, apply a small amount of the alcohol-based hand rub to all surfaces of the hands. Rub hands together until the entire product has dried (usually about 30 seconds)."

A review of a pages 1518 - 1520 from Fundamentals of Nursing, Potter and Perry, 6th edition, the facility's standard of practice, and provided to the surveyor as part of the facility's wound care policy, revealed, in part, the following as the procedure to be followed once a clean dressing has been applied to a wound: "Remove gloves and dispose of soiled supplies. Perform hand hygiene."

(1) Parkinson's disease -- Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families. This information was obtained from:
https://medlineplus.gov/parkinsonsdisease.html

(2) Carbidopa-Levodopa -- Carbidopa and levodopa extended release tablets are indicated in the treatment of the symptoms of idiopathic Parkinson ' s disease (paralysis agitans), postencephalitic parkinsonism, and symptomatic parkinsonism which may follow injury to the nervous system by carbon monoxide intoxication and/or manganese intoxication. This information

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 147	F 441		

was obtained from:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=abff005f-23fc-4d1e-b469-88aa07589a43

(3) Novolog -- NovoLog is an insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus (1.1). This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=9636

(4) HumaLOG -- HUMALOG is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. This information was obtained from:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=C8ECBD7A-0E22-4FC7-A503-FAA58C1B6F3F

(5) Divalproex Sodium -- DIVALPROEX SODIUM is a fatty acid with anticonvulsant properties used in the treatment of epilepsy. This information was obtained from:
https://pubchem.ncbi.nlm.nih.gov/compound/divalproex_sodium#section=Top

(6) Xarelto -- XARELTO is indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation. This information was obtained from:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=10db92f9-2300-4a80-836b-673e1ae91610

(7) Ativan -- Lorazepam is a benzodiazepine used as an anti-anxiety agent with few side effects. It also has hypnotic, anticonvulsant, and considerable sedative properties and has been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 148 proposed as a preanesthetic agent. This information was obtained from: https://pubchem.ncbi.nlm.nih.gov/compound/lorazepam#section=Top	F 441		
F 507 SS=D	LAB REPORTS IN RECORD - LAB NAME/ADDRESS CFR(s): 483.50(a)(2)(iv) (a) Laboratory Services (2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to file laboratory results on the clinical record for 5 of 26 residents in the survey sample; Residents #13, #11, #5, #10, and #7. 1. For Resident #13, the facility staff failed to ensure that physician ordered CBC [1], CMP [2], C-Reactive Protein [3], and ESR [4] were maintained on the clinical record. 2. The facility staff failed to file the 5/5/17 BMP (basic metabolic panel (1)) on Resident #11's clinical record. 3. The facility staff failed to file a laboratory test result in Resident #5's clinical record. 4. The facility staff failed to file Resident #10's urinalysis (1) results (collected on 3/3/17 and	F 507	1. Laboratory results for resident #13, 11, 5, 10, and 7 are now in the clinical record. 2. All residents have the potential to be affected by this deficient practice. 3. DON and or designee(s) will in-service medical records clerk on process of uploading lab results onto the clinical record timely and accurately. 4. DON and or designee(s) will audit lab results 5x a week for 12 weeks to ensure lab results have been uploaded into the clinical record. Results of audits will be take to QAPI meeting x3 months for review and revision as needed.	6/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 149	F 507		

reported on 3/4/17) in the resident's clinical record.

5. The facility staff failed to ensure a physician ordered laboratory test result was filed in Resident # 7's clinical record.

The findings include:

1. For Resident #13, the facility staff failed to ensure that physician ordered CBC [1], CMP [2], C-Reactive Protein [3], and ESR [4] were maintained on the clinical record.

Resident #13 was admitted to the facility on 9/16/13 and readmitted on 10/21/16 with the diagnoses of but not limited to rheumatoid arthritis, high blood pressure, glaucoma, osteoporosis, pulmonary embolism, dementia, anxiety, gastrointestinal bleed, dysphagia, chronic pain, and polymyalgia rheumatica. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 4/30/17. The resident was coded as being moderately impaired in ability to make daily life decisions, scoring a 6 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting and hygiene; supervision for eating; and as incontinent of bowel and bladder.

A review of the clinical record revealed a physician's order dated 11/2/16 for a weekly CBC (complete blood count) on Wednesdays. Review of the lab (laboratory) results maintained on the clinical record revealed that the CBC for 3/1/17, 3/8/17, 3/29/17, 4/5/17, 4/26/17, 5/3/17, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 150	F 507		

5/10/17 were not in the chart.

A physician's order dated 5/6/17 documented a CBC was to be drawn on 5/12/17. Review of the lab results maintained on the clinical record revealed that the result for this CBC was not in the chart.

A physician's order dated 3/2/17 documented a CMP (complete metabolic panel), C - reactive protein, and ESR-Westergren (erythrocyte sedimentation rate) was to be drawn on 3/3/17. Review of the lab results maintained on the clinical record revealed that the results for these labs were not in the chart.

A physician's order dated 2/8/17 documented a CBC, CMP, C - reactive protein, and ESR-Westergren was to be drawn on 3/8/17. Review of the lab results maintained on the clinical record revealed that the results for these labs were not in the chart

A physician's order dated 5/4/17 documented a CBC, CMP, C - reactive protein, and ESR-Westergren was to be drawn on 5/5/17. Review of the lab results maintained on the clinical record revealed that the results for these labs were not in the chart.

On 5/17/17 at approximately 2:00 p.m., LPN #4 (Licensed Practical Nurse) was asked about the above missing laboratory test results for Resident #13. On 5/17/17 at 3:16 p.m., she provided the results for these missing labs and stated that she had them faxed over from the lab because the results were not in the building, and therefore, not available on the clinical record. When asked why the labs were not maintained on the record in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 151	F 507		

facility, LPN #4 stated that at one point in time, the fax machine that the lab faxes the results to the facility on, was not working and therefore, there may have been lab results that they never received.

A review of the facility policy, "Lab /Test Tracking Protocol" documented, "5. When the results are reported to the facility, the nurse receiving the results will immediately report any abnormal results to the physician, and document time and date reported, and if any new orders from the physician on the lab slip. The results will be placed in the physician's communication board/folder/notebook for his/her review at the next facility visit. Once lab report signed, the result will be filed in clinical record."

On 5/17/17 at 5:13 p.m., ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3 the regional director of clinical services were made aware of the findings. No further information was provided by the end of the survey.

References:

[1] According to Mosby's Medical Dictionary, sixth edition, 2002. St. Louis, MO: Mosby, Inc. Page 405, a CBC (complete blood count) is a blood test used to determine the number of red and white blood cells per cubic millimeter of blood; and is one of the most valuable screening and diagnostic techniques

[2] A comprehensive metabolic panel is a group of chemical tests performed on the blood serum (the part of blood that doesn't contain cells). These tests include total cholesterol, total protein,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 152	F 507		

and various electrolytes. Electrolytes in the body include sodium, potassium, chlorine, and many others. The rest of the tests measure chemicals that reflect liver and kidney function. This test helps provide information about your body's metabolism. It gives your doctor information about how your kidneys and liver are working, and can be used to evaluate blood sugar, cholesterol, and calcium levels, among other things. This information was obtained from the website:
<http://www.nlm.nih.gov/medlineplus/ency/article/003468.htm>

[3] The CRP (C - reactive protein) test is a general test to check for inflammation in the body. It is not a specific test. That means it can reveal that you have inflammation somewhere in your body, but it cannot pinpoint the exact location. The CRP test is often done with the ESR or sed rate test which also looks for inflammation. Information obtained from https://medlineplus.gov/ency/article/003356.htm

[4] ESR stands for erythrocyte sedimentation rate. It is commonly called a "sed rate." It is a test that indirectly measures how much inflammation is in the body.
Reasons why a "sed rate" may be done include:
" Unexplained fevers
" Certain types of arthritis
" Muscle symptoms
" Other vague symptoms that cannot be explained
This test may also be used to monitor whether an illness is responding to treatment.
This test can be used to monitor inflammatory diseases or cancer. It is not used to diagnose a specific disorder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 153	F 507		

However, the test is useful for detecting and monitoring:
" Autoimmune disorders
" Bone infections
" Certain forms of arthritis
" Inflammatory diseases that cause vague symptoms
" Tissue death
Information obtained from https://medlineplus.gov/ency/article/003638.htm

2. The facility staff failed to file the 5/5/17 BMP (basic metabolic panel (1)) on Resident #11's clinical record.

Resident #11 was admitted to the facility on 12/3/10 and readmitted on 4/20/16 with diagnoses that included but were not limited to: stroke, high blood pressure, weakness, depression, urinary tract infection and dementia.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/27/17 coded the resident as having scored 10 out of 15 on the BIMS (brief interview mental status) indicating the resident was moderately impaired cognitively to make decisions of daily living. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the May 2017 physician orders documented, "BMP one time only until 05/05/2017."

Review of the May 2017 MAR (medication administration record) documented, "BMP one time only until 05/05/2017." On 5/5/17 it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 154	F 507		

documented, "(Nurse's initials) 0615 (6:15 a.m.)." (Indicating the BMP had been obtained at 6:15 a.m.)

Review of Resident #11's clinical record did not evidence documentation of the 5/5/17 BMP laboratory results.

On 5/17/17 at 5:15 p.m. a request for the BMP laboratory results was made to ASM (administrative staff member) #2, the director of nursing.

On 5/18/17 at 8:00 a.m. a copy of the BMP laboratory report was received. Documented at the bottom of the page was, "Prepared for (Name of staff member) on 17 May 2017 16:06 (4:06 p.m.)"

On 5/18/17 at 9:40 a.m. an interview was conducted with ASM #2, the director of nursing. When asked if the laboratory report had been on Resident #11's record, ASM #2 stated that it had not. When asked if it had been faxed to the facility on 5/17/17 ASM #2 stated it had been.

No further information was provided prior to exit.

(1) BMP -- Chemistry 24 -- The basic metabolic panel (BMP) is a group of tests that measures different chemicals in the blood. These tests usually are done on the fluid (plasma) part of blood. The tests can give doctors information about your muscles (including the heart), bones, and organs, such as the kidneys and liver. This information was obtained from: https://www.nhlbi.nih.gov/health/health-topics/topics/bdt/types

3. The facility staff failed to file a laboratory test

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 155	F 507		

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 nursing, at approximately 9:30 a.m.

On 5/17/17 at 11:56 a.m. the assistant director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 156	F 507		

nursing, administrative staff member (ASM) #4 presented a copy of the laboratory test results dated 12/16/16. When asked where the test results had come from, ASM #4 stated, "We had them faxed over from the lab (laboratory)." When asked if the test results were not on the clinical record, ASM #4 stated, "That is correct."

An interview was conducted with LPN (licensed practical nurse) #5 on 5/17/17 at 11:16 a.m. When asked the process for getting the laboratory test results, LPN #5 stated, "They are faxed over to the unit. If there is a critical level, they call us." When asked how staff verify that results have been received, LPN #5 stated, "We check the order in the TAR (treatment administration record) and we check it off in the lab (laboratory) book." When asked who files the results in the clinical record, LPN #5 stated, "The evening nurse."

An interview was conducted with ASM #4 on 5/17/17 at 1:28 p.m. When asked how results are obtained for laboratory tests that are completed, ASM #4 stated, "The lab faxed the results to the fax machine. They are distributed to the nurses to follow up with the doctor." When asked who is responsible for filing them in the clinical record, ASM #4 stated, "The nurse who they are distributed to."

ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the above on 5/17/17 at 5:25 p.m.

(1) This information was obtained from the following website: https://aidsinfo.nih.gov/understanding-hiv-aids/glo

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 157 ssary/785/hyperlipidemia 4. The facility staff failed to file Resident #10's urinalysis (1) results (collected on 3/3/17 and reported on 3/4/17) in the resident's clinical record. Resident #10 was admitted to the facility on 2/22/17 and readmitted on 3/23/17. Resident #10's diagnoses included but were not limited to: seizures, liver transplant and urinary tract infection. Resident #10's significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 3/30/17, coded the resident's cognitive skills for daily decision making as severely impaired. Review of Resident #10's electronic clinical record revealed a physician's order dated 3/2/17 for a urinalysis. Further review of the resident's clinical record failed to reveal the results of the urinalysis. There was no paper clinical record for Resident #10. On 5/16/17 at 3:50 p.m., ASM (administrative staff member) #4 (the assistant director of nursing) presented Resident #10's urinalysis results that were collected on 3/3/17 and reported on 3/4/17. The bottom of the report documented the report was prepared by ASM #4 on 5/16/17 at 3:28 p.m. On 5/17/17 at 7:52 a.m., an interview was conducted with OSM (other staff member) #4 (the medical records employee). OSM #4 stated she began employment in March 2017 and ASM (administrative staff member) #2 (the director of nursing) wanted to go paperless so she went through all the paper charts beginning with	F 507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 158	F 507		

residents on the first floor. OSM #4 stated once she gets a paper chart, she goes through the chart and separates it by how it should be logged into the computer. OSM #4 stated Resident #10 no longer had a paper chart and all documents were scanned into the computer during the previous week or the week before. OSM #4 stated she tries to scan documents into the electronic clinical record the same day she receives the documents or the next day. OSM #4 stated a few employees at the front desk assist her with scanning documents into the clinical record.

On 5/17/17 at 8:23 a.m., an interview was conducted with ASM #2 (the director of nursing) and ASM #4. ASM #4 confirmed the urinalysis results were obtained from the laboratory website. ASM #2 and ASM #4 were asked if the results were filed in the clinical record. ASM #2 stated, "They are in the process of that. We are still scanning things in to go that way."

On 5/17/17 at 5:30 p.m. ASM #1 (the administrator), ASM #2 and ASM #3 (the regional director of clinical services) were made aware of the above findings. ASM #2 stated Resident #10 still had a paper chart but the record was not accessible on the unit.

On 5/18/17 at 8:07 a.m. ASM #2 confirmed Resident #10 had no paper clinical record on the unit.

No further information was presented prior to exit.

(1) "A urinalysis is a test of your urine. It is often done to check for a urinary tract infections, kidney problems, or diabetes..." This information was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 159	F 507		

obtained from the website:
https://medlineplus.gov/urinalysis.html

5. The facility staff failed to ensure a physician ordered laboratory test result was filed in Resident # 7's clinical record.

Resident # 7 was admitted to the facility on 05/01/14 with diagnoses that included but were not limited to: encephalopathy (1), muscle weakness, depression, aphasia (2), dementia (3), hypertension (4), gastroesophageal reflux disease (5), dysphagia (6) and peripheral vascular disease (7).

Resident # 7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/22/17, coded Resident # 7 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 being cognitively intact for making daily decisions. Resident # 7 was coded as requiring supervision with set up help for activities of daily living.

Review of the POS (physician order sheet) dated May 2017 documented, "BMP (Basic Metabolic Panel [8]) 03/13/2017 and Q (every) 6 (six) months in the morning every 6 months(s) starting on the 13th for 1 (one) day(s)."

Review of Resident #7's clinical record failed to evidence the results of a BMP laboratory test for March 2017.

On 05/17/17 at 11:50 a.m. ASM # 4, the assistant director of nursing provided this surveyor with a copy of the BMP laboratory test results for Resident # 7. When asked where the laboratory

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 160	F 507		

test results were obtained from, ASM # 4 stated, "They were faxed from the lab (laboratory); they were not in the clinical record."

On 05/17/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:

1. A term for any diffuse disease of the brain that alters brain function or structure. This information was obtained from the website: http://www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm.

2. A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html.

3. A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html.

4. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

5. Stomach contents to leak back, or reflux, into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 161 the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. 6. A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. 7. The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html. 8. The basic metabolic panel is a group of blood tests that provides information about your body's metabolism. This information was obtained from the website: https://medlineplus.gov/ency/article/003462.htm.	F 507		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 514		6/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 162 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of 26 residents in the survey sample, Residents #14 and #3. 1. The facility staff failed to document Resident #14's physician's response to a pharmacy warning regarding a drug interaction between the medications ranolazine (chest pain medication) and verapamil (blood pressure medication).	F 514	1. Resident #14 no longer resides in the facility and her record is closed. Resident #3 clinical record has been reviewed and other residents information removed. 2. All residents have the potential to be affected by this deficient practice. 3. DON and or designee(s) will in-service licensed nurses, medical records clerk on HIPPA and required documentation in the medical record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 163 2. The facility staff filed another resident's clinical information in Resident #3's clinical record. The findings include: 1. The facility staff failed to document Resident #14's physician's response to a pharmacy warning regarding a drug interaction between the medications ranolazine (1) and verapamil (2). 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 (3), high blood pressure and major depressive disorder. Resident #14's five day Medicare assessment with an ARD (assessment reference date) of 2/14/17 coded the resident as being cognitively intact. Review of Resident #14's clinical record revealed a physician's order dated 2/7/17 for ranolazine 1000 mg (milligrams) by mouth twice a day for angina (chest pain) and a physician's order dated 2/7/17 for verapamil 120 mg by mouth at bedtime for high blood pressure. A nurse's note dated 2/8/17 documented, "Ranolazine ER (Extended Release) Tablet Extended Release 12 Hour 1000 MG (milligrams); Give 1 tablet by mouth two times a day for angina; pharmacy said ranolazine and verapamil could not be given together in high dose of 1000 mgs (milligrams). md (medical doctor) notified. Further review of Resident #14's clinical record failed to reveal the physician's response regarding the pharmacy warning documented in the above nurse's note.	F 514	4. DON and or designee(s) will audit 5 resident medical records weekly for 4 weeks and then monthly for 2 months to ensure accuracy of the medical record. Results of audits will be taken to QAPI committee x3 months for review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 164 On 5/17/17 at 3:05 p.m. an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if a physician's response to a pharmacy concern should be documented in the clinical record. LPN #1 stated the nurse should document that the pharmacy informed him/her of a possible drug interaction, the name of the medications and that the physician was notified. LPN #1 stated the nurse should also document if the physician said it was okay to give the medications or if not, document the name of the medications that were discontinued and document the new orders. The pharmacy "Grid Notes" obtained from the pharmacy and presented by ASM (administrative staff member) #2 (the director of nursing) on 5/17/17 at 3:34 p.m. documented: "ranexa (ranolazine) - level 1 interaction with verapamil...02/07/2017 9:44:02 PM (9:44 p.m.)... s/w (spoke with) (name of nurse who documented the above note) she will clarify with md...02/08/2017 1:02:07 PM (1:02 p.m.)... STAT (immediately) - PER (name of another nurse) PT (patient) OK TO TAKE RANEXA PLEASE SEND STAT...02/08/2017 7:10:41 PM (7:10 p.m.)..." On 5/17/17 at 5:30 p.m., ASM #1 (the administrator), ASM #2 and ASM #3 (the regional director of clinical services) were made aware of the above findings. The facility pharmacy policy titled, "Physician/Prescriber Authorization and Communication of Orders to Pharmacy" documented, "6. Pharmacy may contact Facility staff via fax or telephone before dispensing a	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 165	F 514		

medication when the pharmacist believes that there is a need to clarify the medication order because the order is unclear, incomplete or vague, contraindicated, or has a drug-drug interaction. 6.1 Facility staff should check the fax machine(s) for any pharmacy communication. 6.2 Pharmacy will hold medication orders until Physician/Prescriber is able to clarify the order. 6.3 Facility should contact Physician/Prescriber when staff is notified by Pharmacy of an order requiring clarification. 6.4 Facility should explain the issue to the Physician/Prescriber document the clarification and document any new orders received..."

No further information was presented prior to exit.

(1) "Ranolazine is used alone or with other medications to treat chronic angina (ongoing chest pain or pressure that is felt when the heart does not get enough oxygen)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a606015.html

(2) "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.html

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 166	F 514		

2. The facility staff filed another resident's clinical information in Resident #3's clinical record.

Resident #3 was admitted to the facility on 7/1/16 with diagnoses that included but were not limited to: arthritis, falls, high blood pressure and dementia.

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.

Review of the 3/30/17 IDT (interdisciplinary team) note documented clinical information about another resident.

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 note, LPN #4 stated, "Oh, it's not on the right resident." When asked if there was any concern about having the wrong resident's information in the clinical record, LPN #4 stated, "Yeah, it's the wrong person should have been struck out. We want what's pertinent to the resident. We don't want someone reading through too quickly and thinking it applies to her when it doesn't. It's a HIPPA (1) thing."

An interview was conducted on 5/17/17 at 1:15 p.m. with RN (registered nurse) #5, the unit manager. When asked to review the 3/30/17 IDT note on Resident #3's record, RN #5 stated, "It's the wrong person. Besides being a privacy issue

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 167 it's incorrect documentation." The nurse who wrote the note was no longer employed at the facility and could not be interviewed. On 5/17/17/at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. (1) HIPPA -- Health Insurance Portability and Accountability Act (HIPAA) This information was obtained from: https://www.ihs.gov/hipaa	F 514		