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 07/19/2018

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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/17/18 through 7/19/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence documentation that the written emergency plan included services the facility would be able to provide during an emergency, how the facility plans to continue operations during an emergency, and delegations of authority and succession plans. The findings include:	E 007	Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. E007 1. Emergency Operations Plan (EOP) and Facility Assessment (FA) is updated to reflect specific at risk populations and actions to take in the event of an emergency.	8/10/18

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

Electronically Signed | 08/10/2018

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 07/19/2018

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
E 007	Continued From page 1 On 7/18/18 at approximately 9:30 a.m., a review and interview of the facility's emergency preparedness plan was conducted with ASM #1 (Administrative Staff Member, the Administrator) and OSM #1 (other staff member, the director of maintenance.) Review of the facility's emergency preparedness plan failed to evidence documentation that the written emergency plan included documentation of the patient populations that would be at risk. On 7/18/18 at 9:36 a.m., ASM #1 stated, "we have it in pieces but it isn't comprehensive in a single location." No evidence was provided that specified the current patient population that would be at risk. No further information was provided prior to exit.	E 007	2. All residents have potential to be affected. 3. DON/ designee will identify at risk residents by reviewing diagnosis and care plan of newly admitted residents. NHA/ designee reviews updates FA/ EOP as needed based on changes to resident population or acuity to ensure at risk residents are identified and appropriate actions planned. Staff educated by Administrator/ designee. Education will include orientation for new employees. 4. NHA/ designee will review resident diagnosis, FA, and EOP to ensure alignment 3X/wk for 4 weeks, 2X/wk for 4 weeks and weekly for 4 weeks. Review in QAPI x 3months. 5. 8/15/18	
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and	E 020		8/10/18

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 07/19/2018

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
E 020	Continued From page 2 primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for a safe evacuation from the facility that included care and treatment needs of	E 020	E020 1. Emergency Operations Plan (EOP) and Facility Assessment (FA) is updated to reflect at risk populations and actions to take in the event of an evacuation. 2. All residents have potential to be affected.	

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 07/19/2018

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
E 020	Continued From page 3 evacuees, staff responsibilities, transportation, identification of evacuation location(s), and primary and alternate means of communication with external sources of assistance. The findings include: On 7/18/18 at approximately 9:30 a.m., a review and interview of the facility's emergency preparedness plan was conducted with ASM #1 (Administrative Staff Member, the Administrator) and OSM #1 (other staff member, the director of maintenance.) Review of the facility's emergency preparedness plan failed to evidence policies and procedures for a safe evacuation from the facility that included care and treatment needs of evacuees and staff responsibilities. On 7/18/18 at 10:03 a.m., ASM #1 stated, "we don't have it. It just says to be cognizant of the care needs, without going into it." No further information was provided prior to exit.	E 020	3. DON/ designee will identify at risk residents by reviewing diagnosis and care plan of newly admitted residents. NHA/ designee reviews updates FA/ EOP as needed based on changes to resident population or acuity to ensure at risk residents are identified and appropriate actions planned for an evacuation. Staff educated by Administrator/ designee. Education will include orientation for new employees. 4. NHA/designee will review resident diagnosis, FA, and EOP to ensure alignment 3X/wk for 4 weeks, 2X/wk for 4 weeks and weekly for 4 weeks. Review QAPI x 3 months. 5. 8/15/18	
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies.	E 032		8/10/18

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 07/19/2018

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
E 032	Continued From page 4 *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, and local emergency management agencies by reviewing the communication plan. The findings include: On 7/18/18 at approximately 9:30 a.m., a review and interview of the facility's emergency preparedness plan was conducted with ASM #1 (Administrative Staff Member, the Administrator) and OSM #1 (other staff member, the director of maintenance.) Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, and local emergency management agencies by reviewing the communication plan. On 7/18/18 at 10:30 a.m., ASM #1 stated, "we have the MedComm 2 Radio, but it is not identified in the plan." No further information was provided prior to exit.	E 032	E032 1. Emergency Operations Plan (EOP) is updated to reflect MEDCOMM 2 radio as an alternate means of communication and specific actions to take in the event of an emergency. 2. All residents in the facility have potential to be affected. 3. NHA/ designee updated EOP to reflect MEDCOMM 2 radio as an alternate means of communication. Staff educated by Administrator/ designee. Education will include orientation for new employees. 4. NHA/designee reviews EOP at each facility location to ensure it is updated on 8/9/18. Review QAPI x 3 months. 5. 8/15/18	

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 07/19/2018

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	Continued From page 5	F 000		
F 000	INITIAL COMMENTS	F 000		
	An unannounced Medicare/Medicaid survey was conducted from 07/17/18 through 07/19/18. Three complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 of the Federal Long Term Care requirements. The life safety code survey/report will follow. The census at this 90 certified bed facility was 82 at the time of the survey. The survey sample consisted of 26 current residents, (Resident #s 71, 43, 34, 54, 51, 45, 63, 33, 69, 66, 37, 21, 44, 48, 286, 38, 36, 35, 19, 82, 76, 131, 67, 57, 331, 184) and five closed records, (Residents #s 334, 500, 81, 282 and 283).			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and	F 622		8/10/18

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 07/19/2018

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 622	Continued From page 6	F 622		

appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot

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 07/19/2018

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 622	Continued From page 7 be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. 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 evidence that all required documentation was provided to the receiving facility for three of 31 residents in the survey sample; Resident #82, Resident # 43, and Resident # 44. 1. The facility staff failed to evidence all required documentation was sent to the receiving facility; and failed to evidence physician documentation	F 622	Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F622 1. Resident # 82 discharged on 05/04/18 with no return. Resident # 43 re-admitted on 06/18/18 with no further discharges. Resident # 44 re-admitted on 05/24/18	

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 07/19/2018

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 622	Continued From page 8 regarding the transfers, for resident #82's facility initiated transfer to the hospital on 4/8/18 and 5/4/18. 2. The facility staff failed to provide documented evidence that the comprehensive care plan goals were provided to the receiving facility for Resident # 43 on 6/16/18. 3. The facility staff failed to provide documented evidence that the comprehensive care plan goals were provided to the receiving facility for Resident # 44 on 5/18/18. The findings include: 1. The facility staff failed to evidence all required documentation was sent to the receiving facility; and failed to evidence physician documentation regarding the transfers, for resident #82's facility initiated transfer to the hospital on 4/8/18 and 5/4/18. Resident #82 was admitted to the facility on 3/21/18 and discharged to the hospital on 5/4/18. The resident had the diagnoses of but not limited to anemia, high blood pressure, heart failure, diabetes, dysphagia, pulmonary embolism, stroke, morbid obesity, pneumonia, bipolar disorder, and hemorrhage of anus and rectum. The most recent MDS (Minimum Data Set) was a 14 day assessment status/post re-entry, with an ARD (Assessment Reference Date) of 4/28/18. The resident was coded as cognitively intact in ability to make daily life decisions. A review of the clinical record revealed the following in the nurse's notes: 4/8/18 at 2:58	F 622	with no further discharges. 2. Any resident being discharged has the potential to be affected. 3. A discharge packet with a checklist of required documents will be used for licensed nurses to check off (is completed when sending a resident to the hospital). Licensed nurses have been educated on the process for discharge by DON/ADON. Education will include orientation for new employees. 4. DON/ designee will audit residents who discharge 5x/ week for 4 weeks, then 3x/ week for 8 weeks for proper documentation. Results will be reviewed in QAPI every month x 3. 5. 08/15/18	

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 07/19/2018

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 622	Continued From page 9	F 622		

p.m.: "Sent pt (patient) to er (emergency room) per family request for aphasia, weakness, pale, and ams (altered mental status). This nurse did a UA {1} (urinalysis)...was unable to draw blood per poor veins. Md (medical doctor) and rp (responsible party) aware."

Further review of the clinical record revealed a "Nursing Home to Hospital Transfer Form" for the facility initiated transfer of Resident #82 on 4/8/18. Review of the form revealed it did not include information for Resident #82's current medications or comprehensive care plan goals.

A review of the "eInteract [electronic interact]" forms and "SBAR [situation, background, assessment, recommendation] Communication Form" completed by the facility reiterated much of the above information but did not include comprehensive care plan goals or the current medication list.

There was no physician documentation regarding why the resident's condition could not be treated at the facility and the reason Resident #82 was transferred to the hospital on 4/8/18.

A review of the clinical record revealed the following in the nurse's notes: 5/4/18 at 12:41 p.m.: "...Change in condition...abnormal labs (laboratory tests) per PCP (primary care physician). This started on 5/4/18...." 5/4/18 at 1:29 p.m.: "Daughter in around lunchtime to inform the staff that the PCP (name of PCP, which was not a facility physician), is requesting the resident be sent to (name of hospital) for direct admit due to impaired renal function. Facility MD notified, OK to transfer to (hospital).

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 07/19/2018

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 622	Continued From page 10	F 622		

(Name of ambulance company) called to transport resident. Daughter to accompany."

Review of the clinical record and the "Nursing Home to Hospital Transfer Form" for the above facility initiated transfer on 5/4/18, revealed the "Nursing Home to Hospital Transfer Form" failed to include information regarding Resident #82's current medications or comprehensive care plan goals.

A review of the "eInteract [electronic interact]" forms and "SBAR [situation, background, assessment, recommendation] Communication Form" completed by the facility reiterated much of the above information did not include care plan goals or the current medication list.

There was no physician documentation regarding why the resident's condition could not be treated at the facility and the reason Resident #82 was transferred to the hospital on 5/4/18.

On 7/18/18 at 2:45 p.m., in an interview with LPN #2 (Licensed Practical Nurse), she stated that staff should send the face sheet, medication list, usually a history and physical, depending what they are going for if there are any relevant labs. LPN #2 stated they print out the transfer form and the SBAR and send it. LPN #2 stated these forms do not include comprehensive care plan goals. LPN #2 stated the information that is sent to the hospital isn't documented.

On 7/18/18 at 2:58 p.m., the Director of Nursing (ASM #2 - Administrative Staff Member) was notified of the concern. ASM #2 stated, "you are correct, these pieces were not done."

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 07/19/2018

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 622	Continued From page 11	F 622		

No further information was provided.

A review of the facility policy "Discharge Planning Policy" documented, "....Documentation Requirements for Involuntary / Unplanned Discharge...When (facility) transfers or discharges a resident for any circumstance, the discharge/transfer must meet the regulatory requirements for transfer/discharge. The facility will take steps to ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.....a. Documentation in the resident's medical record must include: The basis for the transfer or discharge per the regulation (483.15(c)). If the basis is because it is necessary for the resident's welfare and the resident's needs cannot be met in the facility, then the following must be documented: i) the specific resident need(s) that cannot be met, ii) facility attempts to meet the resident needs, iii) the service(s) available at the receiving facility to meet the need(s) b. Designation of Which Physician Must Document: The documentation required above must be made by: The resident's physician when transfer or discharge is necessary because it is necessary for the resident's welfare and the resident's needs cannot be met in the facility.....6. Information to the Receiving Provider. Information provided to the receiving provider must include a minimum of the following: a. Contact information of the practitioner responsible for the care of the resident. b. Resident representative information including contact information. c. Advance Directive information. d. All special instructions or precautions for ongoing care, as appropriate. e.

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 07/19/2018

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 622	Continued From page 12	F 622		

Comprehensive care plan goals. f. All other necessary information, including a copy of the residents discharge summary, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care."

{1} Urinalysis (UA) - A urinalysis is a test of your urine. It is often done to check for a urinary tract infections, kidney problems, or diabetes. You may also have one during a checkup, if you are admitted to the hospital, before you have surgery, or if you are pregnant. It can also monitor some medical conditions and treatments.
Information obtained from https://medlineplus.gov/urinalysis.html

2. The facility staff failed to provide documented evidence that the comprehensive care plan goals were provided to the receiving facility for Resident # 43 on 6/16/18.

Resident #43 was admitted to the facility on 3/18/18 with a most recent readmission on 6/18/18, with diagnoses that included but were not limited to: high blood pressure, history of a stroke, difficulty speaking, difficulty swallowing, diabetes, and difficulty walking.

The most recent MDS (minimum data set) assessment, a quarterly review assessment, with an assessment reference date of 6/15/18, coded the resident as having short and long term memory problems, as well as severely impaired cognitive skills for daily decision making.

The physician's order dated 6/16/18, documented in part, "Send to [hospital's name] ED (emergency department) for evaluation."

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 07/19/2018

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 622	Continued From page 13	F 622		

The nurse's note dated 6/16/18 at 5:32 p.m. documented in part, "Resident unresponsive [sic] Resident has decreased level of consciousness [sic] Resident noted to have seizure ...Reported to primary care clinician: [name of physician's group] on 6/16/18 5:00 PM ...Orders obtained ...Send to ED to get evaluated."

Review of the clinical record failed to evidence physician documentation of the reason for transfer, as well as documentation that the resident's comprehensive care plan goals were included in the resident's transfer documentation provided to the receiving hospital.

An interview was conducted on 7/19/18 at 8:40 a.m. with LPN, licensed practical nurse, #1, unit manager. LPN #1 was asked to describe the process staff follows when transferring a resident to the hospital. LPN #1 stated they first obtain a physician's order and notify the Responsible Representative. They then complete the transfer forms, print paperwork including medications, code status, and any pertinent laboratory reports. When asked if the resident's comprehensive care plan or comprehensive care plan goals were sent with transfer documentation, LPN#1 stated, "No."

An interview was conducted on 7/19/18 at 11:55 a.m. with ASM (administrative staff member), #2, the director of nursing. When asked if the comprehensive care plan or care plan goals were sent with the residents to the receiving facility she stated, "No."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, and LPN #1 where made aware of the above

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 07/19/2018

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 622	Continued From page 14	F 622		

concerns on 7/19/18 at 12:00 p.m.

No further information was provided prior to exit.

3. The facility staff failed to provide documented evidence that care plan goals were provided to the receiving facility for Resident # 44 on 5/18/18.

Resident #44 was admitted to the facility on 2/28/18 with a most recent readmission on 5/24/18, with diagnoses that included but were not limited to: high blood pressure, stroke, difficulty speaking, right sided weakness, and psychosis (a severe mental disorder that cause abnormal thinking and perceptions) (1).

The most recent MDS (minimum data set) assessment, a quarterly review assessment, with an assessment reference date of 6/7/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she has severe cognitive impairment of daily decision making.

The physician's order dated 5/18/18, documented in part, "Send to ER (emergency room) for evaluation of AMS (altered mental status)." (Confusion) (2).

The nurse's note dated 5/18/18 at 1:56 p.m. documented in part, "Resident has increased confusion [sic] Resident has new or worsened delusion or hallucination ...Reported to primary care clinician: [name of physician] on 5/18/18 2:00 PM ...Orders obtained ...Send to ER for eval [evaluation]."

Review of the clinical record failed to evidence

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 07/19/2018

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 622	Continued From page 15	F 622		

that the resident's comprehensive care plan goals were included in the resident's transfer documentation.

An interview was conducted on 7/19/18 at 8:40 a.m. with LPN, licensed practical nurse, #1, unit manager. LPN #1 was asked to describe the process staff follows when transferring a resident to the hospital. LPN #1 stated they first obtain a physician's order and notify the Responsible Representative. They then complete the transfer forms, print paperwork including medications, code status, and any pertinent laboratory reports. When asked if the resident's care plan or care plan goals were sent with transfer documentation, LPN#1 stated, "No."

An interview was conducted on 7/19/18 at 11:55 a.m. with ASM (administrative staff member), #2, the director of nursing. When asked if the care plan or care plan goals were sent with the residents to the receiving facility she stated, "No."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, and LPN #1 where made aware of the above concerns on 7/19/18 at 12:00 p.m.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/psychoticdisorders.html

2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003205.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 07/19/2018

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 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		8/10/18

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 07/19/2018

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 623	Continued From page 17 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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 07/19/2018

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 623	Continued From page 18 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide written notification of a facility initiated transfer for two of 31 residents in the survey sample, Residents #43 and #44. 1. The facility staff failed to provide written notice to Resident/Responsible Representative and the Ombudsman of a facility initiated transfer to hospital for Resident #43 on 6/16/18. 2. The facility staff failed to provide written notice to Resident/Responsible Representative and the Ombudsman of a facility initiated transfer to hospital for Resident #44 on 5/18/18. The findings include: 1. Resident #43 was admitted to the facility on 3/18/18 with a most recent readmission on 6	F 623	F623 1. Resident # 43 and resident # 44 transfer information was faxed to the Ombudsman on 08/01/18 by Social Services. 2. Any resident being discharged has the potential to be affected. Audit of discharges for the past 30 days revealed transfer information was faxed on 08/01/18. 3. Report of all residents discharged in the previous 30 days will be run in point click care by Social Services at the beginning of each month. Social Service personnel have been educated by DON on sending facility initiated transfer info to Ombudsman. Education will include orientation for new employees. 4. List of transfers will be reviewed by Administrator/ designee 5x/ week for 4 weeks, then 3x/ week for 8 weeks.	

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 07/19/2018

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 623	Continued From page 19 /18/18, with diagnoses that included but were not limited to: high blood pressure, history of a stroke, difficulty speaking, difficulty swallowing, diabetes, and difficulty walking. The most recent MDS (minimum data set) assessment, a quarterly review assessment, with an assessment reference date of 6/15/18, coded the resident as having short and long term memory problems, as well as severely impaired cognitive skills for daily decision making. The physician's order dated 6/16/18, documented in part, "Send to [hospital's name] ED (emergency department) for evaluation." The nurse's note dated 6/16/18 at 5:32 p.m. documented in part, "Resident unresponsive [sic] Resident has decreased level of consciousness [sic] Resident noted to have seizure ...Reported to primary care clinician: [name of physician's group] on 6/16/18 5:00 PM ...Orders obtained ...Send to ED to get evaluated." An interview was conducted on 7/19/18 at 8:40 a.m. with LPN, licensed practical nurse, #1, unit manager. LPN #1 was asked to describe the process staff follows when transferring a resident to the hospital. LPN #1 stated they first obtain a physician's order and notify the Responsible Representative. They then complete the transfer forms, print paperwork including medications, code status, and any pertinent laboratory reports. When asked who is responsible for providing written notification to the responsible representative and the Ombudsman for the transfer of the resident to the hospital, LPN #1 stated, "Nursing does not but I believe social services handles that."	F 623	Review in QAPI x 3 months. 5. 08/15/18	

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 07/19/2018

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 623	Continued From page 20	F 623		

An interview was conducted with OSM, (other staff member), #4, social services, on 7/19/18 at 10:30 a.m. OSM #4 was asked who was responsible for notifying representative/responsible representative of a resident's transfer to the hospital. OSM #4 replied that it was the director of social services responsibility to notify the ombudsman, however the director had quit a few weeks ago, so it was probably her responsibility now. When asked if she could verify that the Ombudsman was contacted regarding Resident #43's transfer, OSM #4 stated she would check to see if the Ombudsman had received notification from the previous director. When asked if she notified the family in writing regarding transfers to the hospital, OSM #4 stated "No."

On 7/19/18 at 10:45 a.m., OSM #4 stated that she spoke with the Ombudsman and notification of transfers were only received for transfers that occurred during the following months: December 2017, January 2018 and March 2018. OSM #4 confirmed that there was no evidence of written notification to either the responsible representative or the Ombudsman in regards to Resident #43's transfer to the hospital on 6/16/18.

An interview was conducted on 7/19/18 at 11:55 a.m. with ASM (administrative staff member), #2, the director of nursing. When asked about the notification process to the responsible representative and Ombudsman, ASM #2 stated that they were in the process of updating their transfer policies to include notification to 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 07/19/2018

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 623	Continued From page 21	F 623		

responsible representative and the Ombudsman.

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, and LPN #1 where made aware of the above concerns on 7/19/18 at 12:00 p.m.

No further information was provided prior to exit.

2. The facility staff failed to provide written notice to Resident/Responsible Representative and the Ombudsman of a facility initiated transfer to hospital for Resident #44 on 5/18/18.

Resident #44 was admitted to the facility on 2/28/18 with a most recent readmission on 5/24/18, with diagnoses that included but were not limited to: high blood pressure, stroke, difficulty speaking, right sided weakness, and psychosis (a severe mental disorder that cause abnormal thinking and perceptions) (1).

The most recent MDS (minimum data set) assessment, a quarterly review assessment, with an assessment reference date of 6/7/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she has severe cognitive impairment of daily decision making.

The physician's order dated 5/18/18, documented in part, "Send to ER (emergency room) for evaluation of AMS (altered mental status)." (Confusion) (2).

The nurse's note dated 5/18/18 at 1:56 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 07/19/2018

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 623	Continued From page 22	F 623		

documented in part, "Resident has increased confusion [sic] Resident has new or worsened delusion or hallucination ...Reported to primary care clinician: [name of physician] on 5/18/18 2:00 PM ...Orders obtained ...Send to ER for eval [evaluation]."

An interview was conducted on 7/19/18 at 8:40 a.m. with LPN, licensed practical nurse, #1, unit manager. LPN #1 was asked to describe the process staff follows when transferring a resident to the hospital. LPN #1 stated they first obtain a physician's order and notify the Responsible Representative. They then complete the transfer forms, print paperwork including medications, code status, and any pertinent laboratory reports. When asked who is responsible for providing written notification to the responsible representative and the Ombudsman of the transfer of the resident to the hospital, LPN #1 stated, "Nursing does not but I believe social services handles that."

An interview was conducted with OSM, (other staff member), #4, social services, on 7/19/18 at 10:30 a.m. OSM #4 was asked who was responsible for notifying representative/responsible representative of a resident's transfer to the hospital. OSM #4 replied that it was the director of social services responsibility to notify the ombudsman, however the director had quit a few weeks ago, so it was probably her responsibility now. When asked if she could verify that the Ombudsman was contacted regarding Resident #43's transfer, OSM #4 stated she would check to see if the Ombudsman had received notification from the previous director. When asked if she notified 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 07/19/2018

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 623	Continued From page 23	F 623		

family in writing regarding transfers to the hospital, OSM #4 stated "No."

On 7/19/18 at 10:45 a.m., OSM #4 stated that she spoke with the Ombudsman and that notification of transfers were only received for transfers that occurred during the following months: December 2017, January 2018 and March 2018. OSM #4 confirmed that there was no evidence of written notification to either the responsible representative or the Ombudsman in regards to Resident #44's transfer to the hospital on 5/18/18.

An interview was conducted on 7/19/18 at 11:55 a.m. with ASM (administrative staff member), #2, the director of nursing. When asked about the notification process to the responsible representative and Ombudsman, ASM #2 stated that they were in the process of updating their transfer policies to include notification to the responsible representative and the Ombudsman.

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, and LPN #1 where made aware of the above concerns on 7/19/18 at 12:00 p.m.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/psychoticdisorders.html

2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003205.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 07/19/2018

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 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. 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 evidence that the resident was prepared and oriented for a hospital transfer for one of 31 residents in the survey sample; Resident #82. The facility staff failed to evidence Resident #82 was prepared and oriented for a hospital transfer to the hospital on 4/8/18 and 5/4/18. The findings include: The facility staff failed to evidence Resident #82 was prepared and oriented for a hospital transfer to the hospital on 4/8/18 and 5/4/18. Resident #82 was admitted to the facility on 3/21/18 and discharged to the hospital on 5/4/18. The resident had the diagnoses of but not limited to anemia, high blood pressure, heart failure, diabetes, dysphagia, pulmonary embolism, stroke, morbid obesity, pneumonia, bipolar disorder, and hemorrhage of anus and rectum. The most recent MDS (Minimum Data Set) was a 14 day assessment status/post re-entry, with an	F 624	F624 1. Resident # 82 was discharged on 05/04/18 and has not returned. 2. Any resident being discharged has the potential to be affected. 3. A discharge packet with a checklist of required documents will be used for licensed nurses to check off (is completed when sending a resident to the hospital). Licensed nurses have been educated on this requirement by DON/ designee. Education will include orientation for new employees. 4. DON/ designee will audit residents who discharge 5x/ week for 4 weeks, then 3x/ week for 8 weeks for proper documentation. Results will be reviewed in QAPI every month x 3. 5. 08/15/18	8/10/18

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 07/19/2018

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 624	Continued From page 25	F 624		

ARD (Assessment Reference Date) of 4/28/18. The resident was cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed the following in the nurse's notes:
- on 4/8/18 at 12:11 p.m.: "...Change in condition....Altered mental status...weakness and pale....Resident has increased confusion....resident has memory loss....Pt is pale in appearance, shaky, aphasia, excessive thirst, weakness, hard time following directions...."

- 4/8/18 at 2:58 p.m.: "Sent pt (patient) to er (emergency room) per family request for aphasia, weakness, pale, and ams (altered mental status). This nurse did a UA {1} (urinalysis)....was unable to draw blood per poor veins. Md (medical doctor) and rp (responsible party) aware."

Further review of the clinical record revealed the "Nursing Home to Hospital Transfer Form" which documented the following:
- Resident's name, date of birth, primary diagnoses, contact person, where the resident was being sent to, who to call at the nursing home with any questions, the primary care physician, code status, key clinical information (vital signs were documented), usual mental status (alert and oriented), usual functional status (ambulates only with assistance), additional clinical information (acute change in condition note included, other clinical notes included), devices and treatments (oxygen), isolation precautions, allergies, risk alerts (none of the areas were marked - areas included falls, pressure ulcers, aspiration, seizures, restraints, swallowing precautions, etc.), personal

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 07/19/2018

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 624	Continued From page 26	F 624		

belongings, conditions under which the resident would be accepted back at the nursing home, additional information to be included on a second page (box left unchecked). Page 2 of this document included information for family and other social issues (marked na - not applicable), behavioral issues (na), treatments and frequency (na), Primary goals of care at time of transfer (Rehabilitation and/or Medical Therapy with intent of returning home was checked - this was not inclusive of care plan goals), diet, skin/wound (na), Physical Rehabilitation Therapy, ADLs (activities of daily living), Impairments - General (nothing checked), Impairments - Musculoskeletal (nothing checked), continence (bowel and bladder checked), Additional Relevant Information (pt is pale, weakness, aphasia, pt did not eat breakfast or lunch, pt has excessive thirst - was written on the line).

A review of the "eInteract [electronic interactive]" forms and "SBAR [situation, background, assessment, recommendation] Communication Form" completed by the facility reiterated much of the above information.

The above forms and nurses notes failed to evidence documentation that the resident was prepared and oriented for the transfer on 4/8/18.

Further review of the clinical record revealed the following in the nurse's notes: 5/4/18 at 12:41 p.m.: "...Change in condition....abnormal labs per PCP (primary care physician). This started on 5/4/18...." 5/4/18 at 1:29 p.m.: "Daughter in around lunchtime to inform the staff that the PCP (name of PCP, which was not a facility physician), is requesting the resident be sent to (name of hospital) for direct admit due to impaired renal

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 07/19/2018

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 624	Continued From page 27	F 624		

function. Facility MD notified, OK to transfer to (hospital). (Name of ambulance company) called to transport resident. Daughter to accompany."

Further review of the clinical record revealed the "Nursing Home to Hospital Transfer Form" which documented the following:

- Resident's name, date of birth, primary diagnoses, contact person, where the resident was being sent to, who to call at the nursing home with any questions, the primary care physician, code status, key clinical information (vital signs were documented, as well as the statement "Abnormal Other lab value or study...abnormal kidney function from PCP - direct admit"), usual mental status (alert and oriented), usual functional status (ambulates only with assistance), additional clinical information (acute change in condition note included), devices and treatments (nothing marked), isolation precautions, allergies, risk alerts (falls were marked - areas included falls, pressure ulcers, aspiration, seizures, restraints, swallowing precautions, etc.), personal belongings, conditions under which the resident would be accepted back at the nursing home, additional information to be included on a second page (box left unchecked). Page 2 of this document included information for family and other social issues (left blank), behavioral issues (left blank), treatments and frequency (left blank), Primary goals of care at time of transfer (Rehabilitation and/or Medical Therapy with intent of returning home was checked - this was not inclusive of care plan goals), diet, skin/wound (left blank), Physical Rehabilitation Therapy, ADLs (activities of daily living), Impairments - General (nothing checked), Impairments - Musculoskeletal

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 07/19/2018

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 624	Continued From page 28	F 624		

(nothing checked), continence (bowel and bladder checked), Additional Relevant Information (nothing added).

A review of the "eInteract" forms and "SBAR Communication Form" completed by the facility reiterated much of the above information.

The above forms and nurses notes failed to evidence documentation that the resident was prepared and oriented for the transfer on 5/4/18.

On 7/18/18 at 2:45 p.m., in an interview with LPN #2 (Licensed Practical Nurse), she stated that staff should prepare and orient the resident for transfer and that it should be documented.

On 7/18/18 at 2:58 p.m., the Director of Nursing (ASM #2 - Administrative Staff Member) was notified of the concern. ASM #2 stated, "You are correct, these pieces were not done."

No further information was provided.

A review of the facility policy "Discharge Planning Policy" did not address preparing and orienting the resident to their acute care transfer to a hospital setting.

{1} Urinalysis (UA) - A urinalysis is a test of your urine. It is often done to check for a urinary tract infections, kidney problems, or diabetes. You may also have one during a checkup, if you are admitted to the hospital, before you have surgery, or if you are pregnant. It can also monitor some medical conditions and treatments. Information obtained 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 07/19/2018

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 624	Continued From page 29 https://medlineplus.gov/urinalysis.html	F 624		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. 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 evidence that written bed hold notification was provided to the	F 625	F625 1. Resident # 82 discharged on 05/04/18 with no return. Resident # 43 re-admitted on 06/18/18 with no further discharges.	8/10/18

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 07/19/2018

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 625	Continued From page 30 responsible party upon a transfer to the hospital for three of 31 residents in the survey sample; Resident #82, Resident # 43 and Resident # 44. 1. The facility staff failed to provide written notification regarding a bed hold to Resident/Responsible Representative upon transfer to the hospital for Resident #82 on 4/8/18 and 5/4/18. 2. The facility staff failed to provide written notification regarding bed holds to Resident/Responsible Representative upon transfer to the hospital for Resident #43 on 6/16/18. 3. The facility staff failed to provide written notification regarding bed holds to Resident/Responsible Representative upon transfer to the hospital for Resident #44 on 5/18/18. The findings include: 1. The facility staff failed to provide written notification regarding a bed hold to Resident/Responsible Representative upon transfer to the hospital for Resident #82 on 4/8/18 and 5/4/18. Resident #82 was admitted to the facility on 3/21/18 and discharged to the hospital on 5/4/18. The resident had the diagnoses of but not limited to anemia, high blood pressure, heart failure, diabetes, dysphagia, pulmonary embolism, stroke, morbid obesity, pneumonia, bipolar disorder, and hemorrhage of anus and rectum. The most recent MDS (Minimum Data Set) was a 14 day assessment status/post re-entry, with an	F 625	Resident # 44 re-admitted on 05/24/18 with no further discharges. 2. Any resident being discharged has the potential to be affected. 3. A discharge packet with a checklist of required documents will be used for licensed nurses to check off (is completed when sending a resident to the hospital). All licensed nurses have been educated on this requirement by DON/ designee. Education will include orientation for new employees. 4. DON/ designee will audit residents who discharge 5x/ week for 4 weeks, then 3x/ week for 8 weeks for proper documentation. Results will be reviewed in QAPI every month x 3. 5. 08/15/18	

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 07/19/2018

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 625	Continued From page 31	F 625		

ARD (Assessment Reference Date) of 4/28/18. The resident was cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed the following in the nurse's notes:

- 4/8/18 at 12:11 p.m.: "...Change in condition....Altered mental status...weakness and pale....Resident has increased confusion....resident has memory loss....Pt is pale in appearance, shaky, aphasia, excessive thirst, weakness, hard time following directions...."

- 4/8/18 at 2:58 p.m.: "Sent pt (patient) to er (emergency room) per family request for aphasia, weakness, pale, and ams (altered mental status). This nurse did a UA {1} (urinalysis)...was unable to draw blood per poor veins. Md (medical doctor) and rp (responsible party) aware."

Further review of the clinical record revealed the "Nursing Home to Hospital Transfer Form" which documented the following:

Resident's name, date of birth, primary diagnoses, contact person, where the resident was being sent to, who to call at the nursing home with any questions, the primary care physician, code status, key clinical information (vital signs were documented), usual mental status (alert and oriented), usual functional status (ambulates only with assistance), additional clinical information (acute change in condition note included, other clinical notes included), devices and treatments (oxygen), isolation precautions, allergies, risk alerts (none of the areas were marked - areas included falls,

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 07/19/2018

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 625	Continued From page 32	F 625		

pressure ulcers, aspiration, seizures, restraints, swallowing precautions, etc.), personal belongings, conditions under which the resident would be accepted back at the nursing home, additional information to be included on a second page (box left unchecked). Page 2 of this document included information for family and other social issues (marked na - not applicable), behavioral issues (na), treatments and frequency (na), Primary goals of care at time of transfer (Rehabilitation and/or Medical Therapy with intent of returning home was checked - this was not inclusive of care plan goals), diet, skin/wound (na), Physical Rehabilitation Therapy, ADLs (activities of daily living), Impairments - General (nothing checked), Impairments - Musculoskeletal (nothing checked), continence (bowel and bladder checked), Additional Relevant Information (pt is pale, weakness, aphasia, pt did not eat breakfast or lunch, pt has excessive thirst - was written on the line).

A review of the "eInteract [electronic interactive]" forms and "SBAR [situation, background, assessment, recommendation] Communication Form" completed by the facility reiterated much of the above information.

The above forms and nurses notes failed to document that the resident or responsible party was provided with a written bed hold notice for the facility initiated transfer to the hospital on 4/8/18.

A review of the clinical record revealed the following in the nurse's notes:

- 5/4/18 at 12:41 p.m.: "...Change in

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 07/19/2018

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 625	Continued From page 33	F 625		

condition....abnormal labs (laboratory tests) per PCP (primary care physician). This started on 5/4/18...."

- 5/4/18 at 1:29 p.m.: "Daughter in around lunchtime to inform the staff that the PCP (name of PCP, which was not a facility physician), is requesting the resident be sent to (name of hospital) for direct admit due to impaired renal function. Facility MD notified, OK to transfer to (hospital). (Name of ambulance company) called to transport resident. Daughter to accompany."

Further review of the clinical record revealed the "Nursing Home to Hospital Transfer Form" which documented the following:
Resident's name, date of birth, primary diagnoses, contact person, where the resident was being sent to, who to call at the nursing home with any questions, the primary care physician, code status, key clinical information (vital signs were documented, as well as the statement "Abnormal Other lab value or study...abnormal kidney function from PCP - direct admit"), usual mental status (alert and oriented), usual functional status (ambulates only with assistance), additional clinical information (acute change in condition note included), devices and treatments (nothing marked), isolation precautions, allergies, risk alerts (falls were marked - areas included falls, pressure ulcers, aspiration, seizures, restraints, swallowing precautions, etc.), personal belongings, conditions under which the resident would be accepted back at the nursing home, additional information to be included on a second page (box left unchecked). Page 2 of this document included information for family and other social issues (left blank), behavioral issues (left blank),

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 07/19/2018

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 625	Continued From page 34	F 625		

treatments and frequency (left blank), Primary goals of care at time of transfer (Rehabilitation and/or Medical Therapy with intent of returning home was checked - this was not inclusive of care plan goals), diet, skin/wound (left blank), Physical Rehabilitation Therapy, ADLs (activities of daily living), Impairments - General (nothing checked), Impairments - Musculoskeletal (nothing checked), continence (bowel and bladder checked), Additional Relevant Information (nothing added).

A review of the "eInteract" forms and "SBAR Communication Form" completed by the facility reiterated much of the above information.

The above forms and nurses notes failed to document that the resident or responsible party was provided with a written bed hold notice for the facility initiated transfer to the hospital on 5/4/18.

On 7/18/18 at 2:45 p.m., in an interview with LPN #2 (Licensed Practical Nurse), she stated that the nurses did not send bed hold at that time. LPN #2 stated that they "were not aware at that time, that it was a thing we do."

On 7/18/18 at 2:58 p.m., the Director of Nursing (ASM #2 - Administrative Staff Member) was notified of the concern. ASM #2 stated, "You are correct, these pieces were not done."

No further information was provided.

A review of the facility policy "Discharge/Transfer Letter Policy" documented, "...G) The resident or

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 07/19/2018

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 625	Continued From page 35	F 625		

responsible party will receive a bed hold notice along with the discharge/transfer letter, when applicable. Bed Hold notices can be found within (electronic medical record system)....2. Once form is chosen, form will be printed and filled in where prompted, 3. Information needs to be filled in on how many bed holds are left and/or bed hold rate, if applicable, 4. A copy of the completed bed hold notice will be scanned into (electronic medical record system) and filed in business file with certified receipt attached if applicable, with the copy of the discharge/transfer letter..."

A review of the facility "Notice of Bed Hold Policy" documented, "(the resident) has been sent to the hospital today. If the resident is on Medicaid and is admitted to the hospital, Virginia Medicaid does not pay to hold the resident's bed. Whatever he resident's payment source, unless the nursing home is paid to reserve the bed while the resident is in the hospital, the nursing home may move someone else into the resident's room. However, even if the nursing home is not paid to hold the bed, the resident may have the right to return as soon as a bed is available in a semi-private room in this nursing home as long as the resident still needs the services provided by this nursing home (and, if the resident is on Medicaid, he or she is eligible for Medicaid nursing home services). If the nursing home does not readmit the resident to the first available bed in a semi-private room when the resident is ready to leave the hospital, the resident has the right to: Appeal the nursing home's decision to the Department of Medical Assistance Services, Appeals Division (contact information included); File a complaint with the Office of Licensure and Certification (contact information provided). For help in filing an appeal or a complaint, contact the Office of State Long

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 07/19/2018

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 625	Continued From page 36	F 625		

Term Care Ombudsman at (contact information provided)."

{1} Urinalysis (UA) - A urinalysis is a test of your urine. It is often done to check for a urinary tract infections, kidney problems, or diabetes. You may also have one during a checkup, if you are admitted to the hospital, before you have surgery, or if you are pregnant. It can also monitor some medical conditions and treatments.
Information obtained from https://medlineplus.gov/urinalysis.html

2. The facility staff failed to provide written notification regarding bed holds to Resident/Responsible Representative upon transfer to the hospital for Resident #43 on 6/16/18.

Resident #43 was admitted to the facility on 3/18/18 with a most recent readmission on 6/18/18, with diagnoses that included but were not limited to: high blood pressure, history of a stroke, difficulty speaking, difficulty swallowing, diabetes, and difficulty walking. The most recent MDS (minimum data set) assessment, a quarterly review assessment, with an assessment reference date of 6/15/18, coded the resident as having short and long term memory problems, as well as severely impaired cognitive skills for daily decision making.

The physician's order dated 6/16/18, documented in part, "Send to [hospital's name] ED (emergency department) for evaluation."

The nurse's note dated 6/16/18 at 5:32 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 07/19/2018

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 625	Continued From page 37	F 625		

documented in part, "Resident unresponsive [sic] Resident has decreased level of consciousness [sic] Resident noted to have seizure ...Reported to primary care clinician: [name of physician's group] on 6/16/18 5:00 PM ...Orders obtained ...Send to ED to get evaluated."

An interview was conducted on 7/19/18 at 8:40 a.m. with LPN, licensed practical nurse, #1, unit manager. LPN #1 was asked to describe the process staff follows when transferring a resident to the hospital. LPN #1 stated they first obtain a physician's order and notify the Responsible Representative. They then complete the transfer forms, print paperwork including medications, code status, and any pertinent laboratory reports. When asked who is responsible for providing written notification regarding bed hold, LPN #1 stated that it is included in the envelope that is sent with the resident to the hospital. LPN #1 provided a blank copy for review. LPN #1 stated that they make a copy of the form prior to transfer and "put the copy in the basket to be scanned into the resident's medical record". When asked how long this process has been in effect, LPN #1 stated she was not sure.

A review of the scanned documents in Resident #43's electronic medical record failed to evidence that written bed hold information was provided upon transfer to the hospital on 6/16/18.

An interview was conducted with OSM, (other staff member), #4, social services, on 7/19/18 at 10:30 a.m. OSM #4 was asked who was responsible for providing written bed hold information to the resident or the resident's representative, OSM #4 stated that social

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 07/19/2018

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 625	Continued From page 38	F 625		

services did not currently provide this information.

An interview was conducted on 7/19/18 at 11:55 a.m. with ASM (administrative staff member), #2, the director of nursing. When asked about the written notification of bed hold process to the resident/responsible representative, ASM #2 stated that they were in the process of updating their transfer policies to include notification of bed holds to the resident/responsible representative.

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, and LPN #1 where made aware of the above concerns on 7/19/18 at 12:00 p.m.

No further information was provided prior to exit.

3. The facility staff failed to provide written notification regarding bed holds to Resident/Responsible Representative upon transfer to the hospital for Resident #44 on 5/18/18.

Resident #44 was admitted to the facility on 2/28/18 with a most recent readmission on 5/24/18, with diagnoses that included but were not limited to: high blood pressure, stroke, difficulty speaking, right sided weakness, and psychosis (a severe mental disorder that cause abnormal thinking and perceptions) (1). The most recent MDS (minimum data set) assessment, a quarterly review assessment, with an assessment reference date of 6/7/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she has severe cognitive impairment of daily decision

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 07/19/2018

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 625	Continued From page 39	F 625		

making.

The nurse's note dated 5/18/18 at 1:56 p.m. documented in part, "Resident has increased confusion [sic] Resident has new or worsened delusion or hallucination ...Reported to primary care clinician: [name of physician] on 5/18/18 2:00 PM ...Orders obtained ...Send to ER for eval [evaluation]."

An interview was conducted on 7/19/18 at 8:40 a.m. with LPN, licensed practical nurse, #1, unit manager. LPN #1 was asked to describe the process staff follows when transferring a resident to the hospital. LPN #1 stated they first obtain a physician's order and notify the Responsible Representative. They then complete the transfer forms, print paperwork including medications, code status, and any pertinent laboratory reports. When asked who is responsible for providing written notification regarding bed hold, she stated that it is included in the envelope that is sent with the resident to the hospital. LPN #1 provided a blank copy for review. LPN #1 stated that they make a copy of the form prior to transfer and "put the copy in the basket to be scanned into the resident's medical record". When asked how long this process has been in effect, LPN #1 stated she was not sure.

A review of the scanned documents in Resident #44's electronic medical record failed to evidence that written bed hold information was provided upon transfer to the hospital on 5/18/18.

An interview was conducted with OSM, (other staff member), #4, social services, on 7/19/18 at 10:30 a.m. OSM #4 was asked who 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 07/19/2018

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 625	Continued From page 40 responsible for providing written bed hold information to the resident or the resident's representative, OSM #4 stated that social services did not currently provide this information. An interview was conducted on 7/19/18 at 11:55 a.m. with ASM (administrative staff member), #2, the director of nursing. When asked about the written notification of bed hold process to the resident/responsible representative, ASM #2 stated that they were in the process of updating their transfer policies to include notification of bed holds to the resident/responsible representative. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, and LPN #1 where made aware of the above concerns on 7/19/18 at 12:00 p.m. No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/psychoticdisorders.html 2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003205.htm	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		8/10/18

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 07/19/2018

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 656	Continued From page 41 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review	F 656	F656	

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 07/19/2018

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 656	Continued From page 42 and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for three of 31 residents in the survey sample, Residents #66, #63 and #69. 1. The facility staff failed to document the resident's urinary output as per the comprehensive care plan and the physician's order for Resident #66. 2. The facility staff failed to implement Resident # 63's comprehensive care plan for the administration of insulin. 3. The facility staff failed to implement Resident # 69's comprehensive care plan for the administration of oxygen. The findings include: 1. Resident #66 was admitted to the facility on 6/30/18 with diagnoses that included but were not limited to: anemia, muscle weakness, falls, high blood pressure and inability to urinate. The most recent MDS (minimum data set), a 14 day admission assessment, with an ARD (assessment reference date) of 7/7/18 coded the resident as having scored a 13 out of 15 on the brief interview for mental status, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living except for eating which the resident could perform after the tray was prepared. The resident was coded as having a urinary catheter. Review of the resident's care plan initiated on 7/11/18 documented, "Focus. Resident has an	F 656	1. Resident # 66 discharged on 07/31/18. Resident # 63, medication error report was completed on 07/11/18, and medication pass observations were performed with the 2 licensed nurses involved. Resident # 69, oxygen was set at correct setting. 2. Any resident with a catheter, with insulin or with oxygen has the potential to be affected. 100% audit of catheter output, insulin parameters, and O2 settings completed by DON/ designee on 8/2/18 and 8/3/18. 3. Licensed nurses have been educated on documenting output, following insulin parameters, and correct oxygen settings and following the plan of care by the DON/ designee. Education will include orientation for new employees. 4. Unit managers/ designee will audit output documentation for completion, insulin parameters to ensure accuracy, and oxygen settings 5 x week x 4 weeks, then 3 x week x 8 weeks. Will be reviewed in QAPI monthly x 3 months. 5. 08/15/18	

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 07/19/2018

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 656	Continued From page 43	F 656		

indwelling foley catheter which was present on admission. Interventions. assess and document intake and output as per facility policy."

Review of the July 2018 physician's orders documented, "DOCUMENT FOLEY (urinary catheter) OUTPUT EVERY SHIFT. Start Date 07/01/2018.

Review of the July 2018 treatment administration record documented, DOCUMENT FOLEY OUTPUT EVERY SHIFT. -Start Date- 07/01/2018. Review of the record did not evidence documentation of the urinary output on six occasions.

An interview was conducted on 7/18/18 at 2:55 p.m. with LPN (licensed practical nurse) #1. When asked why residents had care plans, LPN #1 stated, "Interventions are put in place and to let everyone know what is happening." When asked if staff were expected to follow the care plan, LPN #1 stated, "Yes. The plan is individualized and its to keep the resident safe, what their risks are. What they prefer. What you need to care for the patient."

An interview was conducted on 7/18/18 at 3:30 p.m. with LPN (licensed practical nurse #6 and #7, the resident's nurses. When asked why a resident had a care plan, LPN #6 stated, "We have care plan to provide better care. To meet the resident needs." When asked who used the care plan, LPN #6 stated, "The nurses and therapy use it as well." When asked if the staff were expected to follow the care plan, LPN #6 stated, "Yes."

On 7/18/18 at 5:10 p.m. ASM (administrative staff

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 07/19/2018

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 656	Continued From page 44	F 656		

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.

An interview was conducted on 7/19/18 at 10:19 a.m. with RN (registered nurse) #5, the unit manager. When asked why residents had care plans, RN #5 stated, "To direct their care." When asked who used the care plan, RN #5 stated, "The nursing staff." When asked if staff were expected to follow the care plan, RN #5 stated they were.

Review of the facility's policy titled, "Care Plan" documented, "POLICY: An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis. PROCEDURE: Z) All direct care staff must always know, understand and follow their Resident's Care Plan."

No further information was provided prior to exit.

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, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (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 07/19/2018

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 656	Continued From page 45	F 656		

(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.
2. The facility staff failed to follow Resident # 63's comprehensive care plan for the administration of insulin.

Resident # 63 was admitted to the facility on 09/14/16 and a readmission of 11/02/17 with diagnoses that included but were not limited to heart failure, convulsions (3), diabetes mellitus, (4), Parkinson's disease (5), seizures (6), hypertension (7), and hyperlipidemia (8).

Resident # 63's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/02/18, coded Resident # 63 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 63 was coded as requiring extensive assistance of one staff member for activities of daily living. Under section, "N. Medications" Resident # 63 was coded for receiving insulin in the past seven days.

The physician's order sheet (POS) dated July 2018 for Resident # 63, documented "Levemir (9) 100 UNIT/1ML (one milliliter) UNIT. Inject 22 unit subcutaneously (10) in the morning for DM (diabetes mellitus). Hold for BS (blood sugar) < (less than) 100 or BS > (greater than) 300 Notify Hospice."

The eMAR (electronic medication administration record) dated June 2018 for Resident # 63 documented, "Levemir 100 UNIT/1ML (one milliliter) UNIT. Inject 22 unit subcutaneously in the morning for DM (diabetes mellitus). Hold 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 07/19/2018

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 656	Continued From page 46	F 656		

BS (blood sugar) < (less than) 100 or BS > (greater than) 300 Notify Hospice." Further review of the eMAR revealed levemir was administered on 06/01/18 with a blood sugar reading of 91, 06/08/18 with a blood sugar reading of 78, 06/09/18 with a blood sugar reading of 95 and on 06/26/18 with a blood sugar reading of 93.

The eMAR (electronic medication administration record) dated July 2018 for Resident # 63 documented, "Levemir 100 UNIT/1ML (one milliliter) UNIT. Inject 22 unit subcutaneously in the morning for DM (diabetes mellitus). Hold for BS (blood sugar) < (less than) 100 or BS > (greater than) 300 Notify Hospice." Further review of the eMAR revealed levemir was administered on 07/2/18 with a blood sugar reading of 98 and 07/17/18 with a blood sugar reading of 88.

The comprehensive care plan for Resident # 63 dated 10/20/2017 documented, "Focus. The resident has Diabetes Mellitus." Under "Interventions/Tasks" it documented, "Medication as ordered by doctor. Date Initiated 10/20/2017."

On 07/18/18 at approximately 3:00 p.m., an interview was conducted with LPN (licensed practical nurse) # 1 regarding care plans. When asked to describe the purpose of care plan, LPN # 1 stated, "It puts interventions in place and gives us a plan of care individually for each patient." When asked why it was important to follow the resident's care plan, LPN # 1 stated, "It is individualized, it keeps the patient safe, what their risks are, what works for them, the best way to care for the patient, and we can refer to it. If it is on the care plan it should be followed." 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 07/19/2018

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 656	Continued From page 47	F 656		

1 reviewed Resident # 63's care plan for diabetes and agreed it was not being followed when the insulin was being administered for blood sugars below 100.

The facility's policy "Care Plan" documented, "Z. 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 this can be documented or the Care Plan changed if necessary."

On 07/18/18 at approximately 5:15 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3, assistant director of nursing and ASM # 4, regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

References:

(1) With type 1 diabetes, your pancreas does not make insulin. Insulin is a hormone that helps glucose get into your cells to give them energy. Without insulin, too much glucose stays in your blood. If you have type 1 diabetes, you will need to take insulin. Type 2 diabetes, the most common type, can start when the body doesn't use insulin, as it should. If your body can't keep up with the need for insulin, you may need to take pills. Along with meal planning and physical activity, diabetes pills help people with type 2 diabetes or gestational diabetes keep their blood glucose levels on target. Several kinds of pills are available. Each works in a different way. Many people take two or three kinds of pills. Some

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 07/19/2018

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 656	Continued From page 48	F 656		

people take combination pills. Combination pills contain two kinds of diabetes medicine in one tablet. Some people take pills and insulin. This information was obtained from the website: https://medlineplus.gov/diabetesmedicines.html.

(2) Blood sugar, or glucose, is the main sugar found in your blood. It comes from the food you eat, and is your body's main source of energy. Your blood carries glucose to all of your body's cells to use for energy. This information was obtained from the website: https://medlineplus.gov/bloodsugar.html.

(3) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm.

(4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(5) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(6) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.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 07/19/2018

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 656	Continued From page 49	F 656		

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

(8) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.

(9) LEVEMIR® (insulin detemir [rDNA origin] injection) is a sterile solution of insulin detemir for use as a subcutaneous injection. Insulin detemir is a long-acting (up to 24-hour duration of action) recombinant human insulin analog. LEVEMIR® is produced by a process that includes expression of recombinant DNA in Saccharomyces cerevisiae followed by chemical modification. This information was obtained from the website: https://www.rxlist.com/levemir-drug.htm.

(10) The term "subcutaneous" refers to the skin. Subcutaneous means beneath, or under, all the layers of the skin. For example, a subcutaneous cyst is under the skin. This information was obtained from the website: https://medlineplus.gov/ency/article/002297.htm.

3. The facility staff failed to follow Resident # 69's comprehensive care plan for the administration of oxygen.

Resident # 69 was admitted to the facility on 09/15/11 and a readmission of 03/28/17 with

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 07/19/2018

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 656	Continued From page 50	F 656		

diagnoses that included but were not limited to heart failure, shortness of breath, bipolar disorder (1), diabetes mellitus, (2), gastroesophageal reflux disease (3), anxiety (4), hypertension (5), and hyperlipidemia (6).

Resident # 69's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/05/18, coded Resident # 69 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 69 was coded as requiring extensive assistance of one staff member for activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 69 was coded for "C. Oxygen therapy."

An observation on 07/18/18 at approximately 9:45 a.m. revealed Resident # 69 was sitting in bed watching television. Resident # 69 was receiving O2 (oxygen) by nasal cannula from an oxygen concentrator. Observation of the O2 flow meter on the oxygen concentrator revealed the oxygen flow rate at two liters per minute.

An observation on 07/18/18 at approximately 11:17 a.m. revealed Resident # 69 was sitting in bed watching television. Resident # 69 was receiving O2 (oxygen) by nasal cannula from an oxygen concentrator. Observation of the O2 flow meter on the oxygen concentrator revealed the oxygen flow rate at two liters per minute.

An observation on 07/18/18 at approximately 2:07 p.m. revealed Resident # 69 was sitting in bed watching television. Resident # 69 was receiving O2 (oxygen) by nasal cannula from an oxygen concentrator. Observation of the O2 flow meter

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 07/19/2018

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 656	Continued From page 51	F 656		

on the oxygen concentrator revealed the oxygen flow rate at two liters per minute.

The physician's orders for Resident # 69 dated July 2018 documented, "O2 (Oxygen) 3 (three) L/min (liters per minute) via (by) nasal cannula PRN (as needed) q (every) shift: shortness of breath. Order Date: 05/23/2018. Start Date: 05/23/2018."

The eTAR (electronic treatment administration record) dated July 2018 for Resident # 69 documented, "O2 (Oxygen) 3 (three) L/min (liters per minute) via (by) nasal cannula PRN (as needed) q (every) shift: shortness of breath. Start Date: 05/23/2018." Further review of the eTAR failed to evidence Resident # 69 received oxygen on 07/18/18.

The comprehensive care plan for Resident # 69 dated 01/15/2018 documented, "Focus. The resident has altered respiratory status/Difficulty Breathing r/t (related to) Pneumonia, CHF (congestive heart failure), CAD (coronary artery disease), and anxiety." Under "Interventions/Tasks" it documented, "Provide oxygen as ordered. Date Initiated 01/15/2018."

On 07/18/18 at approximately 3:00 p.m., an interview was conducted with LPN (licensed practical nurse) # 1 regarding care plans. When asked to describe the purpose of care plan, LPN # 1 stated, "It puts interventions in place and gives us a plan of care individually for each patient." When asked why it was important to follow the resident's care plan, LPN # 1 stated, "It is individualized, it keeps the patient safe, what their risks are, what works for them, the best way to care for the patient, and we can refer to it. If it

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 07/19/2018

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 656	Continued From page 52	F 656		

is on the care plan it should be followed." LPN # 1 reviewed Resident # 69's respiratory care plan and agreed it was not being followed when the oxygen flow rate was at two liters."

On 07/18/18 at approximately 5:15 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3, assistant director of nursing and ASM # 4, regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(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) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(5) High blood pressure. 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 07/19/2018

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 656	Continued From page 53 obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (6) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		8/10/18

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 07/19/2018

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 657	Continued From page 54 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plan for three of 31 residents in the survey sample, Residents #71, #37, and #66. 1. The facility staff failed to review and revise the comprehensive care plan to address a new pressure area for Resident #71. 2. The facility staff failed to update Resident #37's comprehensive care plan reflecting her chronic edema (1) related to peripheral arterial disease (2). 3. The facility staff failed to revise the care plan after an open area was found on Resident #66's left buttocks. The findings include: 1. The facility staff failed to review and revise the comprehensive care plan to address a new pressure area for Resident #71. Resident #71 was admitted to the facility on 6/8/18 with diagnoses that included but were not limited to: left knee replacement, high blood pressure, and gastroesophageal reflux disease (a backflow of the contents of the stomach into the esophagus) (1). The most recent MDS (minimum data set) assessment, a Medicare 30 day	F 657	F657 1. Resident # 71, care plan was updated on 07/19/18. Resident # 37, care plan revised on 07/19/18. Resident # 66 discharged on 07/31/18. 2. Any resident with pressure area or edema has the potential to be affected. Care plans of residents experiencing pressure area or edema, have been revised/corrected by MDS department. 3. Licensed nurses have been educated on care plan policy which includes developing, revising and implementing the care plan by the DON/ designee. Education will include orientation for new employees. 4. MDS/ designee will review care plans for residents with edema and or pressure areas weekly x12 weeks. Results will be reviewed in QAPI monthly x 3 months. 5. 08/15/18	

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 07/19/2018

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 657	Continued From page 55	F 657		

assessment, with an assessment reference date of 7/6/18 coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living except eating in which she required limited assistance of one person. In Section M - Skin Conditions, the resident was coded as having one unstageable - Deep tissue injury.

The "Weekly Wound Assessment" form dated 6/22/18 at 11:09 a.m. documented in part, "Wound Overview - Wound Type - "Other." Stage - n/a (not applicable), Wound location - left heel, Length - 2.3 cm (centimeters), Width - 2.3 cm. Location Where Wound Was Acquired - In house. Was this skin impairment present on admission - No. Date wound identified - 6/22/18. Treatment - Pending diagnostic."

The physician order dated, 6/22/18, documented in part, "Skin Prep to left heel every shift for heel. Air mattress to bed. Check placement and function every shift for air mattress."

The comprehensive care plan dated, 6/8/18 and revised on 6/29/18, documented in part, "Focus: At risk for skin breakdown related to: decreased mobility, weakness, recent failed total knee, episodic incontinence." The "Interventions" were dated 6/8/18. There was no documentation related to the new wound on the resident's left heel and no new interventions added to the care plan.

An interview was conducted with LPN (licensed practical nurse) #2 on 7/18/18 at 3:21 p.m. When

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 07/19/2018

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 657	Continued From page 56	F 657		

asked the purpose of the care plan, LPN #2 stated it's to show us (the staff) the focus of the care. It's a guideline of the care we are supposed to give." When asked who updates care plans, LPN #2 stated, "The nurse, unit manager and MDS staff." When asked if a new pressure area/discoloration should be on the care plan, LPN #2 stated, "Yes."

An interview was conducted with RN (registered nurse) #5, the unit manager, on 7/18/18 at 3:25 p.m. When asked the purpose of the care plan, RN #5 stated, "It's to guide the care we give." When asked if a newly acquired pressure sore should be on the care plan, RN #5 stated, "Yes, there should be new interventions for treatment." When asked who updates the care plan, RN #5 stated, "Any nurse."

Administrative staff member (ASM) #2, the director of nursing, ASM #3, the assistant director of nursing and ASM #4, the regional director of clinical services were made aware of the above findings on 7/18/18 at 5:20 p.m.

The facility policy "Care Plan" documented in part, "V. The MDS coordinator is to review the 24 - Hour Report daily for significant changes or changes in resident's ADL (activities of daily living) status. The Care Planning Coordinator will add minor changes in resident's status to the existing Care Plans on daily basis."

An interview was conducted with RN #4, the MDS nurse on 7/19/18 at 10:09 a.m. When asked who updates the care plans, RN #4 stated, "Generally it's the unit managers and the staff." The above policy was reviewed with RN #4. When asked if she did what the policy states, RN #4 stated, 'No,

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 07/19/2018

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 657	Continued From page 57	F 657		

they (the unit managers and administration) have a risk meeting on each unit, every day, and anything pertinent the day before and that's when they update the care plan." When asked if the team doing the risk meeting, would update the care plan for a new pressure area, RN #4 stated, "Yes, usually." When asked if she does the day to day updates on the comprehensive care plans, RN #4 stated, "No, they (the nursing staff) do the updates. We update things when we are in the process of completing an MDS."

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.

2. The facility staff failed to update Resident #37's comprehensive care plan reflecting her chronic edema (1) related to peripheral arterial disease (2).

Resident #37 was admitted to the facility on 5/31/16 with diagnoses that included but were not limited to osteoarthritis, chronic kidney disease, peripheral arterial disease (PAD), unspecified psychosis, and high blood pressure. Resident #37's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 6/5/18. Resident #37 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

On 7/17/18 at 10:30 a.m., an observation was conducted of Resident #37. Her bilateral legs and feet appeared to be very swollen. Resident #37

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 07/19/2018

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 657	Continued From page 58	F 657		

stated that her legs hurt but that the nursing staff always encourage her to get into bed an elevate her legs. Resident #37 stated that she did not want to do this.

Review of Resident #37's most recent POS (physician order summary) dated 7/18/18, documented the following order: "Lasix (3) Tablet 40 mg (milligrams) Give 1 tablet by mouth one time a day related to peripheral vascular disease (another name for PAD)."

Review of Resident #37's physician notes revealed that Resident #37 was non-complaint with elevating her legs the following notes were documented by the physician:
- "4/6/18: Edema, LE (lower extremities), on lasix (sic) - will monitor, elevate when possible."

- "6/5/18: Edema- increased in BLE (bilateral lower extremities), sitting up in wheelchair for long periods of time...add 20 mg lasix additionally for 3 days." Review of Resident #37's clinical record revealed that she was ordered and administered the extra dose of lasix for three days.

- "6/28/18: Edema- Has Lasix ordered, advised patient to keep legs elevated as much as possible."

Review of the nursing notes revealed that Resident #37 had a repeated behavior of getting out of bed in the middle of the night, washing up for the day and falling asleep in her wheelchair. The following notes were documented:

- "7/11/18: Resident awoke around 0130 and came out of room to hallway around 0200 (2:00

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 07/19/2018

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 657	Continued From page 59	F 657		

a.m.). Resident washed herself up in the bathroom and changed own clothes. denied (sic) pain or discomfort. Refuses to go back into bed and remains in w/c (wheelchair) since. Resident voices own needs as needed..."

- "7/15/18: Resident got up out of bed around 145 a.m. Currently sitting in w/c in social area. No complaints voiced at this time."

- "7/16/18: Resident got out of bed around 0130 (1:30 a.m.). Resident fell asleep in w/c (wheelchair) and refused to get back in bed when assistance was offered."

- "7/17/18: Resident got out of bed around 0000 (midnight). Resident fell asleep in w/c (wheelchair) and refused to get back in bed when assistance was offered."

Review of Resident #37's comprehensive care plan dated 5/31/16, failed to evidence a current care plan reflecting Resident #37's bilateral lower leg edema related to her PAD and her non-compliance with elevating her legs.

Resident #37's care plan with revisions showed that she had a resolved care plan dated 6/13/16 that documented the following: "The resident has Dx (diagnosis) of PAD (peripheral arterial disease). The resident will remain free of complications related to PAD through next review date. Interventions: assess/document for excessive edema and encourage resident to elevate legs; assess/document/report/to MD (medical doctor) PRN (as needed) any s/sx (signs/symptoms) of complications of extremities: coldness of extremity, pallor, rubor, cyanosis, and pain per routine, when giving care and prn (as

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 07/19/2018

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 657	Continued From page 60	F 657		

needed); assess/document/report to MD PRN any s/sx of skin problems related to PVD: Redness, Edema, Blistering, Itching, Burning, Cuts or other skin lesions; Encourage resident to change positions frequently, assist as needed; Give medications per orders; lotion as needed for dry skin." This care plan was resolved on 2/17/17.

On 7/19/18 at 8:10 a.m., an interview was conducted with RN (registered nurse) #2, a nurse who frequently works with Resident #37. When asked about Resident #37's legs, RN #2 stated that Resident #37 had frequent swelling and edema because she will get out of bed in the middle of the night and stay up in her chair for extended periods of time. RN #2 stated the resident will refuse to elevate her legs. RN #2 could not determine Resident #37's diagnosis that caused her leg swelling and edema. RN #2 stated, "I don't recall her diagnosis without looking at the chart. I believe she is on Lasix." When asked the purpose of the care plan, RN #2 stated that the purpose of the care plan was to serve as a guide to direct nursing care. RN #2 stated that it was important for the care plan to be accurate. When asked if she would expect to see Resident #37's leg edema on the care plan, RN #2 stated she would expect to see that on the care plan because her legs are always swollen. RN #2 verified that Resident #37 did not have a current care plan reflecting her PVD and chronic leg edema. When asked if she would expect to see a care plan documenting Resident #37's non-compliance with elevating her legs, RN #2 stated, "That I am not sure about." RN #2 confirmed that there was a resolved care plan on 2/17/17. RN #2 stated, "Obviously we need to re-update the care plan." RN #2 stated that floor

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 07/19/2018

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 657	Continued From page 61	F 657		

nurses could update the care plans if they see anything new.

On 7/19/18 at 11:15 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), ASM #3, the ADON (assistant director of nursing), and ASM #4, the regional director of clinical services were made aware of the above concerns.

No further information was presented prior to exit.

(1) Edema- "means swelling caused by fluid in your body's tissues. It usually occurs in the feet, ankles and legs, but it can involve your entire body. Causes of edema include Eating too much salt, Sunburn, Heart failure, Kidney disease, Liver problems from cirrhosis, Pregnancy, Problems with lymph nodes, especially after mastectomy, Some medicines, Standing or walking a lot when the weather is warm. To keep swelling down, your health care provider may recommend keeping your legs raised when sitting, wearing support stockings, limiting how much salt you eat, or taking a medicine called a diuretic - also called a water pill." This information was obtained from The National Institutes of Health; https://medlineplus.gov/edema.html.

(2) Peripheral Arterial Disease- "is a disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. Plaque is made up of fat, cholesterol, calcium, fibrous tissue, and other substances in the blood. When plaque builds up in the body's arteries, the condition is called atherosclerosis. Over time, plaque can harden and narrow the arteries. This limits the flow of oxygen-rich blood to your organs

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 07/19/2018

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 657	Continued From page 62	F 657		

and other parts of your body.
P.A.D. usually affects the arteries in the legs, but it also can affect the arteries that carry blood from your heart to your head, arms, kidneys, and stomach. This article focuses on P.A.D. that affects blood flow to the legs." This information was obtained from The National Institutes of Health;
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0023287/.

(3) Lasix (Furosemide)-" belongs to a group of medicines called loop diuretics (also known as water pills). Furosemide is given to help treat fluid retention (edema) and swelling that is caused by congestive heart failure, liver disease, kidney disease, or other medical conditions. It works by acting on the kidneys to increase the flow of urine." This information was obtained from The National Institutes of Health;
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010414/?report=details.

3. The facility staff failed to revise the comprehensive care plan after an open area was found on Resident #66's left buttocks.

Resident #66 was admitted to the facility on 6/30/18 with diagnoses that included but were not limited to: anemia, muscle weakness, falls, high blood pressure and inability to urinate. The most recent MDS (minimum data set), a 14 day admission assessment, with an ARD (assessment reference date) of 7/7/18 coded the resident as having scored a 13 out of 15 on the brief interview for mental status, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff 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 07/19/2018

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 657	Continued From page 63	F 657		

except for eating which the resident could perform after the tray was prepared.

Review of the 7/14/18 nurses notes documented that the resident had an open area on the left buttocks. The open area was documented as being 0.5 cm (centimeters) by 0.3 cm by 0.1 cm. Further review of the clinical record did not evidence documentation regarding the open area.

Review of the care plan initiated on 7/1/18 documented, "Focus Resident is frequently incontinent of bowel and has a bed mobility problem. Has MASD (moisture associated skin damage) in the groin area. At risk for worsening of skin integrity." There was no evidence that the care plan had been reviewed or revised after the open area was found.

An interview was conducted on 7/18/18 at 3:30 p.m. with LPN (licensed practical nurse #6 and #7, the resident's nurses. When asked why a resident had a care plan, LPN #6 stated, "We have care plan to provide better care. To meet the resident needs." When asked who used the care plan, LPN #6 stated, "The nurses and therapy use it as well." When asked when the care plan was revised, LPN #6 stated, "When there's a change in the condition of the patient."

An interview was conducted on 7/19/18 at 10:19 a.m. with RN (registered nurse) #5, the unit manager. When asked why residents had care plans, RN #5 stated, "To direct their care." When asked who used the care plan, RN #5 stated, "The nursing staff." When asked when the care plan was revised, RN #5 stated, "We revise them continually if it's needed. It's always a work in progress." When asked how long after a change

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 07/19/2018

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 657	Continued From page 64	F 657		

in the resident's condition would the care plan be updated, RN #5 stated, "Within a day." RN #5 reviewed Resident #66's care plan for skin care. RN #5 stated, "There was nothing updated." When asked if it should have been updated, RN #5 stated, "Yes." RN #5 was made aware of the concern at that time.

Review of the facility's policy titled, "Care Plan" documented, "POLICY: An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis. PROCEDURE: V) The MDS Coordinator is to review the 24-Hour Report daily for significant changes or changes in resident's ADL (activities of daily living) status. The Care Planning coordinator will add minor changes in resident's status t the the existing Care Plans on daily basis."

No further information was provided prior to exit.

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, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)

(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia

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 07/19/2018

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 657	Continued From page 65 pages 65-77.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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 staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for one of 31 residents in the survey sample, Resident #131. The facility staff failed to clarify the physician's orders for pain medication for Resident #131. The findings include: The facility staff failed to clarify the physician's orders for pain medication for Resident #131. Resident #131 was admitted to the facility on 6/12/18, with diagnoses that included but were not limited to: heart failure, chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (1), high blood pressure, and cancer of the left kidney. The most recent MDS (minimum data set) assessment, a 14 day Medicare assessment, with an assessment reference date of 6/26/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating he has no cognitive impairment for daily decision	F 658	F658 1. Resident #131, physician's order clarified on 07/19/18 and parameters included in the order. 2. Any resident with pain medication has the potential to be affected. 100% audit of all pain medications was completed on 08/07/18 to ensure parameters are in place. 3. Licensed nurses were educated on setting parameters for pain medications by the DON/ designee. Education will include orientation for new employees. 4. New pain medication orders will be audited for parameters 5x week for 12 weeks. Results will be reviewed in QAPI monthly x 3 months. 5. 08/15/18	8/10/18

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 07/19/2018

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 658	Continued From page 66	F 658		

making. The resident was coded as requiring extensive assistance of one staff member for bed mobility, transfers, dressing, toileting, and personal hygiene. In Section N - Medications, the resident was coded as being administered opioids during the look back period.

The physician order dated, 7/13/18, documented, "Oxycodone (an opioid used to treat moderate to severe pain (2)) 5 mg (milligram): Give 5 mg by mouth every 6 hours as needed for pain. Take 1 tablet every 6 hours PRN (as needed) Pain ...Oxycodone 5 mg: Give 5 mg by mouth every 6 hours as needed for pain. Take 2 tablets PRN for pain." Neither order documented how to determine the number of tablets to give based on the resident's pain level.

The July 2018 MAR (medication administration record) documented the above physician orders. One 5 mg tablet of Oxycodone was documented as having been administered on 7/16/18 at 8:41 a.m. for a pain level of 5, on 7/17/18 at 8:57 p.m. for a pain level of 6; and on 7/18/18 at 3:31 p.m. for a pain level of 9. Two five mg tablets of Oxycodone were documented as administered on 7/13/18 at 3:55 p.m. for a pain level of 9; on 7/14/18 at 5:18 a.m. for a pain level of 9; on 7/15/18 at 2:06 a.m. for a pain level of 6; and 7/15/18 at 9:20 a.m. for a pain level of 5.

The comprehensive care plan dated 6/13/18, with a most recent revision date of 6/21/18, documented in part, "Focus: Resident reports that he experiences severe pain at times. Receives prn (as needed) pain medication." The "Interventions" documented in part, "meds (medications) as ordered."

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 07/19/2018

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 658	Continued From page 67	F 658		

An interview was conducted with RN (registered nurse) #1 on 7/19/18 at 8:15 a.m. When asked how staff determined which pain medication to administer, when a resident has multiple orders for pain medications, RN #1 stated, "We ask them the pain level or to number the pain they are having. If they rate their pain as 1-4, I will give 1 tablet. If they rate their pain 5-10, I will give 2 tablets." When asked how she makes that determination, RN #1 stated, Well, I just know." When asked if this determination of pain was a consistent practice among the staff, RN#1 stated, "We need to ask the doctor to clarify which level of pain requires which pain medication."

An interview was conducted with LPN (licensed practical nurse) #1, unit manager, on 7/19/18 at 8:40 a.m. After asking her to review the oxycodone orders, LPN #1 stated, "these orders need clarification and parameters set by the doctor."

According to "Lippincott Manual Of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." On pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate..orders. c. Notify all involved medical and nursing personnel.... d. Document clearly."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing,

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 07/19/2018

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 658	Continued From page 68 ASM #3, the assistant director of nursing, and LPN #1 where made aware of the above concerns on 7/19/18 at 12:00 p.m. No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000091.htm 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/druginfo/meds/a682132.html#why	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to ensure that one of 31 residents in the survey sample, (Resident #57), received treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan.	F 684	F684 1. Resident #57, physician notified on 08/01/18 of midodrine administration. 2. Any resident receiving midodrine has the potential to be affected. 100% audit of all midodrine orders for the past 30 days was completed on 08/03/18 to ensure proper administration per parameters. 3. Licensed nurses were educated on	8/10/18

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 07/19/2018

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 684	Continued From page 69 The facility staff administered a medication when the blood pressure was outside of the parameters prescribed by the physician for Resident #57. The findings include: Resident #57 was admitted to the facility on 5/24/18 with diagnoses that included but were not limited to: heart failure, atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (1)), hypotension (too low blood pressure), prostate cancer, diabetes, and sleep apnea (a condition in which the patient has transient periods of apnea [not breathing] during sleep (2)). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/21/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive decisions. The resident was coded as extensive assistance of one or more staff members for all of his activities of daily living except eating in which he only required supervision with set up assistance. The physician order dated, 5/24/18, documented, "Midodrine* 2.5 mg (milligrams) by mouth three times a day for hypotension. Hold for SBP (systolic blood pressure) > (greater than) 140." *Midodrine is used to treat a kind of low blood pressure that can cause severe dizziness and fainting. (3)	F 684	midodrine administration by the DON/ designee. Education will include orientation for new employees. 4. New midodrine orders will be audited by DON/ designee 5 x week x 12 weeks. Results will be reviewed in QAPI monthly x 3 months. 5. 08/15/18	

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 07/19/2018

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 684	Continued From page 70	F 684		

The medication administration record (MAR) for July 2018 documented the above medication order. On 7/14/18 at 6:00 a.m., Resident #57's blood pressure was documented as "186/74." The medication Midodrine 2.5 mg was documented as administered.

Review of the nurse's notes dated 7/14/18 failed to document a note related to the blood pressure at 6:00 a.m.

The comprehensive care plan dated, 6/4/18, documented in part, "Focus: The resident has impaired cardiovascular status." The "Interventions/Tasks" documented in part, "Vital signs per routine/orders/and prn (as needed). Notify physician of any abnormal readings."

An interview was conducted with LPN (licensed practical nurse) #5 on 7/18/18 at 3:15 p.m., regarding the process staff follows for medication with physician ordered parameters for administration, LPN #5 stated, "You have to check the vital sign documented in the order and hold it if it's outside of the parameters and write a note."

An interview was conducted with RN (registered nurse) #5, the unit manager, on 7/18/18 at 3:29 p.m. When asked what Midodrine is used for, RN #5 stated, "It's to raise the blood pressure." When about the process staff follows if parameters are present with the order, RN #5 stated, "They need to follow the parameters." When shown the parameters for the Midodrine and Resident #57's blood pressure reading of 7/14/18, RN #5 stated, "It (Midodrine) should have been held and a note written."

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 07/19/2018

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 684	Continued From page 71 The facility policy, "General Dose Preparation and Mediation Administration" documented in part, "4.1 - Facility staff should: 4.1.5 If necessary, obtain vital signs...6.1 - Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN [as needed] medications, application sight) on appropriate forms. In "Fundamentals of Nursing" 6th edition, 2005; 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." Administrative staff member (ASM) #2, the director of nursing, ASM #3, the assistant director of nursing and ASM #4, the regional director of clinical services were made aware of the above findings on 7/18/18 at 5:20 p.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 534. (3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011219/?report=details.	F 684		
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		8/10/18

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 07/19/2018

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 686 SS=E	Continued From page 72 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 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 the facility staff failed to provide services for the treatment and care of pressure ulcers/injury for two of 31 residents in the survey process, Residents #71 and Resident #283. 1. The facility staff failed to ensure weekly measurements were completed, and failed to stage a pressure injury on Resident #71's left heel. 2. a. The facility staff failed to measure and stage Resident #283's left heel wound for 20 days. 2. b. The facility staff failed to administer treatments as ordered to Resident #283's left hell pressure wound, on several dates in October 2017.	F 686	F686 1. Care plan for resident # 71 was revised on 07/19/18 by MDS director. Resident # 71 was discharged on 07/20/18. Resident # 283 was discharged on 11/08/17. 2. Any residents with a pressure ulcer have the potential to be affected. 100% skin check audit was completed by unit managers on 07/20/18 and 07/23/18. 3. Licensed nurses were educated on wound protocol and documentation by DON/ designee. Education will include orientation for new employees. 4. Wound assessments will be reviewed by ADON/ designee 5x week for 12 weeks. Results will be reviewed monthly in QAPI x 3 months. 5. 08/15/18	

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 07/19/2018

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 686	Continued From page 73	F 686		

The findings include:

1. The facility staff failed to complete weekly measurements and failed to stage a pressure injury* for Resident #71.

*A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (1)

Resident #71 was admitted to the facility on 6/8/18 with diagnoses that included but were not limited to: left knee replacement, high blood pressure, and gastroesophageal reflux disease (a backflow of the contents of the stomach into the esophagus) (2).

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 7/6/18 coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living except eating in which she required limited assistance of one person. In Section M - Skin Conditions, the resident was coded as having one unstageable - Deep tissue injury*.

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 07/19/2018

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 686	Continued From page 74	F 686		

*Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. (2)

During the entrance conference, the facility was asked to provide a list of residents with pressure ulcers. A list was provided with only Resident #71's name and documented, "Left heel deep tissue injury - intact."

The "Weekly Wound Assessment" form dated 6/22/18 at 11:09 a.m. documented in part, "Wound Overview - Wound Type - "Other." Stage - n/a (not applicable), Wound location - left heel, Length - 2.3 cm (centimeters), Width - 2.3 cm. Location Where Wound Was Acquired - In house. Was this skin impairment present on admission - No. Date wound identified - 6/22/18. Treatment - Pending diagnostic." A LPN (licensed practical nurse) completed this.

There was no "Weekly Wound Assessment" form

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 07/19/2018

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 686	Continued From page 75	F 686		

for 6/29/18.

The "Weekly Wound Assessment" form dated 7/5/18 at 3:12 p.m. documented in part, "Wound Overview - Wound Type - Other. Other Wound Type - discoloration, Stage - 0, Wound location - left heel, Length - 2.0 cm (centimeters), Width - 2.5 cm., Depth - 0, Location Where Wound Was Acquired - In house. Was this skin impairment present on admission - No. Date wound identified - 7/22/18 (sic). Drainage Type - None, Drainage Amount - None, Wound Bed Appearance - n/a, Odor - none, Periwound Appearance - n/a, Wound Status - improving, Treatment - Skin prep Q (every) shift." A LPN signed this.

The "Weekly Wound Assessment" form dated 7/12/18 at 3:12 p.m. documented in part, "Wound Overview - Wound Type - Other, Other Wound Type - discoloration, Stage - 0, Wound location - left heel, Length - 2.0 cm (centimeters), Width - 2.0 cm., Depth - 0, Location Where Wound Was Acquired - In house. Was this skin impairment present on admission - No. Date wound identified - 6/22/18. Drainage Type - None, Drainage Amount - None, Wound Bed Appearance - n/a, Odor - none, Periwound Appearance - n/a, Wound Status - improving, Treatment - Skin prep each shift." A LPN signed this.

The "Bi-Weekly Skin Observation" form dated, 6/25/18, documented in part, "Does the resident have current Skin Issues - yes, Document current Skin Issues: Left heel - discoloration 3x2x0 (length by width by depth), treatment in place." A LPN completed this.

The "Bi-Weekly Skin Observation" form dated, 6/27/18, documented in part, "Does the resident

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 07/19/2018

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 686	Continued From page 76	F 686		

have current Skin Issues - yes, Document current Skin Issues: Other - L (left) heel discoloration." A RN (registered nurse) completed this.

The "Bi-Weekly Skin Observation" form dated, 7/4/18, documented in part, "Does the resident have current Skin Issues - yes, Document current Skin Issues: Other - Left heel discoloration." A LPN completed this.

The "Bi-Weekly Skin Observation" form dated, 7/11/18, documented in part, "Does the resident have current Skin Issues - yes, Document current Skin Issues: Other - Left heel - discoloration 2.5 x 2 x 0. Skin prep applied." A LPN completed this.

The "Bi-Weekly Skin Observation" form dated, 7/16/18, documented in part, "Does the resident have current Skin Issues - yes, Document current Skin Issues: Other - Left heel - discoloration." A LPN completed this.

The "Bi-Weekly Skin Observation" form dated, 7/18/18 at 10:34 a.m., documented in part, "Does the resident have current Skin Issues - yes, Document current Skin Issues: Other - Left heel - discoloration to heel 2.5 x 3 x 0. skin intact skin prep applied." A LPN completed this.

The physician order dated 6/22/18, documented, "Skin prep to left heel every shift for heel."

Observation was made of Resident #71 during the initial screening on 7/17/18 at approximately 10:15 a.m. The resident was sitting up in her wheelchair with orthopedic style shoes on both feet with thick black socks on. The resident was again observed on 7/18/18 at 9:42 a.m. sitting in her wheelchair with shoes and thick black socks

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 07/19/2018

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 686	Continued From page 77	F 686		

on both feet.

Resident #71 was observed on 7/18/18 at 3:48 p.m. with LPN # 4. The resident was in bed with her shoes off but the black socks on. The resident had soft heel booties on both feet. Her heels were not lifted off the surface of the mattress. There was no pillow under the resident's calves. LPN #4 described the heel as "black eschar (scab or crust that forms on the skin (4)) and bogginess (an abnormal texture of tissues characterized by a feeling of sponginess, usually because of high fluid content. (5)) around the black area". When asked if that was discoloration, LPN #4 stated, "No, that's necrotic tissue (death of some or all of the cells in a tissue; usually caused by disease, inadequate blood supply to the tissue and injury (6))."

Administrative staff member (ASM) #3, the assistant director of nursing (ADON), was asked to observe the wound on 7/18/18 at 4:00 p.m. ASM #3 stated the wound had changed, it's now hard." ASM #3 stated that it wasn't that way on Friday; the wound was still soft and was a deep tissue injury. ASM #3 verified the wound now had necrotic tissue but remained unstageable." Review of the nurse's notes failed to evidence documentation by ASM #3 that she observed the wound on Friday. The nurse's note dated, 7/18/18 at 6:18 p.m., written by ASM #3 documented, "Resident's left heel deep tissue injury assessed today and now noted unstageable with dry intact necrotic tissue to wound bed. No s/s (signs and symptoms) of infection. Tx (treatment) remains in place and appropriate. MD (medical doctor) and RP (responsible party) updated."

Review of the clinical record revealed there 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 07/19/2018

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 686	Continued From page 78	F 686		

no documented classification or staging of the left heel pressure ulcer until 7/18/18. On 7/18/18, after it was brought to the attention of the staff, did a registered nurse (ASM #3) assess and classify the wound as a deep tissue injury that was now noted as an unstageable wound with necrotic tissue.

The comprehensive care plan dated, 6/8/18, and revised on 6/29/18, documented in part, "Focus: At risk for skin breakdown related to: decreased mobility, weakness, recent failed total knee, episodic incontinence." The "Interventions" were dated 6/8/18. There was no documentation related to the new wound on the resident's left heel and no new interventions added to the care plan.

An interview was conducted with ASM (administrative staff member) #3, ASM #2, the director of nursing (DON), RN (registered nurse) # 5, the unit manager, and ASM #1, the administrator on 7/19/18 at 8:32 a.m. When asked about the process staff follows for newly identified wounds, ASM #3 stated, "When it is initially found the nurse does a change in condition form. We notify the doctor. Get orders for treatment and notify the responsible party." When asked when measurements of the wound are taken, ASM #3 stated, "They should be done when the new area is found and weekly measurements until healed." When asked if weekly wound rounds are made at the facility, ASM #2 stated, "No, the nurses do the treatments and notify the unit manager of any changes in the wound." When asked who oversees the LPNs that are doing the measurements and treatments, ASM #2 stated, "The unit managers and the ADON." When asked who stages the wounds,

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 07/19/2018

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 686	Continued From page 79	F 686		

ASM #2 stated, "The unit managers, the ADON and myself, the DON. Whenever there is a new wound, we all go and look at it." When asked where this is documented, ASM #3 stated, "In the chart." When asked who oversees the wound program, ASM #2 stated, "The unit manager is aware of any changes in the wounds by the nurses on the unit. The RN will step in when there is no progression of healing of the wounds." When asked if the LPNs have received any training on wound care, ASM #3 stated, "They get training on hire and in nursing school. And there are standing orders." When asked if the nurses get specific training on the assessment of wounds and the treatment of wounds, ASM #3 stated, "There is no formal training, we have no process for that here."

The facility policy, "Wound Management" documented in part, "A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infections, and prevent new ulcers from developing...3. When assessing the ulcer: a. Differentiate the type of ulcer (pressure-related versus non pressure-related). (Pressure ulcers are usually located over a bony prominence, such as the sacrum, heel, the greater trochanter, ischial tuberosity, fibular head, scapula and ankle). b. Determine the ulcer's stage. c. Describe and monitor the ulcer's characteristics. d. Monitor the progress toward healing and for potential complications. e. Assess, treat and monitor pain, if present. f. Monitor dressing and treatments. 4. An evaluation of the pressure ulcer wound should be documented at least weekly to include a. location and stage, b. Size (perpendicular measurements of the greatest

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 07/19/2018

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 686	Continued From page 80	F 686		

extent of length and width of the ulceration), depth, and the presence, location and extent of any undermining or tunneling/sinus tract. c. exudate, if present; type (such as purulent/serous), color, odor and appropriate amount, d. pain, if present; nature and frequency, e. Wound bed: color and type of tissue/character including evidence of healing (e.g., granulation tissue or maceration) as appropriate. f. Appearance of surrounding tissue, g. Any evidence of infection...7. If a pressure ulcer does not show evidence of progress toward healing within 2-4 weeks, the physician will be notified and the residents overall condition will be reassessed for any changes needed in the treatment plan. Monitoring: 1. Should evaluate and document when there are identified changes. 2. Residents will be monitored every shift to ensure that measures are in place as specified on the care plan to prevent/promote skin breakdown. 3. Twice weekly, on bath/shower days, the nursing assistant will look at the resident's skin and place the identified area on the shower sheet. The nursing assistant will report any reddened and/or areas of concern to the licensed nurse. 4. The licensed nurses will complete a head to toe body review twice a week as well. This head to toe body review is in addition to the nursing assistant's skin review...6. The interdisciplinary team will review residents with pressure ulcers during the weekly NAR (Nutritional at Risk) committee/resident review committee."

Administrative staff member (ASM) #2, the director of nursing, ASM #3, the assistant director of nursing and ASM #4, the regional director of clinical services were made aware of the above findings on 7/18/18 at 5:20 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 07/19/2018

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 686	Continued From page 81	F 686		

(1) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/.

(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.

(3) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 207.

(5) This information was obtained from the following website: https://medical-dictionary.thefreedictionary.com/bogginess

(6) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 394.

2. a. The facility staff failed to measure and stage Resident #283's left heel wound for 20 days.

Resident #283 was admitted to the facility on 10/5/17 with diagnoses that included but were not limited to: spinal stenosis (spinal stenosis, is when the spine is narrowed in one or more areas: The space at the center of the spine. The canals where nerves branch out from the spine. The space between the bones of the spine. This

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 07/19/2018

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 686	Continued From page 82	F 686		

narrowing puts pressure on the spinal cord and nerves and can cause pain. (1)), compression fracture of lumbar vertebra, atherosclerotic heart disease of native coronary artery (atherosclerosis is a common disorder of the arteries in which plaques and lipids form on the inner arterial wall. As a result, the vessels become nonelastic and the lumen is narrowed, leading to decreased blood flow. (2)), high blood pressure, edema, depression, glaucoma, atherosclerosis of native arteries of the left leg with ulceration of the heel and peripheral vascular disease (any abnormal condition, including atherosclerosis, affecting blood vessels outside the heart (3)).

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, prior to his transfer from the hospital, with an assessment reference date of 11/2/17, coded the resident as scoring an "11" on the BIMS (brief interview for mental status) score, indicating the resident had moderate difficulty in making daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for most of his activities of daily living; moving in the bed, transfers, toileting and personal hygiene. In Section M - Skin Condition, the resident was coded as having one stage 1 pressure ulcer. No other pressure ulcers were coded.

The admission MDS assessment, with an assessment reference date of 10/12/18 coded the resident in Section M - Skin Conditions, with one stage 1 pressure ulcer and one unstageable wound * that measured 4.0 cm (centimeters) in length, 4.0 cm in width and 0 cm in depth. The wound was coded as having slough (a yellow or white tissue that adheres to the ulcer bed in

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 07/19/2018

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 686	Continued From page 83	F 686		

strings or thick clumps, or is mucinous) Definition obtained directly from the MDS assessment. Under, "Number of Venous or Arterial Ulcers" it was coded as the resident not having any ulcers of this nature.

*Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. (4)

The "Admission Assessment" dated, 10/5/18 at 2:30 p.m. documented in part, "Resident is a 93 year old male who arrived from (Name of inpatient rehab [rehabilitation] center) at 2:20 p.m.

The "Bi-Weekly Skin Observation" dated, 10/5/18 at 2:30 p.m. documented, "1. Does the resident have current Skin Issues?" A "Yes" was documented. Under "Site and Description: edema to ankles, left heel ulcer and bruising to left knee." The nurse who documented this assessment was no longer employed at the facility and was not available for interview.

The physician order dated, 10/5/18 at 11:49 p.m. documented, "Cleanse left heel with wound cleanser and apply Santyl* and cover with foam dressing."

*Santyl is a sterile enzymatic debriding ointment used to that has a unique ability to digest collagen in necrotic tissue. (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 07/19/2018

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 686	Continued From page 84	F 686		

Review of the clinical record failed to reveal any documented staging or measurements of the heel wound until 10/18/17.

The "Weekly Wound Assessment" dated, 10/18/17 documented, "Wound type - pressure. Stage - UTD (unstageable). Wound location: left heel. Length: 3.7 cm (centimeters) x (by) Width 4 cm. Depth: na. [not applicable] Location Where Wound Was Acquired - Community acquired. Was the skin impairment present on admission - yes. Date Wound Identified - 10/5/17. Drainage - serosanguinous. Drainage amount - small. Wound Bed Appearance - slough, red and black. Wound status - unchanged. Treatment: Santyl and Foam."

The comprehensive care plan dated, 10/5/17, documented in part, "Focus: Resident is frequently incontinent of bowel and bladder and has a bed mobility problem. Has a non-blanchable area of redness on his coccyx and an unable to stage area on his left heel, which was present on admission. At risk for worsening of skin integrity." The following interventions were dated 10/5/17: Air mattress to bed as ordered. Immediately report any skin redness or skin breakdown to charge nurse. Provide incontinent care as needed." The following interventions were dated 10/18/17: Apply tx (treatment) as ordered. Assist with toileting upon rising, AC (before meals) PC (after meals) HS (hours of sleep) and PRN (as needed). Assist with turning and positioning routinely as needed. Follow facility skin protocol. Notify MD (medical doctor) of changes in skin 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 07/19/2018

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 686	Continued From page 85	F 686		

An interview was conducted with administrative staff member (ASM) #6, the primary care physician at the facility, on 7/18/18 at 2:10 p.m. When asked what he remembered of Resident # 283's heel wound, ASM #6 stated the resident had come to the facility end of September or beginning of October. He stated the resident had come in for spinal problems. ASM #6 stated, Resident #238 had come in with the heel wound to the facility and received treatment immediately to the wound.

A request was made to ASM #3, the assistant director of nursing (ADON), on 7/18/18 at approximately 1:45 p.m. for all the wound assessments and measurements for Resident # 283. ASM #3 returned on 7/18/18 at 2:00 p.m., to this surveyor, and stated, "We don't have any weekly wound measurements prior to 10/18/17."

An interview was conducted with LPN (licensed practical nurse) #6 on 7/18/18 at 3:06 p.m. When asked about the process staff follows for a resident's skin upon admission to the facility, LPN #6 stated, "I go in with a CNA (certified nursing assistant) and we undress the resident. We look at every crevice and measure any open area, surgical sites that we see. We count the stitches or staples if they have any." When asked about the process staff follows if a resident is admitted with a heel wound, LPN #6 stated, "We go assess, measure, and put appropriate treatment in place. We document the size, and odor description." When asked if assessing, measuring and treating wounds is in her scope of practice, LPN #6 stated, "Yes." LPN #6 stated, "If we are uncertain of what the wound is, we grab (name of unit manager) or (name of ASM #3)." When asked how often wounds are measured.

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 07/19/2018

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 686	Continued From page 86	F 686		

LPN #6 stated they are measured weekly. When asked where the measurements are documented, LPN #6 stated, "On the "Weekly Wound Assessment."

An interview was conducted with LPN #4 on 7/18/18 at 3:10 p.m. When asked how often wounds are measured, LPN #4 stated they are measured weekly. When asked where the measurements are documented, LPN #4 stated, on the 'Weekly Wound Assessment.' When asked if it is in his scope of practice to assess and make decisions about a wound, classify the wound, i.e., stage 1 or stage 2, LPN #4 stated, "No, I don't think so." When asked who stages or classifies the wounds, LPN #4 stated, "The RN (registered nurse) does that after we do the initial assessment."

An interview was conducted with RN #5, the unit manager, on 7/18/18 at 3:25 p.m. When asked if the LPN's can do the initial assessment of wounds, RN #5 stated, "Yes and they can implement treatment." When asked if there is anything an RN would have to do, RN #5 stated, "Measurements and staging." when asked how often wounds are measured, RN #5 stated, "Weekly." When asked where the measurements are documented, RN #5 stated, "On the 'Weekly Wound Assessment Form."

An interview was conducted with ASM #3, ASM #2, the director of nursing (DON), RN # 5, the unit manager, and ASM #1, the administrator on 7/19/18 at 8:32 a.m. When asked about the process staff follows for new wounds, ASM #3 stated, "When it is initially found the nurse does a change in condition form. We notify the doctor. Get orders for treatment and notify 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 07/19/2018

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 686	Continued From page 87	F 686		

responsible party." When asked when measurements of the wound are taken, ASM #3 stated, "They should be done when the new area is found and weekly measurements until healed." When asked if weekly wound rounds are made at the facility, ASM #2 stated, "No, the nurses do the treatments and notify the unit manager of any changes in the wound." When asked who oversees the LPNs that are doing the measurements and treatments, ASM #2 stated, "The unit managers and the ADON." When asked who stages the wounds, ASM #2 stated, "The unit managers, the ADON and myself, the DON. Whenever there is a new wound, we all go and look at it." When asked where that is documented, ASM #3 stated, "In the chart." When asked who oversees the wound program, ASM #2 stated, "The unit manager is aware of any changes in the wounds by the nurses on the unit. The RN will step in when there is no progression of healing of the wounds." When asked where the measurements and documentation was located, for Resident #283's heel wound, identified on admission, ASM #2 stated, "They weren't done." When asked if the LPNs have received any training on wound care, ASM #3 stated, "They get training on hire and in nursing school, and there are standing orders." When asked if the nurses get specific training on the assessment of wounds and the treatment of wounds, ASM #3 stated, "There is no formal training, we have no process for that here." At this time ASM #1, the administrator, ASM #2, the DON, ASM #3, the ADON and RN #5 were made aware of the above concern at this time.

2. b. The facility staff failed to administer treatments as ordered to Resident #283's left hell

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 07/19/2018

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 686	Continued From page 88	F 686		

pressure wound, on several dates in October 2017.

The "Bi-Weekly Skin Observation" dated, 10/5/18 at 2:30 p.m. documented, "1. Does the resident have current Skin Issues?" A "Yes" was documented. Under "Site and Description: edema to ankles, left heel ulcer and bruising to left knee." The nurse who documented this assessment was no longer employed at the facility and was not available for interview.

The physician order dated, 10/5/18 at 11:49 p.m. documented, "Cleanse left heel with wound cleanser, apply Santyl, and cover with foam dressing."

The "Treatment Administration Record" (TAR) for October 2017 documented the above treatment. The treatment was not documented as completed on 10/7/17, 10/8/17, 10/10/17 and 10/22/17. The place for the nurse's initials was blank.

An interview was conducted with LPN #5 on 7/18/18 at 3:18 p.m. When asked what blanks on the TAR mean, LPN #5 stated, "Obviously it was not done. If it's done a check mark would be documented there." When asked why it is important to administer what is ordered, LPN #5 stated, "Every order is given for a reason, there will be consequences if the treatment is not administered and can lead to more complications."

An interview was conducted with RN #5, the unit manager, on 7/18/18 at 3:32 p.m. When asked what blanks on the TAR mean, RN #5 stated, "It means it wasn't signed off. If there is no nurse's note explaining why it wasn't done then the blank

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 07/19/2018

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 686	Continued From page 89 means it wasn't done." ASM #1, ASM #2, ASM #3 and RN #5 were made aware of the above concern on 7/19/18 at 8:45 a.m. No further information was provided prior to exit. COMPLAINT DEFICIENCY (1) This information was obtained from the following website: https://www.niams.nih.gov/health-topics/spinal-stenosis. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 53. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447. (4) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (5) This information was obtained from the following website: http://www.rxlist.com/santyl-drug.htm.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		8/10/18

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 07/19/2018

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 690	Continued From page 90 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services for an indwelling urinary catheter for one of 31 residents in the survey sample, Resident #66. The facility staff failed to document the urinary catheter output as ordered by the physician for Resident #66. The findings include:	F 690	F690 1. Resident #66 discharged on 07/31/18. Physician has been notified about the days and times that output was not documented although resident has been discharged. 2. Any resident with a urinary catheter has the potential to be affected. 100% audit of catheter output for the previous 30 days was completed by DON/ADON on 08/02/18.	

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 07/19/2018

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 690	Continued From page 91 Resident #66 was admitted to the facility on 6/30/18 with diagnoses that included but were not limited to: anemia, muscle weakness, falls, high blood pressure and inability to urinate. The most recent MDS (minimum data set), a 14 day admission assessment, with an ARD (assessment reference date) of 7/7/18 coded the resident as having scored a 13 out of 15 on the brief interview for mental status, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living except for eating which the resident could perform after the tray was prepared. The resident was coded as having a urinary catheter. Review of the July 2018 physician's orders documented, "DOCUMENT FOLEY (urinary catheter) OUTPUT EVERY SHIFT. Start Date 07/01/2018. Review of the July 2018 treatment administration record documented, DOCUMENT FOLEY OUTPUT EVERY SHIFT. -Start Date- 07/01/2018. Review of the record did not evidence documentation of the urinary output on six occasions. Review of the resident's care plan initiated on 7/11/18 documented, "Focus. Resident has an indwelling foley catheter which was present on admission. Interventions. assess (sic.) and document intake and output as per facility policy." An interview was conducted on 7/18/18 at 3:35 p.m. with LPN (licensed practical nurse) #6 and LPN #7, the resident's nurses. When asked who emptied the urinary catheter drainage bags, LPN	F 690	3. New residents admitted with catheter added to audit during morning risk meeting. Licensed nurses have been educated by DON/ designee about documenting urinary output. Education will include orientation for new employees. 4. Residents with foley catheter to include output will be audited 5 x week x 3 months by UM/ designee. Results will be reviewed in QAPI monthly x 3 months. 5. 08/15/18	

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 07/19/2018

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 690	Continued From page 92	F 690		

#6 stated, "The CNAs or sometimes I will if I'm worried about it." When asked who documented the output in the clinical record, LPN #6 stated, "We do." LPN #6 and #7 reviewed the July 2018 treatment administration record for Resident #66. When asked what a blank space meant, LPN #6 stated, "It wasn't documented." LPN #6 stated, "It is important because it tells us if the kidneys are working appropriately." When asked who used the information in the resident's clinical record, LPN #7 stated, "We use it and sometimes the doctor uses it." When asked if staff were expected to follow the doctor's orders, LPN #6 and LPN #7 stated they were.

On 7/18/18 at 5:10 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 findings.

An interview was conducted on 7/19/18 at 10:19 a.m. with RN (registered nurse) #5, the unit manager. When asked why it was necessary for staff to document the resident's urinary output as ordered by the physician, RN #5 stated, "To prove something was done. Continuity of care. They should document it every shift."

No further information was provided prior to exit.

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

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 07/19/2018

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 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. 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 implement nutritional interventions to address a significant weight loss for one of 31 residents in the survey sample, Resident #334. The facility staff failed to address a 14-pound weight loss for Resident #334. The findings include: Resident #334 no longer resided at the facility, and was assigned #334 for purposes of	F 692	F692 1. Resident # 334 discharged on 12/11/17. 2. Any resident has the potential to be affected. All resident weight losses were audited for interventions on 08/02/18 and 08/03/18 by DON/ADON/Unit managers. 3. The CDM was educated on weight policy process by DON on 8/10/18 and will provide a weekly list of current weight losses to the Dietician for follow up and interventions. CNAs were educated by DON/ designee on the action of taking weights, reporting discrepancies and on the weight policy. Education will include	8/10/18

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 07/19/2018

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 692	Continued From page 94 identification. Resident #334 was admitted to the facility on 11/2/17 with diagnoses that included but were not limited to: stroke, seizures and dementia. The most recent MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 11/30/17 coded the resident as usually understanding others and usually making self understood. The resident was coded as requiring assistance for all activities of daily living. Review of the care plan initiated on 11/13/17 and revised on 11/29/18 documented, "Focus. Resident has increased nutrition/hydration risk related to: need for therapeutic diet...Interventions Monitor weight per protocol. Offer alternate foods if < (less than) 50%." Review of the weight summary record documented the resident's weight to be 121 pounds on 11/22/17 and 107 pounds on 12/5/17. A 14-pound weight loss in 13 days. Review of the November and December CNA (certified nursing assistant) activities record documented that the resident ate zero to 50 percent at each meal. Review of the December 2017 physician's orders documented, "NAS (No Added Salt) diet. Regular texture. Thin consistency." There was no evidence that the resident was prescribed a weight gain supplement. Review of the December 2017 notes did not evidence documentation from the dietitian regarding the weight loss. Review of the December 2017 nurse's notes did	F 692	orientation for new employees. 4. Weights will be reviewed weekly x12 weeks for weight loss and appropriate interventions by IDT. Results will be reviewed monthly in QAPI x 3 months. 5. 08/15/18	

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 07/19/2018

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 692	Continued From page 95	F 692		

not evidence documentation regarding the weight loss.

An interview was conducted on 7/18/18 at 3:55 p.m. with CNA #3, the aide who obtained the resident's weights. When asked about the process staff follows when obtaining weights, CNA #3 stated, "I take the weight and I go back and check if they had a weight change" When asked what staff did if there was a weight change, CNA #3 stated, "I recheck it." CNA #3 reviewed the resident's weights. CNA stated, "That's a big weight loss. I remember her. She wasn't eating as much as when she first got here." When asked if the nurse had been notified of the weight loss, CNA #3 stated, "They have the weigh meeting on Thursdays." When asked if she communicated this at the weight meeting, CNA #3 stated, "I'm not sure."

An interview was conducted on 7/19/18 at 9:49 a.m. with RN (registered nurse) #5, the unit manager. When asked about the process staff follows for weight changes, RN #5 stated, "When they're entering the weight they should be looking at the previous weight." RN #5 stated, "Ultimately the dietitian and I coordinate if there's questions about weight loss. We put an immediate intervention into place." RN #5 reviewed Resident #334's clinical record for the weight loss documented above, and any interventions. RN #5 there was no documentation regarding any interventions or a dietitian's note.

An attempt to contact the dietitian was unsuccessful.

On 7/19/18 at 11:30 a.m. ASM (administrative staff member) #1, the administrator and 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 07/19/2018

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 692	Continued From page 96 the director of nursing were made aware of the concern. Review of the facility's policy titled, "WEIGHT POLICY" documented, "Policy: Weights must be obtained routinely in order to monitor parameters of nutrition over time. Procedure: Obtaining accurate weights is vital for the nutritional assessment of each resident and is used as the basis for Medical Nutrition Therapy intervention. Nursing is responsible for the determination of each individual's weight. (C) Weekly Weights. 2. The day following weekly weight day the weights will be reviewed by the DON (director of nursing) or DON designee to ensure compliance to (name of corporation) standards and to determine if any re-weights are required. (D) Reweighs. 3. All significant weight changes must be communicated to the resident if appropriate, the attending physician, and responsible party." No further information was provided prior to exit.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it	F 695	F695 1. CPAP mask storage was corrected	8/10/18

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 07/19/2018

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 695	Continued From page 97 was determined that the facility staff failed to ensure respiratory care was provided consistent with professional standards of practice, the comprehensive person-centered care plan for two of 31 residents in the survey sample, Resident #331 and # 69. 1. The facility staff failed to store the CPAP mask in a sanitary manner for Resident #331. 2. The facility staff failed to administer Resident # 69's oxygen according to the physician's orders. The findings include: 1. Resident #331 was admitted to the facility on 7/14/18 with diagnoses that included but were not limited to: chronic lung disease, high blood pressure and fractured right shoulder. The most recent minimum data set, a nursing home and swing bed tracking set; with an assessment, reference date of 7/14/18 did not include information regarding the resident's cognitive status. Review of the nurse's notes documented that the resident was alert, oriented, and required assistance with activities of daily living. Review of the care plan initiated on 7/16/18 documented, "Focus. Alteration in sleep pattern r/t (related to) need for CPAP (1)." An observation was made on 7/17/18 at 10:35 a.m., of Resident #331. The resident was lying in the bed. The CPAP mask was on top of the CPAP machine, uncovered.	F 695	immediately. Resident # 331 discharged on 07/30/18. Oxygen setting corrected immediately for resident # 69 and pulmonary assessment was performed on 07/18/18 by charge nurse. 2. Any resident with respiratory disorders has the potential to be affected. Unit managers audited residents with oxygen for correct settings with 100% accuracy and CPAP storage on 08/02/18. 3. UM/ designee will conduct audits on residents receiving O2 and CPAPs to include oxygen settings and proper mask storage. Licensed nurses were educated on following MD orders for oxygen settings; and mask storage by DON/ designee. Education will include orientation for new employees. 4. UM/ designee audits will be reviewed 5 x week for 12 weeks. Results will be reviewed in QAPI monthly x 3 months. 5. 08/15/18	

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 07/19/2018

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 695	Continued From page 98	F 695		

An observation was made on 7/17/18 at 2:30 p.m., of Resident #331. The resident was up in a wheelchair. The CPAP mask was on top of the CPAP machine, uncovered.

An observation was made on 7/18/18 at 7:57 a.m. of Resident #331. The resident was sitting up on the side of bed. The CPAP mask was on top of the CPAP machine uncovered.

An observation was made on 7/18/18 at 3:35 p.m. of Resident #331's room with LPN (licensed practical nurse) #6 and LPN #7, the resident nurses. The CPAP mask was observed on top of the CPAP machine. The mask was uncovered. When asked how the mask should be stored when not in use, LPN #6 stated, "In a plastic bag." When asked why, LPN #6 and LPN #7 stated, "Infection control."

Review of the July 2018 physician's orders documented, "pt (patient) to put on own cpap (1) at night for sleep apnea home settings."

Review of the July 2018 treatment administration record documented, "pt to put on own cpap at night for sleep apnea home settings." The CPAP was documented as being on each night.

On 7/18/18 at 5:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2 the director of nursing were made aware of the findings.

An interview was conducted on 7/19/18 at 10:19 a.m. with RN (registered nurse) #5, the unit manager. When asked how a CPAP mask was stored when not in use, RN #5 stated, "In a plastic bag." When asked why, RN #5 stated,

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 07/19/2018

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 695	Continued From page 99	F 695		

"For infection control. To keep it contained."

On 7/19/18 at approximately 10:30 a.m., a request for the facility's policy on oxygen and equipment storage was made to ASM #4.

On 7/19/18 at 12:28 p.m. ASM #4, the regional director of clinical services stated, "I don't have a policy about storage."

No further information was provided prior to exit.

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment."

1. CPAP -- Continuous positive airway pressure. It involves using a CPAP machine that includes a mask or other device that fits over your nose or your nose and mouth, straps to position the mask, a tube that connects the mask to the machine ' s motor, and a motor that blows air into the tube. CPAP is used to treat sleep-related breathing disorders including sleep apnea. It also may be used to treat preterm infants who have underdeveloped lungs. This information was obtained from: https://www.nhlbi.nih.gov/health-topics/cpap

2. The facility staff failed to administer Resident # 69's oxygen according to the physician's orders.

Resident # 69 was admitted to the facility on 09/15/11 and a readmission of 03/28/17 with

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 07/19/2018

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 695	Continued From page 100	F 695		

diagnoses that included but were not limited to heart failure, shortness of breath, bipolar disorder (1), diabetes mellitus, (2), gastroesophageal reflux disease (3), anxiety (4), hypertension (5), and hyperlipidemia (6).

Resident # 69's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/05/18, coded Resident # 69 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 69 was coded as requiring extensive assistance of one staff member for activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 69 was coded for "C. Oxygen therapy."

An observation on 07/18/18 at approximately 9:45 a.m. revealed Resident # 69 was sitting in bed watching television. Resident # 69 was receiving O2 (oxygen) by nasal cannula from an oxygen concentrator. Observation of the O2 flow meter on the oxygen concentrator revealed the oxygen flow rate at two liters per minute.

An observation on 07/18/18 at approximately 11:17 a.m. revealed Resident # 69 was sitting in bed watching television. Resident # 69 was receiving O2 (oxygen) by nasal cannula from an oxygen concentrator. Observation of the O2 flow meter on the oxygen concentrator revealed the oxygen flow rate at two liters per minute.

An observation on 07/18/18 at approximately 2:07 p.m., revealed Resident # 69 was sitting in bed watching television. Resident # 69 was receiving O2 (oxygen) by nasal cannula from an oxygen concentrator. Observation of the O2 flow meter

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 07/19/2018

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 695	Continued From page 101	F 695		

on the oxygen concentrator revealed the oxygen flow rate at two liters per minute.

The physician's orders for Resident # 69 dated July 2018 documented, "O2 (Oxygen) 3 (three) L/min (liters per minute) via (by) nasal cannula PRN (as needed) q (every) shift: shortness of breath. Order Date: 05/23/2018. Start Date: 05/23/2018."

The eTAR (electronic treatment administration record) dated July 2018 for Resident # 69 documented, "O2 (Oxygen) 3 (three) L/min (liters per minute) via (by) nasal cannula PRN (as needed) q (every) shift: shortness of breath. Start Date: 05/23/2018." Further review of the eTAR failed to evidence Resident # 69 received oxygen on 07/18/18.

The comprehensive care plan for Resident # 69 dated 01/15/2018 documented, "Focus. The resident has altered respiratory status/Difficulty Breathing r/t (related to) Pneumonia, CHF (congestive heart failure), CAD (coronary artery disease), and anxiety." Under "Interventions/Tasks" it documented, "Provide oxygen as ordered. Date Initiated 01/15/2018."

On 7/18/18 at approximately 2:13 p.m., an interview was conducted with LPN (licensed practical nurse) # 1, unit manager. When asked how often the oxygen flow rate is check for a resident receiving PRN and continuous oxygen, LPN # 1 stated, "I check every time I go into the room." When asked what the oxygen flow rate was for Resident # 69, LPN # 1 stated, "I'll check the orders." LPN # 1 looked up the physician's orders on the EHR (electronic health record) for Resident # 69 and stated, "Three liters per

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 07/19/2018

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 695	Continued From page 102	F 695		

minute." When asked how the oxygen flow rate is read, LPN # 1 stated, "Get eye level in front of the O2 concentrator, the ball show be in the middle of the flow rate line, the line should cut the ball in half." At 2:23 p.m., LPN # 1 observed the flow rate on Resident # 69's oxygen concentrator and stated, "It's on two liters, it should be three." LPN # 1 then adjusted the flow rate on the oxygen concentrator to three liters. When asked why it was important to maintain the correct oxygen flow rate, LPN # 1 stated, "Their [the resident's] O2 saturation could be low and result in respiratory issues such as shortness of breath, hypoxia and distress." When asked about the eTAR failing to document the administration of the O2 on 07/18/18, LPN # 1 stated, "It's documented at the end of the shift, at 3:00 p.m."

On 07/18/18 at approximately 5:15 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3, assistant director of nursing and ASM # 4, regional director of clinical services were made aware of the findings.

Nursing Interventions and Clinical Skills, 2nd edition, Elkin, Perry and Potter 2000, page 936, "Oxygen is a drug and is administered and monitored with the same care as any other medication."

No further information was provided prior to exit.

References:
(1) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-dis

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 07/19/2018

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 695	Continued From page 103 order/index.shtml. (2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (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) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (6) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §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-	F 757		8/10/18

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 07/19/2018

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 757	Continued From page 104 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to ensure medication regimen was free from unnecessary drugs for two of 31 residents in the survey sample, (Resident # 63 and Resident #57). 1. The facility staff failed to hold the administration of insulin (1) when the Resident # 63's blood sugar (2) was below 100. 2. The facility staff administered Midodrine (used to treat a kind of low blood pressure that can cause severe dizziness and fainting (3)) to Resident #57, when the resident's blood pressure was outside of the parameters prescribed by the physician for Resident #57. The findings include:	F 757	F757 1. Resident #57, physician notified of medication error on 8/1/18. Resident #63, physician notified of medication errors on 07/11/18. For resident #57, medication error completed 07/19/18 and licensed nurse was educated on midodrine administration. For resident #63, medication error completed on 7/11/18 and licensed practical nurse educated on parameters, med pass and following physician's orders. 2. All residents receiving midodrine or insulin have the potential to be affected. Audit completed on 08/03/18 by DON to ensure midodrine/ insulin was given appropriately. 3. Licensed nurses educated on midodrine and insulin parameters by	

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 07/19/2018

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 757	Continued From page 105 1. Resident # 63 was admitted to the facility on 09/14/16 and a readmitted on 11/02/17 with diagnoses that included but were not limited to heart failure, convulsions (3), diabetes mellitus, (4), Parkinson's disease (5), seizures (6), hypertension (7), and hyperlipidemia (8). Resident # 63's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/02/18, coded Resident # 63 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 63 was coded as requiring extensive assistance of one staff member for activities of daily living. Under section "N. Medications" Resident # 63 was coded for receiving insulin in the past seven days. The physician's order sheet (POS) dated July 2018 for Resident # 63 documented "Levemir (9) 100 UNIT/1ML (one milliliter) UNIT. Inject 22 unit subcutaneously (10) in the morning for DM (diabetes mellitus). Hold for BS (blood sugar) < (less than) 100 or BS > (greater than) 300 Notify Hospice." The eMAR (electronic medication administration record) dated June 2018 for Resident # 63 documented, "Levemir 100 UNIT/1ML (one milliliter) UNIT. Inject 22 unit subcutaneously in the morning for DM (diabetes mellitus). Hold for BS (blood sugar) < (less than) 100 or BS > (greater than) 300 Notify Hospice." Further review of the eMAR revealed levemir was administered on 06/01/18 with a blood sugar reading of 91, 06/08/18 with a blood sugar reading of 78, 06/09/18 with a blood sugar	F 757	DON/ designee. Education will include orientation for new employees. 4. MDS nurse/ designee will review midodrine and insulin orders 5 x week x 12 weeks for accuracy. Results will be reviewed in QAPI monthly x 3 months. 5. 08/15/18	

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 07/19/2018

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 757	Continued From page 106	F 757		

reading of 95 and on 06/26/18 with a blood sugar reading of 93.

The eMAR (electronic medication administration record) dated July 2018 for Resident # 63 documented, "Levemir 100 UNIT/1ML (one milliliter) UNIT. Inject 22 unit subcutaneously in the morning for DM (diabetes mellitus). Hold for BS (blood sugar) < (less than) 100 or BS > (greater than) 300 Notify Hospice." Further review of the eMAR revealed levemir was administered on 07/2/18 with a blood sugar reading of 98 and 07/17/18 with a blood sugar reading of 88.

The comprehensive care plan for Resident # 63 dated 10/20/2017 documented, "Focus. The resident has Diabetes Mellitus." Under "Interventions/Tasks" it documented, "Medication as ordered by doctor. Date Initiated 10/20/2017."

On /18/18 at approximately 2:13 p.m., an interview was conducted with LPN (licensed practical nurse) # 1, unit manager. LPN # 1 was asked to review the eMAR (electronic medication administration record) dated June 2018 and July 2018. LPN #1 was asked about the insulin administered on 06/01/18 with blood sugar of 91, 06/08/18 with blood sugar of 78, 06/09/18 with blood sugar of 95 and on 06/26/18 with blood sugar of 93, 07/2/18 with blood sugar of 98 and 07/17/18 with blood sugar of 88. LPN # 1 stated, "The blood sugar was outside the parameter and should not have been given."

The facility's policy "6.0 General Dose Preparation and Medication Administration" documented, "4.1.1 Verify each time a medication is administered that it is the correct

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 07/19/2018

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 757	Continued From page 107	F 757		

medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident ..."

On 07/18/18 at approximately 5:15 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3, assistant director of nursing and ASM # 4, regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

References:

(1) With type 1 diabetes, your pancreas does not make insulin. Insulin is a hormone that helps glucose get into your cells to give them energy. Without insulin, too much glucose stays in your blood. If you have type 1 diabetes, you will need to take insulin. Type 2 diabetes, the most common type, can start when the body doesn't use insulin, as it should. If your body can't keep up with the need for insulin, you may need to take pills. Along with meal planning and physical activity, diabetes pills help people with type 2 diabetes or gestational diabetes keep their blood glucose levels on target. Several kinds of pills are available. Each works in a different way. Many people take two or three kinds of pills. Some people take combination pills. Combination pills contain two kinds of diabetes medicine in one tablet. Some people take pills and insulin. This information was obtained from the website: https://medlineplus.gov/diabetesmedicines.html.

(2) Blood sugar, or glucose, is the main sugar found in your blood. It comes from the food you eat, and is your body's main source of energy.

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 07/19/2018

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 757	Continued From page 108	F 757		

Your blood carries glucose to all of your body's cells to use for energy. This information was obtained from the website: https://medlineplus.gov/bloodsugar.html.

(3) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm.

(4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(5) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(6) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html.

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

(8) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting

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 07/19/2018

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 757	Continued From page 109	F 757		

heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.

(9) LEVEMIR® (insulin detemir [rDNA origin] injection) is a sterile solution of insulin detemir for use as a subcutaneous injection. Insulin detemir is a long-acting (up to 24-hour duration of action) recombinant human insulin analog. LEVEMIR® is produced by a process that includes expression of recombinant DNA in Saccharomyces cerevisiae followed by chemical modification. This information was obtained from the website: https://www.rxlist.com/levemir-drug.htm.

(10) The term "subcutaneous" refers to the skin. Subcutaneous means beneath, or under, all the layers of the skin. For example, a subcutaneous cyst is under the skin. This information was obtained from the website: https://medlineplus.gov/ency/article/002297.htm.
2. The facility staff administered Midodrine (used to treat a kind of low blood pressure that can cause severe dizziness and fainting (3)) to Resident #57, when the resident's blood pressure was outside of the parameters prescribed by the physician for Resident #57.

Resident #57 was admitted to the facility on 5/24/18 with diagnoses that included but were not limited to: heart failure, atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (1)), hypotension (too low blood pressure), prostate cancer, diabetes, 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 07/19/2018

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 757	Continued From page 110	F 757		

sleep apnea (a condition in which the patient has transient periods of apnea [not breathing] during sleep (2)).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/21/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive decisions. The resident was coded as extensive assistance of one or more staff members for all of his activities of daily living except eating in which he only required supervision with set up assistance.

The physician order dated, 5/24/18, documented, "Midodrine* 2.5 mg (milligrams) by mouth three times a day for hypotension. Hold for SBP (systolic blood pressure) > (greater than) 140."

*Midodrine is used to treat a kind of low blood pressure that can cause severe dizziness and fainting. (3)

The medication administration record (MAR) for July 2018 documented the above medication order. On 7/14/18 at 6:00 a.m., Resident #57's blood pressure was documented as "186/74." The medication Midodrine 2.5 mg was documented as administered.

Review of the nurse's notes dated 7/14/18 failed to document a note related to the blood pressure at 6:00 a.m.

The comprehensive care plan dated, 6/4/18, documented in part, "Focus: The resident has impaired cardiovascular status." The "Interventions/Tasks" documented in part, "Vital

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 07/19/2018

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 757	Continued From page 111	F 757		

signs per routine/orders/and prn (as needed). Notify physician of any abnormal readings."

An interview was conducted with LPN (licensed practical nurse) #5 on 7/18/18 at 3:15 p.m., regarding the process staff follows for medication with physician ordered parameters for administration, LPN #5 stated, "You have to check the vital sign documented in the order and hold it if it's outside of the parameters and write a note."

An interview was conducted with RN (registered nurse) #5, the unit manager, on 7/18/18 at 3:29 p.m. When asked what Midodrine is used for, RN #5 stated, "It's to raise the blood pressure." When about the process staff follows if parameters are present with the order, RN #5 stated, "They need to follow the parameters." When shown the parameters for the Midodrine and Resident #57's blood pressure reading of 7/14/18, RN #5 stated, "It (Midodrine) should have been held and a note written."

The facility policy, "General Dose Preparation and Mediation Administration" documented in part, "4.1 - Facility staff should: 4.1.5 If necessary, obtain vital signs...6.1 - Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN [as needed] medications, application sight) on appropriate forms.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses 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 07/19/2018

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 757	Continued From page 112 obligated to follow physician's orders unless they believe the orders are in error or would harm clients." Administrative staff member (ASM) #2, the director of nursing, ASM #3, the assistant director of nursing and ASM #4, the regional director of clinical services were made aware of the above findings on 7/18/18 at 5:20 p.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 534. (3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011219/?report=details.	F 757		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. 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 ensure residents were free from of a significant medication error for one of 31 residents in the survey sample, Resident # 63. The facility staff failed to hold the administration of insulin (1) as ordered by the physician when	F 760	F760 1. Resident #63, medication error was completed on 07/11/18. MD was notified of error on 07/11/18. 2. Any resident with insulin orders to hold for blood sugar below 100 has the potential to be affected. Audits of like residents have been completed by	8/10/18

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 07/19/2018

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 760	Continued From page 113 Resident # 63's blood sugar (2) was below 100. The findings include: Resident # 63 was admitted to the facility on 09/14/16 and a readmission of 11/02/17 with diagnoses that included but were not limited to heart failure, convulsions (3), diabetes mellitus, (4), Parkinson's disease (5), seizures (6), hypertension (7), and hyperlipidemia (8). Resident # 63's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/02/18, coded Resident # 63 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 63 was coded as requiring extensive assistance of one staff member for activities of daily living. Under section "N. Medications" Resident # 63 was coded for receiving insulin in the past seven days. The physician's order sheet (POS) dated July 2018 for Resident # 63 documented "Levemir (9) 100 UNIT/1ML (one milliliter) UNIT. Inject 22 unit subcutaneously (10) in the morning for DM (diabetes mellitus). Hold for BS (blood sugar) < (less than) 100 or BS > (greater than) 300 Notify Hospice." The eMAR (electronic medication administration record) dated June 2018 for Resident # 63 documented, "Levemir 100 UNIT/1ML (one milliliter) UNIT. Inject 22 unit subcutaneously in the morning for DM (diabetes mellitus). Hold for BS (blood sugar) < (less than) 100 or BS > (greater than) 300 Notify Hospice." Further review of the eMAR revealed levemir was	F 760	DON/ADON/UM on 08/06/18. 3. Licensed nurses were educated on following MD orders by the DON/ designee. Education will include orientation for new employees. 4. Residents receiving insulin will be audited 3 x week by UM/ designee x 12 weeks. Results will be reviewed at QAPI monthly x 3 months. 5. 08/15/18	

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 07/19/2018

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 760	Continued From page 114	F 760		

administered on 06/01/18 with a blood sugar reading of 91, 06/08/18 with a blood sugar reading of 78, 06/09/18 with a blood sugar reading of 95 and on 06/26/18 with a blood sugar reading of 93.

The eMAR (electronic medication administration record) dated July 2018 for Resident # 63 documented, "Levemir 100 UNIT/1ML (one milliliter) UNIT. Inject 22 unit subcutaneously in the morning for DM (diabetes mellitus). Hold for BS (blood sugar) < (less than) 100 or BS > (greater than) 300 Notify Hospice." Further review of the eMAR revealed levemir was administered on 07/2/18 with a blood sugar reading of 98 and 07/17/18 with a blood sugar reading of 88.

The comprehensive care plan for Resident # 63 dated 10/20/2017 documented, "Focus. The resident has Diabetes Mellitus." Under "Interventions/Tasks" it documented, "Medication as ordered by doctor. Date Initiated 10/20/2017."

On /18/18 at approximately 2:13 p.m., an interview was conducted with LPN (licensed practical nurse) # 1, unit manager. LPN # 1 was asked to review the eMAR (electronic medication administration record) dated June 2018 and July 2018. LPN #1 was asked about the insulin administered on 06/01/18 with blood sugar of 91, 06/08/18 with blood sugar of 78, 06/09/18 with blood sugar of 95 and on 06/26/18 with blood sugar of 93, 07/2/18 with blood sugar of 98 and 07/17/18 with blood sugar of 88. LPN # 1 stated, "The blood sugar was outside the parameter and should not have been given."

The facility's policy "6.0 General Dose

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 07/19/2018

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 760	Continued From page 115	F 760		

Preparation and Medication Administration" documented, "4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident ..."

On 07/18/18 at approximately 5:15 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3, assistant director of nursing and ASM # 4, regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

References:

(1) With type 1 diabetes, your pancreas does not make insulin. Insulin is a hormone that helps glucose get into your cells to give them energy. Without insulin, too much glucose stays in your blood. If you have type 1 diabetes, you will need to take insulin. Type 2 diabetes, the most common type, can start when the body doesn't use insulin, as it should. If your body can't keep up with the need for insulin, you may need to take pills. Along with meal planning and physical activity, diabetes pills help people with type 2 diabetes or gestational diabetes keep their blood glucose levels on target. Several kinds of pills are available. Each works in a different way. Many people take two or three kinds of pills. Some people take combination pills. Combination pills contain two kinds of diabetes medicine in one tablet. Some people take pills and insulin. This information was obtained from the website: https://medlineplus.gov/diabetesmedicines.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 07/19/2018

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 760	Continued From page 116	F 760		

(2) Blood sugar, or glucose, is the main sugar found in your blood. It comes from the food you eat, and is your body's main source of energy. Your blood carries glucose to all of your body's cells to use for energy. This information was obtained from the website: https://medlineplus.gov/bloodsugar.html.

(3) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm.

(4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(5) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(6) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html.

(7) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.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 07/19/2018

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 760	Continued From page 117 (8) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm. (9) LEVEMIR® (insulin detemir [rDNA origin] injection) is a sterile solution of insulin detemir for use as a subcutaneous injection. Insulin detemir is a long-acting (up to 24-hour duration of action) recombinant human insulin analog. LEVEMIR® is produced by a process that includes expression of recombinant DNA in Saccharomyces cerevisiae followed by chemical modification. This information was obtained from the website: https://www.rxlist.com/levemir-drug.htm. (10) The term "subcutaneous" refers to the skin. Subcutaneous means beneath, or under, all the layers of the skin. For example, a subcutaneous cyst is under the skin. This information was obtained from the website: https://medlineplus.gov/ency/article/002297.htm.	F 760		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		8/10/18

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 07/19/2018

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 842	Continued From page 118	F 842		

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when

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 07/19/2018

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 842	Continued From page 119 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(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, and clinical record review, it was determined the facility staff failed to ensure a complete an accurate clinical record for one of 31 residents in the survey sample, Resident #66. The facility staff failed to document a wound assessment for Resident #66. The findings include: Resident #66 was admitted to the facility on 6/30/18 with diagnoses that included but were not limited to: anemia, muscle weakness, falls, high blood pressure and inability to urinate. The most recent MDS (minimum data set), a 14 day admission assessment, with an ARD (assessment reference date) of 7/7/18 coded the resident as having scored a 13 out of 15 on the brief interview for mental status, indicating the	F 842	F842 1. Resident # 66 wound documentation updated by ADON on 07/19/18. 2. All residents with a wound have the potential to be affected. A 100% skin audit was conducted on 07/20/18 and 07/23/18 in comparison with current documentation on most recent skin assessments. 3. Licensed nurses were reeducated on biweekly skin check policy to include documentation expectation by DON/ designee. Education will include orientation for new employees. 4. Biweekly skin checks will be audited 5 x week x 12 weeks by DON/designee. Results of audits will be reviewed at QAPI monthly x 3 months. 5. 08/15/18	

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 07/19/2018

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 842	Continued From page 120	F 842		

resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living except for eating which the resident could perform after the tray was prepared. The resident was coded as having a urinary catheter.

Review of the 7/14/18 nurses notes documented that the resident had an open area on the left buttocks. The open area was documented as being 0.5 cm (centimeters) by 0.3 cm by 0.1 cm. Further review of the clinical record did not evidence documentation regarding the open area.

An interview was conducted on 7/18/18 at 3:35 p.m. with LPN (licensed practical nurse) #6 and LPN #7, the resident's nurses." When asked why documentation was done, LPN #6 stated, "It is important because it tells us if the kidneys are working appropriately." When asked who used the information in the resident's clinical record, LPN #7 stated, "We use it and sometimes the doctor uses it."

An interview was conducted on 7/19/18 at 8:36 a.m. with ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing and RN (registered nurse) #5, the unit manager. When asked about the process staff follows if a wound was found, RN #5 stated, "Initially if a new area is found the nurse should do an e-interact (a type of nursing note), change of condition. Notify the physician and get treatment orders and notify the RD (registered dietitian)." When asked who oversaw the wound care, ASM #3 stated, "The unit manager on the first floor and myself." When asked about the follow up with Resident #66's wound, 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 07/19/2018

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 842	Continued From page 121 stated, "We saw him on Monday morning. There was nothing there. It was red." When asked if that would be documented, ASM #2 stated, "It should be." ASM #2 stated, "We all saw it but we didn't document it." 7/19/18 at 10:19 a.m. with RN (registered nurse) #5, the unit manager. When asked why it was necessary for staff to document RN #5 stated, "To prove something was done. Continuity of care." No further information was provided prior to exit.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(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;	F 880		8/10/18

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 07/19/2018

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 880	Continued From page 122 §483.80(a)(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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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 07/19/2018

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 880	Continued From page 123 §483.80(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 the facility staff failed to maintain infection control practices in one of two dining rooms, the first floor dining room. The dietary staff failed to wash their hands after removing gloves and entering the dining room and serving residents their food in the first floor dining room. The findings include: Observation was made of the first floor dining room on 7/17/18 at 12:47 p.m. Other staff member (OSM) #6 came out of the kitchen. He had blue gloves on. He removed the gloves and shoved them into the back pocket of his trousers. He did not wash his hands. He proceeded to serve a resident at the second table from the front near the windows. He assisted that resident with opening his butter packet and putting it into his hot cereal. An interview was conducted with OSM #6, dietary aide and OSM #7, the dietary manager, on 7/18/18 at 12:04 p.m., regarding the process staff follows when removing gloves, OSM #6 stated, "We have to wash our hands." The above observation was shared with OSM #6. He stated, "That was wrong, I should have washed my hands." When asked about the process staff follows for serving food to residents, OSM #7 stated, "The staff should wash their hands prior to	F 880	F880 1. OSM # 6 was re-educated at the time. 2. All residents have potential to be affected. 3. Dietary Manager/ designee reeducated facility staff on infection control procedures involving glove use and handwashing procedures in the dining room and when serving residents. Education will include orientation for new employees. 4. DM/ designee will audit 6 meals/ wk for 4 weeks, 3 meals/ wk for 4 weeks, and 1 meal week for 4 weeks for appropriate use of glove and handwashing during meal service. Results will be reviewed in QAPI x3 months. 5. 8/15/18.	

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 07/19/2018

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 880	Continued From page 124	F 880		

serving. There should be no gloves in the dining room. When they take gloves off, they should wash their hands."

The facility policy, "Hand Washing" documented in part, "3. Perform hand hygiene: b. After removing gloves."

Administrative staff member (ASM) #2, the director of nursing, ASM #3, the assistant director of nursing, and ASM #4, the regional director of clinical services, were made aware of the above concern on 7/18/18 at 5:20 p.m.

No further information was obtained prior to exit.