PRINTED: 10/08/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
		495407	B. WING_				C 06/2019
	ROVIDER OR SUPPLIER N NURSING AND REHA	ı		STREET ADDRESS, CITY, STATE, ZIF 140 BRIMLEY DRIVE FREDERICKSBURG, VA 2240		<u> </u>	00/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	survey was conducted 09/06/2019. The fact compliance with 42 0	g-Term Care Facilities.	F (000			
	conducted from 9/4/1 complaint was invest Corrections are requ following 42 CFR Pa	igated during the survey. ired for compliance with the rt 483 of the Federal Long ents. The life safety code					
F 578	at the time of the sur consisted of 34 curre records.	O certified bed facility was 80 vey. The survey sample ent residents and six closed entrue Trmnt;FormIte Adv Dir	E	578			9/23/19
SS=E	CFR(s): 483.10(c)(6) §483.10(c)(6) The rig discontinue treatment to participate in expe formulate an advance §483.10(c)(8) Nothin construed as the right the provision of mediaservices deemed me	(8)(g)(12)(i)-(v) ght to request, refuse, and/or it, to participate in or refuse rimental research, and to					3/23/19
ADODATODY	requirements specific subpart I (Advance D (i) These requirement	facility must comply with the ed in 42 CFR part 489, Directives). Its include provisions to		TITLE			(X6) DATE

Electronically Signed 09/23/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495407	B. WING _				C 06/2019
	ROVIDER OR SUPPLIER	AB CENTER	•	14	TREET ADDRESS, CITY, STATE, ZIP CODE 40 BRIMLEY DRIVE REDERICKSBURG, VA 22406	1 00.0	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 578	residents concernin medical or surgical resident's option, fo (ii) This includes a variable facility's policies to it and applicable State (iii) Facilities are perentities to furnish the legally responsible for requirements of this (iv) If an adult indivitime of admission a information or articulas executed an admay give advance of individual's resident with State Law. (v) The facility is no provide this information or articulate information to the information of information or articular than the information of information or articular than the information of information or articular than the information or articular than the information of information or articular than the	written information to all adult g the right to accept or refuse treatment and, at the rmulate an advance directive. Written description of the mplement advance directives e law. I mitted to contract with other is information but are still for ensuring that the exection are met. I dual is incapacitated at the ind is unable to receive elate whether or not he or she wance directive, the facility directive information to the exercise representative in accordance to the representative in accordance to the individual once he individual directly at the exercise such information. The individual directly at the exercise facility document record review, the facility staff the Advanced Directives indice reviews with resident party, were provided to Directives, or, if applicable, eir existing Advance in them as written, for seven the survey sample, Residents #57, #36, and #14.	F	578	F578 1. Advanced directives were reviewed with the following Residents and/or Responsible Party for resident #22, #19 #30, #20, #57, #36, and #14. OSM #1 OSM#4 received education on the Advance Directives policy and periodic reviews with resident and/or responsible party. 2. All residents who reside at Falls Run Nursing and Rehabilitation have the potential to be affected. The Administra or designee conducted a quality review.	and le n	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495407	B. WING _			l	C (06/2019
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406			00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 578	Directives, the facility periodic review to deresponsible party wis Directives later. Resident #22 was ad 3/8/18. Diagnoses in stroke, aphasia, high gastrostomy, quadrip failure to thrive, and of MDS (Minimum Data (Assessment Referenthe resident as sever make daily life decisic coded as requiring to activities of daily livin. A review of the clinical presence of any Advareview revealed that party were provided to developing Advance admission, dated 3/1. Review of the clinical evidence that the resistatus was periodical resident/responsible opportunity and deter RP (responsible party Advance Directives later the conducted with OSM Social Services. Whe review of residents A	not have any Advance staff failed to conduct a termine if the resident or hed to develop Advance mitted to the facility on cluded but are not limited to blood pressure, diabetes, legia, dysphagia, adult contractures. The quarterly Set) with an ARD noce Date) of 6/15/19 coded ely impaired in ability to ons. The resident was tal care for all areas of g. al record failed to reveal the ence Directives. Further the resident/responsible with information for Directives around the time of 4/18. record failed to reveal any ident's Advance Directives ly reviewed with the party, to provide an emine if the resident and or of wished to develop an after.	F	578	current residents for periodic review of Advance directives. 3. Advanced directives will be reviewed admission and at least annually for all residents. Social Services department been educated on advanced directive review by Administrator/Designee. 4. SW will audit new admissions and residents with care plan meetings 5x/week for 4 weeks, then 3x/week for 8 weeks for periodic review of advanced directives. Audit results will be present monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. 5. Date of Compliance: October 1, 201	d on has ed	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495407	B. WING _				C 06/2019
	ROVIDER OR SUPPLIER IN NURSING AND REHA	B CENTER		140 B	ET ADDRESS, CITY, STATE, ZIP CODE SRIMLEY DRIVE DERICKSBURG, VA 22406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 578	Continued From page 3 and documented in the care plan meetings. OSM #1 was informed that only code status was		F!	578			
	noted on the care pla and was asked about Directives. OSM #1 s status is reviewed, th not. OSM #1 was as reviews Advance Dire not have one in place develop one, or to de Advance Directives, v OSM #1 stated, "No, statuses." When ask Advance Directives w admitted, OSM #1 stat them [Advanced Dire When asked if, Advanduring the first care p only code status is di	n meeting documentation reviews of Advanced tated that only the code e Advance Directives are ked if she periodically ectives with residents who do to determine if they wish to termine if a resident with an wishes to change anything. we only review code ed , if she reviews their with residents that are newly lated she does not review ctives], only the code status. Ince Directives are discussed lan meeting, OSM #1 stated scussed.					
	on Advance Directive I will ask them if they copy into the medical ask them if they know is and provide them is want to execute one, Worker or Administra facility evidence the rinformation on Advan stated, "they are give contains information they sign a receipt the handbook." She also resident's admission	#4, the Admissions was asked if newly e provided any information s. OSM #4 stated, "Yes, and have one, and if so get a record." OSM #4 stated, "I what an Advance Directive information on it, and if they I direct them to the Social tor." When asked how the esident was provided with ce Directives, OSM #4 in a facility handbook which on Advance Directives and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495407	B. WING _			C 09/06/2019	
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	•	00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 578	When asked about Advance Directives wish to formulate or OSM #4 stated, "Th with the social work don't have anything A review of the facil Protocol" document future medical care make decisionsTh healthcare directive during Your Path M will be discussed wirepresentative to de directives have be { directives will be reaccording to MDS social of the concern. No fur provided. 2. The facility staff review to determine responsible party wand or maintain the written.	eveloping Advance Directives. periodically reviewing the with residents to see if they ne and or make any changes, nat is done in the meetings er (care plan meetings). I to do with that." ity policy, "Advance Directives ed, "Written instructions about should you become unable to nese are also called s. Upon Admission and eetings, advance directives th resident and/or resident etermine if any advance sic} chosenAdvance viewed at minimum annually chedule" AM, ASM #1 (Administrative Administrator, was notified of ther information was failed to conduct a periodic of the Resident #15 or the ished to make any changes Advance Directives as	F 5				
	1/1/11 and was read 10/19/18, with the diperipheral vascular disorders, ischemic depression, bladder	Idmitted to the facility on dimitted to the facility on liagnoses of but not limited to: disease, intervertebral disc heart disease, diabetes, dysfunction, osteoporosis, and anxiety. The quarterly					

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495407	B. WING _				C 06/2019
	ROVIDER OR SUPPLIER	B CENTER		140 E	EET ADDRESS, CITY, STATE, ZIP CODE BRIMLEY DRIVE DERICKSBURG, VA 22406	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 578	Continued From page MDS (Minimum Data (Assessment Referent the resident as cognidally life decisions. Trequiring extensive or dressing, hygiene, ar assistance for bathing. A review of the clinical presence of Advance chart, dated 10/20/12 clinical record failed to the resident's Advance periodically reviewed resident/responsible provide opportunity for the resident's existing. On 9/5/18 at 4:32 PM conducted with OSM Social Services. Whereview of residents A stated that it (advance and documented in the OSM #1 was informed noted on the care pla and was asked about	Set) with an ARD noce Date) of 6/13/19, coded tively intact in ability to make the resident was coded as are for mobility, transfers, and toileting; limited g; and supervision for eating. All record revealed the Directives in the resident's and record revealed the Directives in the resident's and record revealed the Directives status was with the porty, to determine if, and por, making any changes to go Advance Directives. And interview was #1 (Other Staff Member) and asked about periodic divance Directives, OSM #1 and directives) is reviewed and care plan meetings. At that only code status was and meeting documentation areviews of Advanced		578		ME.	
	status is reviewed, the not. OSM #1 was as reviews Advance Directives of the not have one in placed develop one, or to de Advance Directives, oSM #1 stated, "No, statuses." When ask Advance Directives wadmitted, OSM #1 stated, "States of the note	tated that only the code e Advance Directives are ked if she periodically ectives with residents who do e to determine if they wish to termine if a resident with an wishes to change anything. we only review code ed , if she reviews their vith residents that are newly ated she does not review ctives], only the code status.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495407	B. WING _			C 09/06/2019
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406		00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ENCED TO THE APPROPRIATE	
F 578			F 5	78		
	•	ance Directives are discussed plan meeting, OSM #1 stated discussed.				
	conducted with OSM Coordinator. OSM # admitted residents a on Advance Directiv I will ask them if the copy into the medica ask them if they know is and provide them want to execute one Worker or Administr facility evidence the information on Adva stated, "they are give contains information they sign a receipt thandbook." She also resident's admission that the resident was opportunity about down when asked about Advance Directives wish to formulate or OSM #4 stated, "The	M, an interview was M #4, the Admissions F4 was asked if newly are provided any information res. OSM #4 stated, "Yes, and y have one, and if so get a all record." OSM #4 stated, "I low what an Advance Directive information on it, and if they e, I direct them to the Social rator." When asked how the resident was provided with rece Directives, OSM #4 ren a facility handbook which in on Advance Directives and that they are given the responsible of provided pages from the in agreement that reflected is offered information and reveloping Advance Directives. Periodically reviewing the with residents to see if they he and or make any changes, at is done in the meetings er (care plan meetings). I to do with that."				
	Protocol" document future medical care make decisionsTh healthcare directive during Your Path Me will be discussed wi	ity policy, "Advance Directives ed, "Written instructions about should you become unable to lese are also called s. Upon Admission and leetings, advance directives the resident and/or resident letermine if any advance				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		495407	B. WING			C 09/06/2019		
	ROVIDER OR SUPPLIER JN NURSING AND REHA	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	'	03/03/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 578	directives have be {s directives will be reviaccording to MDS so On 9/6/19 at 10:15 A Staff Member), the A the concern. No furt provided. 3. Resident #30 did Directives, the facility periodic review to de responsible party wis Directives later. Resident #30 was ac 6/28/17, with the diaglimited to: high blood disorder, diabetes, sidisorder. The annual assessment with an according to MDS accord	ic) chosenAdvance ewed at minimum annually chedule" I.M. ASM #1 (Administrative dministrator, was notified of her information was not have any Advance y staff failed to conduct a termine if the resident or shed to develop Advance dmitted to the facility on gnoses including, but not pressure, psychosis, anxiety troke, and affective mood il MDS (Minimum Data Set)	F 57	· ·				
	decisions. The resid total care for bathing transfers, mobility, di hygiene; and supervi A review of the clinic presence of any Adv review revealed that responsible party we for developing Advar admission, dated 8/2 Review of the clinica	al record failed to reveal the ance Directives. Further the resident and/or re provided with information nee Directives at the time of 1/17. I record failed to reveal any sident's Advance Directives						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495407	B. WING _			C 09/06/2019
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	1	3373372010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 578		party, to determine if, and for, the development of	F 5	78		
	Social Services. Whereview of residents A stated that it (advantant documented in 10 OSM #1 was informated on the care pland was asked about Directives. OSM #1 status is reviewed, tot. OSM #1 was as reviews Advance Directives, OSM #1 stated, "No statuses." When as Advance Directives admitted, OSM #1 statuses." When as Advance Directives admitted, OSM #1 statuses if, Advance Directives admitted, OSM #1 statuses." When as Advance Directives admitted, OSM #1 statuses if, Advance Directives admitted, OSM #1 status is confused with OSM Coordinator. OSM # admitted residents a on Advance Directiv I will ask them if the copy into the medical	In #1 (Other Staff Member) en asked about periodic Advance Directives, OSM #1 ced directives) is reviewed the care plan meetings. ed that only code status was an meeting documentation at reviews of Advanced stated that only the code the Advance Directives are sked if she periodically rectives with residents who do the to determine if they wish to the to determine if a resident with an wishes to change anything. The we only review code the deep in the code status was the code was the code status was the code was the code status was the code				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495407	B. WING _			C 09/06/2019
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406		30,00,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 578	Worker or Administra facility evidence the information on Advarstated, "they are give contains information they sign a receipt the handbook." She also resident's admission that the resident was opportunity about downward about part and the formulate on OSM #4 stated, "The with the social worked don't have anything." A review of the facility Protocol" documented future medical care is make decisionsThe	in I direct them to the Social lator." When asked how the resident was provided with more Directives, OSM #4 in a facility handbook which in a Advance Directives and mat they are given the corporated pages from the agreement that reflected is offered information and eveloping Advance Directives. Desiriodically reviewing the with residents to see if they are and or make any changes, at is done in the meetings are (care plan meetings). If to do with that."	F 5	78		
	will be discussed wit representative to def directives have be {s directives will be revaccording to MDS so On 9/6/19 at 10:15 A Staff Member), the A the concern. No further provided. 4. The facility staff for review to determine	AM, ASM #1 (Administrative Administrator, was notified of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		495407	B. WING			C 09/06/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	1	3370672013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 578	Resident #20 was ac 6/16/14, with diagnost limited to, cerebrovation obstructive pulmonar Esophagus, depress The significant changwith an ARD (Assess 6/13/19, coded the reability to make daily was coded as requiring extensive assistance dressing, toileting an for eating. A review of the clinic presence of Advance chart, dated 3/27/14, clinical record failed the resident's Advance periodically reviewed resident/responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity for the clinical record failed the resident'responsible provide opportunity fai	dmitted to the facility on ses that included but are not scular disease, chronic ry disease, Barrett's ion, and high blood pressure. ge MDS (Minimum Data Set) sment Reference Date) of esident as cognitively intact in life decisions. The resident ring total care for bathing, of for transfers, mobility, d hygiene; and supervision all record revealed the endirectives in the resident's Further review of the to reveal any evidence that ce Directives status was	F 5	78			
	Social Services. Whe review of residents A stated that it (advance and documented in the OSM #1 was informed noted on the care planary and was asked about Directives. OSM #1 status is reviewed, the	M, an interview was #1 (Other Staff Member) en asked about periodic dvance Directives, OSM #1 ed directives) is reviewed the care plan meetings. ed that only code status was an meeting documentation t reviews of Advanced stated that only the code the Advance Directives are sked if she periodically					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495407	B. WING _		09	C 9/06/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				140 BRIMLEY DRIVE			
FALLS RU	IN NURSING AND REHA	B CENTER		FREDERICKSBURG, VA 22406			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE ISS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 578	Continued From page reviews Advance Directives, vosm #1 stated, "No, statuses." When ask Advance Directives wadmitted, OSM #1 statem [Advance Directives wadmitted, OSM #1 statem [Advance Directives wadmitted, OSM #1 statem [Advanced Directives wadmitted, osm #1 statem [Advanced Directives wadmitted, osm #1 statem [Advanced Directive when asked if, Advarduring the first care ponly code status is disconducted with OSM Coordinator. OSM #4 admitted residents amon Advance Directive I will ask them if they copy into the medical ask them if they know is and provide them in	e 11 ectives with residents who do to determine if they wish to termine if a resident with an vishes to change anything. we only review code ed , if she reviews their ith residents that are newly ated she does not review ctives], only the code status. Ince Directives are discussed lan meeting, OSM #1 stated scussed. , an interview was #4, the Admissions was asked if newly e provided any information s. OSM #4 stated, "Yes, and have one, and if so get a record." OSM #4 stated, "I what an Advance Directive information on it, and if they	F 5	DEFICIENCY)			
	Worker or Administratifacility evidence the reinformation on Advanstated, "they are give contains information of they sign a receipt the handbook." She also resident's admission at that the resident was opportunity about dev. When asked about per Advance Directives with the to formulate one OSM #4 stated, "That	provided pages from the agreement that reflected offered information and reloping Advance Directives. Priodically reviewing the rith residents to see if they and or make any changes, is done in the meetings (care plan meetings).					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		DNSTRUCTION	(X3) DATE	SURVEY PLETED			
		495407	B. WING			1	C / 06/2019
	ROVIDER OR SUPPLIER	B CENTER		140	BRIMLEY DRIVE EDERICKSBURG, VA 22406	1 09/	00/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 578	Protocol" documente future medical care s make decisionsThe healthcare directives during Your Path Mee will be discussed with representative to dete directives have be {si directives will be reviaccording to MDS sc On 9/6/19 at 10:15 A Staff Member), the Acthe concern. No furth provided. 5. The facility staff fair Resident #36's (or the	y policy, "Advance Directives d, "Written instructions about hould you become unable to see are also called Upon Admission and etings, advance directives a resident and/or resident ermine if any advance c} chosenAdvance ewed at minimum annually hedule" M, ASM #1 (Administrative dministrator, was notified of her information was led to periodically review e resident's representative)	F	578			
	with diagnoses, that is to heart failure (1) and Resident #36's most set), a quarterly asses (assessment reference Resident #36 as scor assessment for ment of 0 - 15, 6- being set daily decisions. Review of Resident # reveal documentation regarding advance displacements.	mitted to the facility admission on 04/20/2016 ncluded but were not limited d atrial fibrillation (2). recent MDS (minimum data assment with an ARD ce date) of 07/17/19, coded ing a 6 (six) on the staff al status (BIMS) of a score werely impaired for making					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495407	B. WING			C 09/06/2019	
	ROVIDER OR SUPPLIER N NURSING AND REHA	B CENTER		14	REET ADDRESS, CITY, STATE, ZIP CODE BRIMLEY DRIVE REDERICKSBURG, VA 22406		00.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 578	chosen full code state 01/19/2018 Revision "Interventions", it door routine with resident 201/19/2018." On 9/5/19 at approximate was made to OSM #/documentation of reversident #36. On 9/6/19 at approximate was made to OSM #/documentation of reversident #36. On 9/6/19 at approximate was made to OSM #/documentation of reversident #36. On 9/6/19 at approximate document titled, "Ack Resident #36 was provided to the document reversident handbook. If Advance Directive Polynomials and provided to the document reversident handbook. If Advance Directive Polynomials and provided to the document reversident handbook. If Advance Directive Polynomials and provided to the document of the	cumented, "Resident has us. Date Initiated: on: 01/19/2018." Under umented, "Review per and/or responsible party. 2018. Revision on: mately 4:40 p.m., a request of iew of Advance Directives mately 8:15 a.m., a request of iew of Advance Directives mately 9:00 a.m., a request of iew of Advance Directives mately 9:00 a.m., a request of iew of Advance Directives mately 9:00 a.m., a request of iew of Advance Directives mately 9:00 a.m., a request of Receipt" for ovided by OSM #4. Review aled a date of 12/3/2010 or for Resident #36's ging receipt of the facility's to documented, "vi. Facility's olicy and explanation of erning Advance Directives" mately 10:00 a.m., ASM nember) #1, the document "Care Planated 8/11/19 for Resident revealed "DNR Status: Full vidence periodic review of	F	578			
	(administrative staff r						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495407	B. WING		09/06/2019
	ROVIDER OR SUPPLIER	AB CENTER	14	TREET ADDRESS, CITY, STATE, ZIP CODE 40 BRIMLEY DRIVE REDERICKSBURG, VA 22406	, 33/30/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 578	Continued From pag	ge 14	F 578		
	I '	#2, the director of nursing and all director of clinical services, the findings.			
	No further information	on was provided prior to exit.			
	References:				
	pump oxygen-rich blefficiently. This cause throughout the body obtained from the weather. It is information to the website:	the heart is no longer able to ood to the rest of the body es symptoms to occur. This information was ebsite: gov/ency/article/000158.htm.			
		ailed to periodically review ne resident's representative) advance directives.			
	08/22/2017 with diag were not limited to re weakness generalize Resident #14's most set), an annual asse (assessment referent Resident #14 as social	dmitted to the facility gnoses, that included but epeated falls and muscle ed. I recent MDS (minimum data issment with an ARD ince date) of 06/08/19, coded oring a 12 on the staff tal status (BIMS) of a score cognitively intact for making			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION LAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495407	B. WING			C 9/06/2019
	ROVIDER OR SUPPLIER JN NURSING AND REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	1 0	9/06/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 578	Continued From pag	ue 15	F 57	78		
	interview was conductives when asked if he is care, Resident #14 standard meetings but not alwadvanced directives meetings or at any content of the comprehensive dated 07/26/2019 do code. Date Initiated "Interventions", it do PRN (as needed) wiresponsible party. If the comprehensive dated 07/26/2019 do code. Date Initiated "Interventions", it do PRN (as needed) wiresponsible party. If the comprehensive dated 07/26/2019 do code. Date Initiated "Interventions", it do PRN (as needed) wiresponsible party. If the comprehensive documentation of refor Resident #14. On 9/5/19 at approx was made to OSM # documentation of refor Resident #14. On 9/6/19 at approx document titled, "Ad Page" for Resident # Review of the documentation of the docum	are discussed with him at the other time, Resident #14 to think so or did not discussed. #14's clinical record failed to not periodic review directives. care plan for Resident #14 coumented, "Resident has full to 05/15/2018." Under coumented, "Review annually, the resident and/or pate Initiated: 05/15/2018." Imately 4:40 p.m., a request to for any evidence of view of Advance Directives Imately 8:15 a.m., a request to for any evidence of view of Advance Directives				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
				_			С
		495407	B. WING			09/	06/2019
	ROVIDER OR SUPPLIER	B CENTER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 40 BRIMLEY DRIVE REDERICKSBURG, VA 22406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 583 SS=D	documented failed to Advance Directives. On 9/6/19 at approxin (administrative staff madministrator provided Conference Notes" da The document reveal but failed to evidence Directives for Resider On 9/06/19 at approxi (administrative staff madministrator, ASM #5, the regional were made aware of the No further information Personal Privacy/Con CFR(s): 483.10(h)(1)-\$483.10(h) Privacy ar The resident has a rig confidentiality of his orecords. \$483.10(h)(l) Personal accommodations, metelephone communication and meetings of familithis does not require the private room for each \$483.10(h)(2) The fact residents right to personal to Advance Directives.	Advanced Directive." The evidence periodic review of mately 10:00 a.m., ASM member) #1, the difference that the document "Care Plan ated "618" for Resident #14. The difference of Advance of the document of Advance of the difference of Advance of the difference of Advance of the difference of clinical services, the findings. In was provided prior to exit. In the difference of the differe		578			9/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495407	B. WING			C 9/06/2019	
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406		9/00/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 583	mail and other letters materials delivered to including those delivered to including those delivered to than a postal service. §483.10(h)(3) The reand confidential personal and mediprovided at §483.70(if federal or state laws. (ii) The facility must a Office of the State Loto examine a residen administrative record law. This REQUIREMENT by: Based on observation document review it we failed to protect confirecord for one of 40 resample, Resident #25 The findings include: Resident #25 was ad 12/04/2017 with a read	promptly receive unopened, packages and other of the facility for the resident, pred through a means other desident has a right to secure onal and medical records. The right to refuse the release cal records except as an excep	F 5	F583 1. Electronic Health Record (Elfor resident #25 was immediate corrected. LPN #8 received ed providing confidentiality of the record. 2. All residents who reside at Fandard Nursing and Rehabilitation have potential to be affected. The DON/designee conducted a quantum potential to be affected and the poon to be a significant to be affected.	HR) privacy ely ducation on medical falls Run e the		
	limited to chronic obs (1) and hyperlipidemi recent MDS (minimum assessment with an A date) of 07/01/19, coo a 15 on the staff asse	oses included but were not tructive pulmonary disease a (2). Resident #25's most m data set), a quarterly ARD (assessment reference ded Resident #25 as scoring essment for mental status 0 - 15, 15- being cognitively y decisions.		of electronic health records to e proper privacy practices and confidentiality of electronic heal 3. Licensed nurses have been on on EHR confidentiality practices 4. DON/Designee will audit four medication carts for EHR privacy week for 4 weeks, then 3x/ week weeks for proper privacy practic confidentiality of the medical re	olth record. educated s. r cy 5x/ ek for 8 ces and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		CONSTRUCTION		PLETED			
		495407	B. WING _				C / 06/2019
	ROVIDER OR SUPPLIER	AB CENTER		14	REET ADDRESS, CITY, STATE, ZIP CODE BO BRIMLEY DRIVE REDERICKSBURG, VA 22406	1 00/	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 583	nurse) #8 was obsert to Resident #25. LP cart to the hallway of Resident #25's room Omeprazole (3) 40 n medication cup confit the computer screen (electronic medication LPN #8 proceeded to drawers and take the cup of water into Rescomputer screen dismedical record in the unlocked when LPN cart to enter the residual mistering the medication cart and computer screen." On 9/05/19 at 3:57 p conducted with LPN process of securing a during medication act that the computer screen in the the computer screen in the computer screen in the computer screen in the computer screen when he give the medication. computer screen shop protect Resident #25's in a target and the computer screen when he give the medication.	ved administering medication N #8 pushed the medication oposite the doorway to be some the control of the contr	F	583	results will be presented monthly for the months to the Quality Assurance Performance Improvement committee review and recommendation. 5. Date of Compliance: October 1, 20:	for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495407	B. WING _			C 9/06/2019	
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406		3/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 583	#HIPAA (Health Insurance Accountability Act) 6 11/30/2016" documer appropriate administr safeguards to protect and accessibility of P Information) consiste these HIPAA Policies intentional and uninter uses and disclosures General Safeguards of facility] will use rea PHI on computer screen unauthorized persons computer workstation leaving the workstation leaving the workstation protected screen sav computer screen whe being used." On 9/06/2019 at apprecation of the first administrator, ASM # ASM #5, the regional were notified of the first No further information References: 1. Chronic obstructive (COPD) Disease that makes is lead to shortness of the obtained from the weight administration was a supplementation.	afeguards. Privacy Policy rance Portability and (six). Effective Date: nted in part, "will maintain rative, technical and physical at the confidentiality, integrity (HI (Protected Health nt with the requirements of and to safeguard PHI from rentional non-permissible" Under "Procedure: A. "it documented "(c) [name asonable safeguards so that reens will not be visible to so, including locking down as when not in use or when on by activating a password rend clearing PHI from the render the PHI is not actually and director of clinical services and ings. The was provided prior to exit. The pulmonary disease the difficult to breath that can breath. This information was	F 5	883			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495407	B. WING			C / 06/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	03/	00/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 583	2. Hyperlipidemia Cholesterol is a fat (a body needs to work p cholesterol can increa heart disease, stroke medical term for high disorder, hyperlipiden This information was https://medlineplus.go 3. Omeprazole Indications: Frequent Not intended for imme (may take 1-4 days fo information was obtai https://www.empr.cor 4. HIPPA The HIPAA Privacy R standards to protect i and other personal he to health plans, health those health care pro health care transaction requires appropriate a privacy of personal he limits and conditions that may be made of patient authorization. patients' rights over th including rights to exa their health records, a This information was	Iso called a lipid) that your properly. Too much bad ase your chance of getting, and other problems. The blood cholesterol is lipid nia, or hypercholesterolemia. obtained from the website: ov/ency/article/000403.htm. heartburn (?2 days/week). ediate relief of heartburn or full effect). This ned from the website: n/drug/prilosec-otc/ ule establishes national ndividuals' medical records ealth information and applies in care clearinghouses, and viders that conduct certain ons electronically. The Rule safeguards to protect the ealth information, and sets on the uses and disclosures such information without	F 58	3		
F 622 SS=D	Transfer and Dischar	-	F 62	2		9/23/19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495407	B. WING			C 09/06/2019	
NAME OF PI	ROVIDER OR SUPPLIER	430401	1 2		STREET ADDRESS, CITY, STATE, ZIP CODE	09/	06/2019
	IN NURSING AND REHA	B CENTER		1	40 BRIMLEY DRIVE REDERICKSBURG, VA 22406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	(A) The transfer or dis resident's welfare and cannot be met in the resident's welfare and cannot be met in the resident's ufficiently so the resiservices provided by (C) The safety of indirendangered due to the status of the resident; (D) The health of indirendangered due to the status of the resident; (D) The health of indirendangered due to the status of the resident; (D) The health of indirendangered due to the status of the resident; (D) The health of indirendangered due to the status of the resident has appropriate notice, to under Medicare or Me	and discharge- requirements- ermit each resident to and not transfer or at from the facility unless- scharge is necessary for the dithe resident's needs facility; scharge is appropriate is health has improved ident no longer needs the the facility; viduals in the facility is the clinical or behavioral gividuals in the facility would tered; failed, after reasonable and pay for (or to have paid tedicaid) a stay at the facility. If the resident does not paperwork for third party third party, including I, denies the claim and the tay for his or her stay. For a tays eligible for Medicaid after tay, the facility may charge a the charges under Medicaid; the sto operate. The facility may charge the to transfer or discharge the tot transfer or discharge the total transfer or discharge transfer or discharge transfer or dischar	F	622			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495407	B. WING _				C (06/2019
	ROVIDER OR SUPPLIER JN NURSING AND REHA	B CENTER		140 I	EET ADDRESS, CITY, STATE, ZIP CODE BRIMLEY DRIVE EDERICKSBURG, VA 22406	1 03/	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622	facility. The facility methat failure to transfer §483.15(c)(2) Docume When the facility transersident under any of in paragraphs (c)(1)(is section, the facility medical record and a communicated to the institution or provider (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of parsection, the specific robe met, facility attempneeds, and the service facility to meet the net (ii) The documentation (2)(i) of this section method (2)(i) of this section method (3) The resident's phedischarge is necessar (A) or (B) of this section (B) A physician when necessary under parathis section. (iii) Information provident include a minimal (A) Contact information (C) Advance Directive (C) Advance Directive (C) Advance Directive (C)	rust document the danger or discharge would pose. Identation. In sfers or discharges a state circumstances specified (a)(A) through (F) of this ust ensure that the transfer mented in the resident's ppropriate information is receiving health care. In the resident's medical record transfer per paragraph (c)(1) I agraph (c)(1)(i)(A) of this resident need(s) that cannot post to meet the resident receiving red(s). In required by paragraph (c) (nust be made by-ysician when transfer or ry under paragraph (c) (1) on; and transfer or discharge is regraph (c)(1)(i)(C) or (D) of reded to the receiving provider rum of the following: on of the practitioner are of the resident. Intative information including the information of the precautions for	F	522			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495407	B. WING		C 09/06/2019
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	05/06/2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 622	copy of the resident	care plan goals; sary information, including a 's discharge summary,	F 62	2	
	any other document a safe and effective This REQUIREMENT by: Based on staff interest and facility document that the facility staff the required document receiving health car	rview, clinical record review, nt review, it was determined failed to evidence that any of entation was provided to the e institution on transfer to the oresidents in the survey		F622 1. Resident #43 was readmitted to the facility on 07/18/19 and discharged to Emergency Room on 09/03/19 with packet of required documentation ser hospital in place. Resident returned to facility on 09/03/19 with no further discharges at this time. Nurse who	nt to
	diagnoses included Alzheimer's disease dysphagia, anxiety thrive. The quarterl Set) with an ARD (A of 7/25/19 coded through trough thrive in the cognitively impaired decisions. The resi total care for bathing transfers, mobility, of hygiene. A review of the nurs documented, "Around observed with large emesis on his clothing vitals 136/92 (blood	admitted on 12/27/18; but are not limited to e, high blood pressure, disorder, and adult failure to y/5-day MDS (Minimum Data assessment Reference Date) e resident as severely I in ability to make daily life dent was coded as requiring g; and extensive care for dressing, eating, toileting and se's notes dated 7/14/19 and 4:15 a.m. resident amounts of coffee ground ang, mouth, and blankets. I pressure), 69 (pulse rate), 18 (respiration rate), 85%		discharged resident received education on required documentation to provide receiving health care institution on transfer to the hospital. 2. All residents who reside at Falls Runursing and Rehabilitation and transfithe hospital have the potential to be affected. The Administrator or designer conducted a quality review of current residents who discharged to the hosp in the last 30 days for documentation support information was provided to receiving health care institute on transmantations. Licensed nurses have been educated on required documentation for unplant discharges by DON/Designee. 4. DON/Designee will audit discharge hospital 5x/ week for 4 weeks, then 3x week for 8 weeks for required documentation to provide receiving he care institution on transfer to the hosp Audit results will be presented monthless.	er to ee ital to sfer. ded ined s to x/ ealth oital.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495407	B. WING _	B. WING		C	
NAME OF DE	ROVIDER OR SUPPLIER	430407	5: 11:10 _	STREET ADDRESS, CITY, STATE, ZIP CODE	0;	9/06/2019	
NAIVIE OF PI	ROVIDER OR SUPPLIER						
FALLS RU	N NURSING AND REHAI	B CENTER		140 BRIMLEY DRIVE			
				FREDERICKSBURG, VA 22406			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 622	Continued From page 24 (Medical office) on call, MD (medical doctor)		F 6	22 Performance Improvement comm	ittee for		
	notified ordered to set for eval (evaluation). to ER, CNA (certified nurse report resident more coffee ground e emergency medical to 445am, resident out of notified at 5a.m. Unit Further review of the reveal any evidence of documentation was p facility upon the 7/14/On 9/5/19 at 2:06 PM (Registered Nurse), was sent to the hospital stated, "face sheet, more recent MD notes, recent MD notes, recent more considerable of the sent to the sent as that these forms were	nd to ER (emergency room) While this writer was in call nursing assistant) and other to begin projectile vomiting mesis. EMTx2 (two echnicians) arrived around of facility via stretcher. Wife manager aware." clinical record failed to of what, if any, rovided to the receiving 19 hospital transfer. , in an interview with RN #2 when asked what paperwork with a resident, RN #2 led list, care plan, bed hold, ent labs, Advance ked where staff document e sent, RN #2 stated, "The n." (This form was not		review and recommendation. 5. Date of Compliance: October			
	On 9/5/19 at 2:10 PM (Licensed Practical N when asked what paphospital with a resider [medication] list, faces bed hold, plan of care document that these is stated, "In the nurse's On 9/5/19 at 2:15 PM	in an interview with LPN #2 urse) the unit manager, betwork is sent to the nt, LPN #2 stated, "The med sheet, Advance Directives, " When asked where staff forms were sent, LPN #2 notes." , LPN #2 was notified of the on of what paperwork was					

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
			A. BOILD	A. BOILDING		С	
		495407	B. WING			09/	06/2019
	ROVIDER OR SUPPLIER IN NURSING AND REHA	AB CENTER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 40 BRIMLEY DRIVE REDERICKSBURG, VA 22406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622	LPN #2 stated that significant completed check off transfer was not reduced by provided a titled, "E.R. Discharg documented to the receiving of the receiving o	rm] is not in the computer." he did not see that the m was completed or a enting what was sent. A teract form revealed that the would have been provided if completed. Including the hic information, functional sident was sent to, the sponsible party, medications ces, risk alerts, precautions, needs, immunizations, d rehab therapy status. If not contain any prompting aprehensive care plan goals. If older with a paper attached the Check Off List." This form uired transfer documents to ting facility, including the plan goals. The inside of two copies of the bed hold the tremainder of the forms as from the clinical record and ording to the check off list der. However, a copy of the list for this resident's hospital ined as evidence of that the inpleted and sent to the Ty policy, "Discharge/Transfer include any criteria of what quired to be sent to the tr. No other policy for tre provided.	F	622			

PRINTED: 10/08/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495407	B. WING	B. WING		1	C 06/2019
	ROVIDER OR SUPPLIER	L		1	TREET ADDRESS, CITY, STATE, ZIP CODE 40 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	1 03/	00/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622 F 623 SS=D	Continued From page the concern. No furth provided. Notice Requirements CFR(s): 483.15(c)(3)-	ner information was Before Transfer/Discharge		622 623			9/23/19
	the reasons for the manguage and manner facility must send a corepresentative of the Long-Term Care Omb (ii) Record the reasond discharge in the residuaccordance with paral and (iii) Include in the noting paragraph (c)(5) of the \$483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, discharge required urmade by the facility a resident is transferred (ii) Notice must be materially be endangered under this section; (B) The health of indivible endangered, under this section; (C) The resident's health of the control of the section; (C) The resident's health of the control of	fers or discharges a nust- and the resident's ne transfer or discharge and ove in writing and in a rethey understand. The opy of the notice to a Office of the State oudsman. Is for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in its section. of the notice. If in paragraphs (c)(4)(ii) and the notice of transfer or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495407	B. WING		09/06/201	19
	ROVIDER OR SUPPLIER JN NURSING AND REH	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	03/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMP	X5) PLETION ATE
F 623	Continued From pa	ge 27	F 62	23		
	under paragraph (c (D) An immediate tr required by the resi under paragraph (c (E) A resident has r days. §483.15(c)(5) Conte notice specified in p must include the fol (i) The reason for tr (ii) The effective dar (iii) The location to r transferred or disch (iv) A statement of t including the name, and telephone num receives such reque to obtain an appeal completing the form hearing request; (v) The name, addretelephone number of Long-Term Care Or (vi) For nursing faci and developmental disabilities, the mail telephone number of the protection and a developmental disa C of the Developme and Bill of Rights Ac codified at 42 U.S.C (vii) For nursing fac disorder or related of email address and the agency responsible	o(1)(i)(B) of this section; ransfer or discharge is dent's urgent medical needs, o(1)(i)(i)(A) of this section; or not resided in the facility for 30 ments of the notice. The written paragraph (c)(3) of this section lowing: ransfer or discharge; the of transfer or discharge; which the resident is arged; the resident's appeal rights, address (mailing and email), ber of the entity which ests; and information on how form and assistance in and submitting the appeal ess (mailing and email) and of the Office of the State				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '			(X3) DATE SURVEY COMPLETED	
	495407	B. WING _			C 09/06/2019	
	B CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	DE	3000.2010	
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
established under the for Mentally III Individes §483.15(c)(6) Change If the information in the effecting the transfer must update the recipant as practicable once to become available. §483.15(c)(8) Notice In the case of facility the administrator of the written notification provides to the State Survey A State Long-Term Catthe facility, and the rewell as the plan for the relocation of the resident as the plan for the REQUIREMENT by: Based on staff internant facility document that the facility document that the facility staff for notification of a hosp the resident represent transfer for two of 40 sample, Residents #	es to the notice. he notice changes prior to or discharge, the facility pients of the notice as soon he updated information in advance of facility closure closure, the individual who is he facility must provide ior to the impending closure agency, the Office of the re Ombudsman, residents of resident representatives, as the transfer and adequate dents, as required at § It is not met as evidenced alled to evidence that written ital transfer was provided to notative upon a hospital residents in the survey 43 and #22.	F6	F623 1. Resident # 43 was most re readmitted to facility on 09/03 further discharges at this time #22 was readmitted to facility with no further discharges at OSM #1 received education or resident and/or resident represident with written notification of a h transfer. 2. All residents who reside at Nursing and Rehabilitation ar	ecently 8/19 with no e. Resident on 07/17/19 this time. on providing esentative ospital Falls Run nd are		
Resident #43 was ac	lmitted on 12/27/18, with		affected. The Administrator o conducted a quality review of residents who discharged to	r designee f current the hospital		
	CORRECTION ROVIDER OR SUPPLIER N NURSING AND REHA SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page established under the for Mentally III Individe §483.15(c)(6) Chang If the information in the effecting the transfer must update the recip as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility the administrator of the written notification pr to the State Survey A State Long-Term Car the facility, and the re well as the plan for the relocation of the resid 483.70(I). This REQUIREMENT by: Based on staff interv and facility document that the facility staff finotification of a hosp the resident represer transfer for two of 40 sample, Residents #4 The findings include: 1. The facility staff fa or the resident representation of a hosp Resident #43 was according to the resident representation of a hosp Resident #43 was according to the resident representation of a hosp Resident #43 was according to the resident representation of a hosp Resident #43 was according to the resident representation of a hosp	A95407 ROVIDER OR SUPPLIER N NURSING AND REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 established under the Protection and Advocacy for Mentally III Individuals Act. §483.15(c)(6) Changes to the notice. 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(I). This REQUIREMENT is not met as evidenced	A BUILDIN A95407 ROVIDER OR SUPPLIER N NURSING AND REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 established under the Protection and Advocacy for Mentally III Individuals Act. \$483.15(c)(6) Changes to the notice. 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 staff interview, clinical record review, and facility staff failed to evidence that written notification of a hospital transfer was provided to the resident representative upon a hospital transfer for two of 40 residents in the survey sample, Residents #43 and #22. The findings include: 1. The facility staff failed to provide Resident #43 or the resident representative with written notification of a hospital transfer on 7/14/19. Resident #43 was admitted on 12/27/18, with	ROUDER OR SUPPLIER N NURSING AND REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 established under the Protection and Advocacy for Mentally Ill Individuals Act. \$483.15(c)(6) Changes to the notice. 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, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at \$43.70(l). 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 notification of a hospital transfer was provided to the resident representative upon a hospital transfer for two of 40 residents in the survey sample, Residents #43 and #22. The findings include: 1. The facility staff failed to provide Resident #43 or the resident representative with written notification of a hospital transfer on 7/14/19. Resident #43 was admitted on 12/27/18, with	A BUILDING	

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495407	B. WING _				06/ 2019	
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 03/	00/2013	
					RIMLEY DRIVE			
FALLS RU	JN NURSING AND REHA	B CENTER			PERICKSBURG, VA 22406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	Continued From page	e 29	F 6	523				
	disease, high blood p disorder, and adult fa quarterly/5-day MDS ARD (Assessment Recoded the resident as impaired in ability to recoded the resident as impaired in ability to recode with large at emesis on his clothin Vitals 136/92 (blood p 97.3 (temperature), 1 (RA) (oxygen saturati (Name of Medical offi doctor) notified order (emergency room) for this writer was in call nursing assistant) and to begin projectile voremesis. EMTx2 (two technicians) arrived at of facility via stretche Unit manager aware. Further review of the reveal any evidence to resident representative the 7/14/19 hospital to the 7/14/19 hospital to the 7/14/19 at 4:28 PM #1 (Other Staff Membasked about providing with a written notice of #1 stated that she do	ressure, dysphagia, anxiety illure to thrive. The (Minimum Data Set) with an eference Date) of 7/25/19 is severely cognitively make daily life decisions. Is notes dated 7/14/19 if 4:15 a.m. resident imounts of coffee ground g, mouth, and blankets. pressure), 69 (pulse rate), 85 (respiration rate), 85% ion at 85% on room air). Ice) on call MD (medical ed to send to ER reval (evaluation). While to ER, CNA (certified dother nurse report resident miting more coffee ground emergency medical iround 445am, resident out r. Wife notified at 5a.m. In clinical record failed to that the facility provided the rewith written notification for ransfer. It in an interview with OSM per), Social Services, when g the resident representative of a hospital transfer, OSM es not do that.		su to 3. ec fo fo Ad 4. ho ww do ho re ww m Po re	upport written notification was provided resident and/or resident representated Social Services department has been ducated on required written notification resident and/or resident representation of hospital transfers by diministrator/Designee. SW/Designee will audit discharges to spital 5x/ week for 4 weeks, then 3x/ eek for 8 weeks for required ocumentation of written notification of espital transfers to resident and/or esponsible representative. Audit result ill be presented monthly for three onths to the Quality Assurance enformance Improvement committee eview and recommendation. Date of Compliance: October 1, 200	ive. en on tive o ' ts		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495407	B. WING	 		09/06/2019	
	ROVIDER OR SUPPLIER JN NURSING AND REH	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406		, 00.00.20.0	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 623		resident/family/responsible notice of the resident being	F 62	23			
	A review of the facil Letter Policy" docum complete discharge according to all federegulationsThe foimmediate discharge practicable and an iletter will be issued: transfer/discharge is resident's urgent menotices must have to the reason for discharge; appropriate verbiage transfer/discharge; appropriate verbiage transf	ity policy, "Discharge/Transfer nented, "The Facility will letters appropriately and eral, state, and local sillowing situations will result in e / transfer from the facility as mmediate discharge/transfer4. An immediate is required due to the edical needsD) Discharge the following components: 1. harge/transfer, to include e2. The effective date of 3. The location to which the ed/discharged"					
	or the resident repre	failed to provide Resident #22 esentative with written pital transfer on 7/15/19.					
	3/8/18 with the diag stroke, aphasia, hig gastrostomy, quadri failure to thrive, and MDS (Minimum Dat (Assessment Refere	dmitted to the facility on noses of but not limited to h blood pressure, diabetes, plegia, dysphagia, adult contractures. The quarterly a Set) with an ARD ence Date) of 6/15/19 coded erely impaired in ability to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495407	B. WING _			C 09/06/2019
	ROVIDER OR SUPPLIER	AB CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	'	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 623	note dated 7/15/19 dobserved having seiz (3:30 AM), blood not mouth, possibly due of her mouth. Order physician) to send redepartment) for seiz can no longer be me (responsible party) horder party have reveal any evidence resident representation the 7/15/19 hospital. On 9/5/19 at 4:28 PM #1 (Other Staff Mem asked about providing with a written notice #1 stated that she down on 9/6/19 at 8:45 AM #1 (Administrative Stadministrator, he stabeen providing the reparty with a written in transferred to the horder possible party 5:00 F	al record revealed a nurse's ocumented, "Resident zure episodes around 0330 ed coming out of resident's to resident biting the inside received from (name of sident to ED (emergency ures and the resident's needs t in this Facility. RP as been notified." clinical record failed to that the facility provided the ve with written notification of transfer. M in an interview with OSM ber), Social Services, when g the resident representative of a hospital transfer, OSM bes not do that. M, in an interview with ASM aff Member) the ted that the facility has not esident/family/responsible otice of the resident being spital. of day meeting at PM, ASM #1 (Administrative dministrator, was notified of	F6	23		
F 641 SS=D	Accuracy of Assessn CFR(s): 483.20(g)	nents	F 6	41		9/23/19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495407	B. WING			C 09/06/2019
NAME OF PI	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STA	TE. ZIP CODE	09/00/2019
				140 BRIMLEY DRIVE	,	
FALLS RU	IN NURSING AND REI	HAB CENTER		FREDERICKSBURG, VA	22406	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIAT IEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From pa	age 32	F 6	341		
	The assessment mesident's status. This REQUIREME by: Based on staff into and facility docume failed to maintain a Minimum Data Set residents in the sur #57. The findings included 1. The facility staff the discharge dispendischarge Minimum with an ARD (asset 06/27/2019). Resident #73 was 106/10/2019. Her dired blood cells), hy pressure), and diatated blood cells), hy pressure, and diatated blood cells, hy pressure, and diatated blood cells	cy of Assessments. Itust accurately reflect the NT is not met as evidenced erview, clinical record review, entation review, the facility staff complete and accurate assessment for three of 40 rey sample: #73, #15, and e: failed to correctly document osition on Resident #73's in Data Set (MDS) Assessment esment reference date) of admitted to the facility on agnoses included anemia (low pertension (high blood oetes. Resident #73's most esment was a Discharge in ARD (assessment reference in ARD (assessment reference in The Brief Interview for its) scored Resident #73 at a the BIMS could not be int #73 was coded as requiring oe of one person for bed ers, and as requiring limited berson for ambulation.		resubmitted to refle discharge disposition MDS section N was resubmitted to refle insulin. Resident #5 corrected and resubtracted and resubtracted and resubtracted and resubtracted and Rehabtracted and Rehabtracted and Rehabtracted and O for accuracted and O for accuracted and O for accuracted and O for 5 MDS by 4. MDS/Designee was O for 5 MDS assessed weeks, then 3x/ we accurate document be presented month the Quality Assurant Improvement commerced insuling in the province of the province	on. Resident # 15's corrected and ct the administration for's section O was omitted to reflect the ygen. In reside at Falls Run illitation have the sted. MDS Coordinated a quality review of MDS section A, N, of coding. It staff has been impleteness and y DON/Designee. will audit sections A, N essments/ week for 4 ek for 8 weeks for ation. Audit results wonly for three months to	of or of N
	A review of Reside revealed Resident	nt #73's closed record #73 was flagged as having Hospital by the MDS system.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495407	B. WING		C 09/06/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	09/00/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 641	06/27/2019, it was di had not discharged thad a planned discharged thad a planned discharged thad a planned discharge of the plant of t	ischarge nurse's note dated scovered that Resident #73 of the Hospital, but rather had arge home with family. 26p.m., an interview was stered Nurse (RN) #1, the N #1 was asked to review all record and confirm their in RN #1 confirmed that scharged home with family. The review Resident #73's clarify whether or not it was ption of her discharge tated that the Discharge tated that the Discharge tated, and that she would file a sely. RN #1 was asked if she at Assessment Instrument completing MDS confirmed that she did. Member (ASM) #1, the facility SM #2, the Director of the findings at the end 10/06/2019. No further rided. Incorrectly coded Resident dated 6/13/19 for the	F 64	41		

, ,	IDENTIFICATION NUMBER		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
	495407	B. WING			C 09/06/2019	
NAME OF PROVIDER OR SUPPLIER FALLS RUN NURSING AND REHAB CENT	TER		STREET ADDRESS, CITY, STATE, ZIP C 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	ODE	03/00/2013	
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIA	DATE	
in ability to make daily life do resident was coded as requisor mobility, transfers, dress toileting; limited assistance supervision for eating. A review of the above MDS "Medications" the resident winder received insulin injections for seven-day look back period of days that insulin injection during the last 7 days or singler reentry if less than 7 days." A review of the May 2019 and (Medication Administration Fither were no current orders administration during the time. A review of the physician's conder dated 11/28/18 for "Insuling solution (1)per sliding solution (1) at 3:18 PM, in and (Registered Nurse), the MD was asked about the complete MDS assessment. RN shock period for medications she looks at the MAR and the see if they were giving any of medications during the look asked about the coding of Requarterly 6/13/19 MDS assess RN #2 stated that it might be she would check on it. Whe facility uses as a policy for colline and the see if they were as a policy for colline and the see if they were as a policy for colline and the see if they were as a policy for colline and the see if they were as a policy for colline and the see if they were as a policy for colline and the see if they were as a policy for colline and the see if they were as a policy for colline and the see if they were as a policy for colline and the see if they were as a policy for colline and the see if they were as a policy for colline and the see if they were as a policy for colline and the see if they were as a policy for colline and the see if the see if they were as a policy for colline and the see if they were as a policy for colline and the see if they were as a policy for colline and the see if they were as a policy for colline and the see if they were as a policy for colline and the see if they were as a policy for colline and the see if they were as a policy	iring extensive care ing, hygiene, and for bathing; and revealed in Section N was coded as having or seven days of the . "Record the number s were received ce admission/entry or and June 2019 MAR Record) revealed that is for insuling the of the above MDS. Orders revealed an sulin Regular Human ale" which was ofurther insuling the that date. Interview with RN #2 S coordinator. RN #2 etion of Section N of #2 stated that the look is seven days and the nurses notes to of the listed back period. When Resident #15's essment for insuling e miscoded but that the nasked what the	F 6	41			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED		
		495407	B. WING		0.00	C V06/2010	
	ROVIDER OR SUPPLIER JN NURSING AND REHA	1		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406		09/06/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 641	on 9/5/19 at the end approximately 5:00 F Staff Member), the Athe concern. No furt provided. A review of the RAI I 2017, page N-1 to N the items in this sect of days, during the la admission/entry or reany type of injection, medications were reany type of injection, medications during the 3. Determine if the practitioner, physicial specialist if allowable changed the residen look-back period. 4. Count the number were received and/o Enter in Item N0350, the 7-day look-back admission/entry or reinsulin injections were Enter in Item N0350, the 7-day look-back admission/entry or reinsulin significance.	IN #2 returned and stated terly MDS was miscoded. of day meeting at PM, ASM #1 (Administrative dministrator, was notified of her information was Manual 3.0, dated October documented, "The intent of ion is to record the number last 7 days (or since lentry if less than 7 days) that insulin, and/or select lecived by the resident Int's medication last for the 7-day look-back ission/entry or reentry if less lesident received insulin look-back period. The insulin orders during the less of days insulin injections or insulin orders changed A, the number of days during period (or since lentry if less than 7 days) that the received B, the number of days during the less than 7 days during period (or since lentry if less than 7 days) that the received B, the number of days during	F 64	11			

AND DIAN OF CORRECTION INDESTRUCTION NUMBERS		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495407	B. WING		09/06/2019	
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	1 03/00/2013	5
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLI	.ETION
F 641	cover different dosage does not count as an because a different on the sliding scale of the sliding scale of is the first sliding scale of is the slid	e laws) changed the ers ers: age schedule that is written to ges depending on lab values a order change simply lose is administered based guidelines. order is new, discontinued, or ale order for the resident, butted and coded. sulin pumps, code only the the resident actually required action to restart the pump. a hormone produced by the body use and store glucose. of fuel for the body. With annot regulate the amount of (called glycemia or blood by can help some people with eir blood sugar levels. from ov/ency/patientinstructions/0 ailed to accurately code erly MDS (minimum data an ARD (assessment and ARD)	F 64	41		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495407	B. WING		09/06/2019	
	ROVIDER OR SUPPLIER JN NURSING AND REH	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	1 33.33.23.13	
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 641	assessment for mer of 0 - 15, 15- being daily decisions. See evidence documents receiving oxygen the On 9/04/19 at 11:26 conducted with Res stated that she uses the day and wears it asked how long she Resident #57 stated Resident #57 was o cannula in her nose oxygen concentrato room. Additional observation oxygen were made 9/5/19 at 8:18 a.m. The physician order 9/05/2019 document (liters per minute) as of breath). Order Da 05/22/2019." The progress note of p.m.) documented "Method: Oxygen via Method: Oxygen via Metho	pring a 15 on the staff stall status (BIMS) of a score cognitively intact for making ction O of the MDS failed to ation of Resident #57 erapy while a resident. a.m., an interview was ident #57. Resident #57 sher oxygen frequently during the every night in bed. When has been using oxygen ly, "About a year now." beserved wearing a nasal, that was connected to an or during the interview in her cons of Resident #57 using on 9/04/19 at 1:47 p.m. and summary report dated ted, "O2 (oxygen) at 3L/Min is needed for SOB (shortness ste: 05/22/2019. Start Date: Jated 07/5/2019 14:00 (2:00O2 98.0%-6/28/19 14:45 Nasal Cannula."	F 64*			
	record) dated 7/1/20					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495407	B. WING _			C 09/06/2019	
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406		1 00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 641	needed for SOB. Sta (10:30 a.m.)." The comprehensive altered respiratory s' (related to) hx (histo (congestive heart fai artery disease) (4), a Date Initiated 01/15/07/19/2018." On 09/05/19 at 3:26 conducted with RN ((minimum data set) assessment process stated that she utiliz treatment administra and visualizing if the or not to conduct he reviewed section J of MDS (minimum data ARD (assessment reand agreed that if fa for Resident #57. R revised the MDS for thought she had incl #1 stated that Resid oxygen for over a yeneeded to be update.	care plan "The resident has tatus/Difficulty Breathing r/t ry) of Pneumonia (2), CHF lure) (3), CAD (coronary and anxiety (5) Uses O2. 2018. Revision on: p.m., an interview was registered nurse) # 1, MDS coordinator regarding the for oxygen use. RN #1 es the eTAR (electronic ation record), physician orders resident is wearing oxygen assessments. RN #1 f Resident #57's quarterly a set) assessment with an eference date) of 07/12/19, illed to document oxygen use N #1 stated that she had a medication and had uded the oxygen as well. RN ent #57 has been using ar now and that the MDS ed.	F 6				
	#57 wears oxygen, I oxygen on a regular is ordered as neede	#8. When asked if Resident LPN #8 stated that she wears basis. LPN #8 stated that it d for shortness of breath but it frequently, especially when					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495407	B. WING _			C 99/06/2019
	NAME OF PROVIDER OR SUPPLIER FALLS RUN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	· ·	3/00/2013
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	conducted with LPN asked if Resident #5 stated, "Yes, she use On 09/05/19 at appropriate (administrative staff administrator and AS were made aware of No further information Reference: 1. Atrial fibrillation A problem with the sheartbeat. This information the website: https://www.nlm.nih.on.html. 2. Pneumonia An infection in one of germs, such as bact cause pneumonia. Yes inhaling a liquid of was obtained from the https://medlineplus.go. 3. Congestive heart A condition in which blood to meet the bod does not mean that ye about to stop workin not able to pump blo affect one or both side.	#2, the unit manager. When 7 wears oxygen, LPN #2 es it when in bed." oximately 5:00 p.m., ASM member) #1, the SM #2, the director of nursing ithe findings. on was provided prior to exit. peed or rhythm of the rmation was obtained from gov/medlineplus/atrialfibrillati or both of the lungs. Many eria, viruses, and fungi, can fou can also get pneumonia or chemical. This information he website: gov/pneumonia.html. failure the heart can't pump enough by sneeds. Heart failure your heart has stopped or is g. It means that your heart is od the way it should. It can des of the heart. This ained from the website:	F			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7 5 25			С	
		495407	B. WING _		0:	9/06/2019	
	ROVIDER OR SUPPLIER N NURSING AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 641	https://www.nlm.nih.grydisease.html. 5. Anxiety Fear. This information website:	sease	Fé	341			
F 655 SS=D	#summary. Baseline Care Plan CFR(s): 483.21(a)(1) §483.21 Comprehens Planning	-(3) sive Person-Centered Care	F 6	955		9/23/19	
	implement a baseline that includes the instruction and personthat meet professiona. The baseline care pla (i) Be developed with admission. (ii) Include the minim necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services (E) Social services.	cility must develop and e care plan for each resident ructions needed to provide centered care of the resident al standards of quality care. In mustin 48 hours of a resident's sum healthcare information of care for a resident ted to-d on admission orders.					
	§483.21(a)(2) The factomprehensive care care plan if the comp	plan in place of the baseline					

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495407 B. WING				C 09/06/2019	
	ROVIDER OR SUPPLIER JN NURSING AND REHA	11.1		STREET ADDRESS, CITY, STATE, ZIP CO. 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 655	Continued From page 41 (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).		F 65	55			
	resident and their report the baseline care plimited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the fon behalf of the facilit (iv) Any updated inform of the comprehensive This REQUIREMENT by: Based on observation interview, facility door record review, it was staff failed to develop plan for two of 40 residents #67 and # to develop Resident include the use of an staff failed to develop to the use of bed rails. The findings include: 1. The facility staff fa #67's baseline care princentive spirometer.	d treatments to be facility and personnel acting ty. rmation based on the details e care plan, as necessary. T is not met as evidenced on, resident interview, staff ument review and clinical determined that the facility of a complete baseline care sidents in the survey sample, 222. The facility staff failed #67's baseline care plan to incentive spirometer and of a baseline care plan related in the survey sample, 222. The facility staff failed for the survey sample, 222. The facility staff failed for some care plan to incentive spirometer and of a baseline care plan related in the survey sample, 222.		F655 1. Baseline care plan was up include the use of incentive services. Resident #67 on 09/05/19. Resident #67 on 09/05/19. Resident #67 on 09/11/19 2. All residents who reside a Nursing and Rehabilitation he potential to be affected. 3. Licensed nurses have been on baseline care plan develocompleteness by DON/Designon or designee conducted review of all current resident admitted in the last 21 days and development and completen Baseline Care Plan. 4. MDS/Designee will audit to plans for development and completen and completen and completen baseline Care Plan.	spirometer for Resident #222 t Falls Run ave the en educated opment and gnee. The a quality s who were for ess of the easeline care		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495407	B. WING				C /06/2019
	ROVIDER OR SUPPLIER	B CENTER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 40 BRIMLEY DRIVE REDERICKSBURG, VA 22406	1 00/	00/2013
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG				(X5) COMPLETION DATE
F 655	were not limited to diff and surgical aftercare circulatory system. RMDS (minimum data assessment with an Adate) of 8/30/19, code cognitively intact. Resident #67's baselit 8/16/19 failed to reverant incentive spiromet #67's clinical record for order for an incentive On 9/4/19 at 3:50 p.m observed in bed. An observed in a bag on interview was conducted in a bag on interview was conductime and the resident incentive spirometer. Uses the incentive spirometer and the resident incentive spirometer. Uses the incentive spirometer. Uses the incentive spirometer and the resident incentive spirometer. Uses the incentive spirometer. Uses the incentive spirometer and the resident incentive spirometer. Uses the incentive spirometer and the resident incentive spirometer. Uses the incentive spirometer. Uses	ficulty swallowing, tremore following surgery on the desident #67's most recent set), a 14 day Medicare ARD (assessment reference ed the resident as being the resident as being the care plan initiated on all documentation regarding er. Review of Resident ailed to reveal a physician's spirometer. In, Resident #67 was incentive spirometer was the nightstand. In, Resident #67 was incentive spirometer was the nightstand. In, Resident #67 stated she incentive spirometer was the nightstand as sked if she uses the Resident #67 stated she incenter some but could not ten she uses the device. In, an interview was licensed practical nurse) #1. In a resident's care plan to of an incentive spirometer. When asked why, LPN #1 their personalized plan of the totake care of the patient with them." In, ASM (administrative staff	F	655	weeks. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. 5. Date of Compliance: October 1, 20		
		ninistrator) and ASM #2 (the ere made aware of the					

AND DUAN OF CORDECTION		` '	PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED	
		495407	B. WING		00	C V06/2040
	NAME OF PROVIDER OR SUPPLIER FALLS RUN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406		/06/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 655	"B) An 'Interim' Base developed within 48 that the resident's not until the Comprehencompleted" No further information (1) "An incentive spin help you keep your I when you have a lur pneumonia. Using the teaches you how to Deep breathing keep and healthy while your obtained from the whole that the care plan related to the Resident #222. Resident #222 was a 8/19/19 with diagnostic cancer of the escobstructive pulmonarecent MDS (minimulassessment with an date) of 8/26/19, Rehaving mild cognitive decisions, having so BIMS (brief interview coded as requiring the complete in the sident in the code of the second	ed, "Care Plan" documented, eline Care plan must be hours of admission to insure eleds are met appropriately sive Care Plan is on was presented prior to exit. rometer is a device used to ungs healthy after surgery or any illness, such as the incentive spirometer take slow deep breaths. The power lungs well-inflated on heal and helps prevent lungtonia. This information was rebsite: gov/ency/patientinstructions/O sailed to develop a baseline the use of bed rails for admitted to the facility on ses including, but not limited to phagus and COPD (chronic ry disease) (1). On the most um data set), an admission ARD (assessment reference seident #222 was coded as a impairment for making daily ored 11 out of 15 on the for mental status). He was the extensive assistance of r bed mobility and for	F 68	55		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495407	B. WING	B. WING		C 09/06/2019	
	NAME OF PROVIDER OR SUPPLIER FALLS RUN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 655	Continued From pag	e 44	F 65	55			
	was observed sitting p.m. and 3:59 p.m., 9 p.m., 9/6/19 at 7:40 a bars) was attached to side rails were up du On 9/4/19 at 1:19 p.r. interviewed. When as said, "They are up al bed. I use them to he to them when I need On 9/5/19 at 2:50 p.r. nurse) #1, the assistatinterviewed. When as care plan, she stated know how to take care the care plan, she stated with a care plan, she stated with a care plan access the consider a care plan access the consider a care plan access the consider a care plan access the care plan access the consider a care plan access the	n., LPN (licensed practical ant director of nursing, was sked about the purpose of a l, "The care plan is how you re of a patient." LPN #1 have an updated care plan take care of a patient. The care plans at any computer." n., LPN #3 was interviewed. tesident #222's use of the licens are plans at the care of the licens are plans.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495407	B. WING			С	
NAME OF D	ROVIDER OR SUPPLIER	493407	D. WINO	_	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	06/2019
	IN NURSING AND REHA	B CENTER		1	40 BRIMLEY DRIVE FREDERICKSBURG, VA 22406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656 SS=D	DON (director of nurs concerns, and asked Resident #222's base use of side rails for be on 9/6/19 at 8:54 a.m. this is a concern. The side rails, not side rail an assessment or not are doing a 100% aud that need updating. We ducation on it." No further information (1) COPD is "a gener nonreversible lung discombination of emphy bronchitis." Barron's If for the Non-Medical FRothenberg and Chap Develop/Implement CCFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The faci implement a comprehe care plan for each resident rights set for §483.10(c)(3), that incobjectives and timeframedical, nursing, and needs that are identificated assessment. The condescribe the following (i) The services that a or maintain the reside	ting) were informed of these to present any evidence that eline care plan included the eld mobility and transferring. In., ASM #2 stated, "I agree enurses see the devices as ls. That is why there is not thing on the care plan. We dit, and updating the ones We are doing some In was provided prior to exit. It all term for chronic, sease that is usually a sysema and chronic Dictionary of Medical Terms Reader, 5th edition, pman, page 124. Comprehensive Care Plan comprehensive Care Plan ensive Plan densive person-centered sident, consistent with the that §483.10(c)(2) and coludes measurable armes to meet a resident's mental and psychosocial ided in the comprehensive care plan must		655			9/23/19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495407	B. WING _			C 09/06/2019
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	•	30.00.20.10
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	(ii) Any services that under §483.24, §483 provided due to the under §483.10, inclu treatment under §48 (iii) Any specialized rehabilitative service provide as a result or recommendations. If findings of the PASA rationale in the resid (iv)In consultation wiresident's representa (A) The resident's godesired outcomes. (B) The resident's profuture discharge. Farwhether the resident community was assellocal contact agencial entities, for this purp (C) Discharge plans plan, as appropriate, requirements set for section. This REQUIREMEN by: Based on observation interview, facility docrecord review, it was staff failed to implement of 40 residents in the #222 and #57. Residents.	24, §483.25 or §483.40; and would otherwise be required 8.25 or §483.40 but are not resident's exercise of rights ding the right to refuse 3.10(c)(6). Services or specialized is the nursing facility will f PASARR a fa facility disagrees with the RR, it must indicate its ent's medical record. It the resident and the ative(s)-bals for admission and reference and potential for cilities must document a desire to return to the resident and repropriate ose. In the comprehensive care in accordance with the resident interview, staff requested to the plan of care for two resurvey sample, Residents and the plan of care for two resurvey sample, Residents and the plan of care for two resurvey sample, Resident #57 roung oxygen at a rate that by the physician.	F6	F656 1. Comprehensive care plan f #57 was updated on 09/05/19 resident #222 was discharged 09/11/19. 2. All residents who reside at Nursing and Rehabilitation ha potential to be affected. The E designee conducted a quality current residents who require services for staff following /	and d on Falls Run live the DON or review of all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407 B. WING		B. WING		C 09/06/2019
	NAME OF PROVIDER OR SUPPLIER FALLS RUN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	1 03/06/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 656	#222's comprehensive oxygen at the physicial Resident #222 was a 8/19/19 with diagnose to cancer of the esopobstructive pulmonar recent MDS (minimur assessment with an Adate) of 8/26/19, Reshaving mild cognitive decisions, having scould be	led to implement Resident e care plan to administer an-ordered rate. dmitted to the facility on es including, but not limited hagus and COPD (chronic y disease) (1). On the most m data set), an admission ARD (assessment reference ident #222 was coded as impairment for making daily ored 11 out of 15 on the for mental status). He was kygen in the facility on all period. s and times, Resident #222 up in his bed. At each wearing oxygen delivered ula connected to an oxygen tes, times, and rates of ws: - 2.5 lpm (liters per minute) - 2.5 lpm - 3.5 lpm - 3.5 lpm #222's physicians' orders g order, written 8/19/19, M (liters per minute) via shift for SOB (shortness of	F 65	implementation of the care plan. 3. Licensed nurses have been edu on following / implementing the placare by DON/Designee. 4. MDS/Designee will audit five cat for respiratory services implement week for 4 weeks, then 3x/ week for weeks for accurate documentation results will be presented monthly formonths to the Quality Assurance Performance Improvement comminaries and recommendation. 5. Date of Compliance: October 1	re plans ation/ or 8 i. Audit or three

	DEFICIENCIES CORRECTION			(X3) DATE SURVEY COMPLETED	
		495407	B. WING		C 09/06/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	1 09/06/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 656	Continued From page	e 48	F 65	6	
	interviewed. When as oxygen rate, he state that. I can't reach it, a do with it if I could reach owith it is	a., LPN (licensed practical ewed regarding how staff receiving oxygen at the e. LPN #5 stated, "Usually, I thing. I look on the assignments. I look on the ministration record) and TAR tion record) to see what is is a skilled floor. We have ad out all the time." When are of Resident #222's e, LPN #5 stated, "I would t. I am not usually working ed to check." LPN #5 then Resident #222's oxygen, be three liters." LPN #5 veyor to Resident #555's hat rate Resident #222's PN #5 stated, "Three and a down." She then adjusted e of three liters per minute. check on that this morning. Herapy. When he came back, ask. Someone must have ank back to the			
	director of nursing, wa about the purpose of "The care plan is how	n., LPN #1, the assistant as interviewed. When asked a care plan, LPN #1 stated, y you know how to take care stated, "The staff can			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED		
		495407	B. WING		0	C 9/06/2019	
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	•	3/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	member) #1, the add DON (director of nur concerns. On 9/6/19 at approx gave the surveyor a of practice regarding standard is from the Practice, 10th editio the standard reveals "Performance phase		F 6:	56			
	A review of the facili revealed, in part, the be familiar with each approaches must be No further information (1) COPD is "a gene nonreversible lung of combination of emploronchitis." Barron's for the Non-Medical Rothenberg and Characteristic States (2). The facility staff of comprehensive care oxygen as ordered for Resident #57 was an 09/15/2011 with a rewith diagnoses, that	eral term for chronic, lisease that is usually a hysema and chronic Dictionary of Medical Terms Reader, 5th edition, apman, page 124. failed to implement the e plan for administering					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495407	B. WING _			1	C 06/2019	
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406			00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOUL		3E	(X5) COMPLETION DATE	
F 656	Resident #57's most set), a quarterly asset (assessment reference Resident #57 as score assessment for ment of 0 - 15, 15- being or daily decisions. Sect evidence documentar receiving oxygen the On 9/04/19 at 11:26 acconducted with Resident with the stated that she uses the day and wears it asked how long she Resident #57 stated, Resident #57 was obcannula in her nose or revealed the oxygen L/Min (liters/minute). Additional observation and on 09/05/19 at 8 concentrator flow mere (liter/minute). The order summary redocumented, "O2 (oxinute) as needed for Order Date: 05/22/20. The comprehensive caltered respiratory stated to) hx (history (congestive heart fail artery disease) (4), a Date Initiated 01/15/2	recent MDS (minimum data issment with an ARD ce date) of 07/12/19, coded fing a 15 on the staff al status (BIMS) of a score orgitively intact for making ion O of the MDS failed to tion of Resident #57 rapy while a resident. a.m., an interview was dent #57. Resident #57 her oxygen frequently during every night in bed. When has been using oxygen, "About a year now." served wearing an oxygen during the interview in her of the oxygen concentrator flowrate to be set on 2 1/2 Ins on 09/04/19 at 1:47 p.m. at 8 a.m. revealed the oxygen ter was set on 2 1/2 L/Min Teport dated 9/05/2019 raygen) at 3L/Min (liters per or SOB (shortness of breath). The resident has atus/Difficulty Breathing r/t by) of Pneumonia (2), CHF ure) (3), CAD (coronary and anxiety (5) Uses O2.	F	656				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495407	B. WING _				C 06/2019
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	ordered. Monitor for effects. Date Initiated 01/15/2018. Provide Initiated: 01/15/2018. Provide Initiated: 01/15/2018. Provide Initiated: 01/15/2018. The eMAR (medicated dated 7/1/2019-7/31/2 and 9/1/2019-9/30/20 documented, "O2 at 3 Start Date- 05/22/2010 On 9/05/19 at 3:57 p. conducted with LPN ##57 wears oxygen, LI oxygen on a regular has been been been been been been been bee	ster medication/puffers as effectiveness and side do 1/15/2018, Revision on oxygen as ordered. Dated Revision on 01/15/2018." on administration record) 2019, 8/1/2019-8/31/2019, 19 for Resident #57 BL/Min as needed for SOB. 9 1030 (10:30 a.m.)." m., an interview was #8. When asked if Resident PN #8 stated that it for shortness of breath, but the frequently, especially when then asked to describe the enditorial form of the inturn the knob to the correct downward. When asked to describe the enditorial for the silver ball. LPN #8 ter on the concentrator 57's room and agreed that it gost. Jal. Jal. Jal. Jal. Jal. Jal. Jal. Jal	F	956			
	On 9/05/19 at 4:50 p.	m., an interview was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495407	B. WING				C (06/2019	
	ROVIDER OR SUPPLIER JN NURSING AND REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406			06/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 656	conducted with LPN: asked if Resident #57 stated, "Yes, she use stated that she was owas changing it becarrequently. On 09/05/19 at 4:57 written list to ASM (at #1, the administrator oxygen administration. On 09/06/19 at 7:39 a facility did not have a administration and prinstructions for use for used for Resident #5 The manufacturer ins Respironics, EverFlo documented, "Chapte 6. Adjust the flow to the turning the knob on the ball is centered of specific flow rate." A review of the facility revealed, in part, the befamiliar with each approaches must be On 09/05/19 at approaches must be On 09/05/19 at approaches must be on one of the facility revealed and a proaches must be on one of the facility revealed and a proaches must be on one of the facility revealed and a proaches must be on one of the facility revealed and a proaches must be on one of the facility revealed and a proaches must be on one of the facility revealed and a proaches must be one of the facility revealed and a proache	#2, the unit manager. When 7 wears oxygen, LPN #2 is it when in bed." LPN #2 concerned that the resident use it was being checked D.m., a request was made by dministrative staff member) for the facility policy on in. a.m., ASM #1 stated that the policy on oxygen rovided the manufacturer or the oxygen concentrator 7. Structions for use "Philips, EverFlo Q, User Manual" er 2: Operating Instructions, the prescribed setting by the top of the flow meter until in the line marking the y policy, "Care Plan" following: "D) All staff must resident's Care Plan and all implemented" eximately 5:00 p.m., ASM member) #1, the M #2, the director of nursing	F	656				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495407	B. WING _			C 09/06/2019	
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	E	00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	heartbeat. This infor the website: https://www.nlm.nih.gon.html. 2. Pneumonia An infection in one of germs, such as bacticause pneumonia. Yeby inhaling a liquid of was obtained from the https://medlineplus.go 3. Congestive heart A condition in which blood to meet the bodoes not mean that yeabout to stop working not able to pump bloaffect one or both sid information was obtained from the subject of the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect one or both sid information was obtained from the pump bloaffect	peed or rhythm of the rmation was obtained from gov/medlineplus/atrialfibrillati or both of the lungs. Many eria, viruses, and fungi, can fou can also get pneumonia or chemical. This information he website: lov/pneumonia.html. failure the heart can't pump enough dy's needs. Heart failure your heart has stopped or is go. It means that your heart is od the way it should. It can des of the heart. This lined from the website: lov/heartfailure.html	F 6	56			
F 695	5. Anxiety Fear. This information website: https://www.nlm.nih.g	on was obtained from the gov/medlineplus/anxiety.html stomy Care and Suctioning	F 6	95		9/23/19	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILD			, ا	C
		495407	B. WING				06/2019
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
E4110 DI	IN AUTOONIO AND DELLA	D OFWED		1	40 BRIMLEY DRIVE		
FALLS RU	IN NURSING AND REHA	BCENTER		F	REDERICKSBURG, VA 22406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695 SS=D	The facility must ensured respiratory car care and tracheal succare, consistent with	ry care, including nd tracheal suctioning. ure that a resident who re, including tracheostomy ctioning, is provided such professional standards of	F	695			
	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, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide respiratory care and services consistent with professional standards of practice, the comprehensive person-centered care plan, for three of 40 residents in the survey sample, Residents #222, #57, and #67. The facility staff failed to administer oxygen at the physician-ordered rate during multiple observations conducted for Resident #222 and #57, and failed to obtain a physician's order for Resident #67's use of an incentive spirometer.				F695 1. Oxygen settings for resident #222 ar #57 were immediately corrected at time survey. Resident #67 was provided wit an order by facility MD for Incentive Spirometer. 2. All residents who reside at Falls Rur Nursing and Rehabilitation and receive respiratory services have the potential be affected. The DON or designee conducted a quality review of all currer residents who are provided respiratory care and services for administration of oxygen per physician order, and obtain orders for the use of an incentive	e of h	
	failed to administer of the physician-ordered Resident #222 was a 8/19/19 with diagnose to cancer of the esop obstructive pulmonar recent MDS (minimus	distributions the facility staff exygen to Resident #222 at distribution rate. distribution distribution rate including, but not limited hagus and COPD (chronic y disease) (1). On the most m data set), an admission ARD (assessment reference			spirometer. 3. Licensed nurses have been educate on providing respiratory care and serviconsistent with professional standards practice, administering oxygen at the physician-ordered rate, and obtaining orders for the use of an incentive spirometer by DON/Designee. 4. DON/Designee will audit five resider a week for provision of respiratory services consistent with professional	ces of	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495407	B. WING _				C 09/06/2019	
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406		I	00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI EACH CORRECTIVE ACTION SHOUL DSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 695	Continued From page date) of 8/26/19, Rehaving mild cognitive decisions, having so BIMS (brief interview coded as receiving days of the lookback). On the following date was observed sitting observation, he was through short tubes and rates of oxygen – 9/4/19 at 1: 25 p.m – 9/4/19 at 3:59 p.m – 9/5/19 at 9:00 a.m – 9/5/19 at 2:15 p.m. A review of Resident revealed the following "Oxygen @ (at) 3 LF nasal cannula every breath)" A review of Resident revealed, in resident has COPD therapy as ordered on 9/5/19 at 9:00 a.m.	ge 55 sident #222 was coded as e impairment for making daily cored 11 out of 15 on the v for mental status). He was expected in the facility on all comparison of the period. The session of the session of the period of the session	F 6	standard weeks. A monthly t Assurand committe recomme	ds and per physician orders Audit results will be presente for three months to the Qua ce Performance Improveme ee for review and endation. of Compliance: October 1,	ed ality ent		
	that. I can't reach it, do with it if I could re On 9/5/19 at 2:50 p. nurse) #5 was interv how she makes sure oxygen at the physic	ed, "No, only the staff does and I would not know what to each it." m., LPN (licensed practical riewed. When asked about e residents are receiving cian-ordered rate, LPN #5 ake my rounds first thing. I						

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495407	B. WING		09/) 06/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	03/1	56/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 695	look on the MAR (merecord) and TAR (trearecord) to see what not skilled floor. We have all the time." When as Resident #222's physistated, "I would need usually working over check." LPN #5 check #222's oxygen, and sliters." LPN #5 accom Resident #555's room \$#22's oxygen. Wheo oxygen was set at, LF half. I need to turn it coxygen to the rate of #5 stated, "I did check went out for therap was still on the tank him from the tank back didn't do it." On 9/5/19 at 3:10 p.m director of nursing, where we will be the beginning of the possible throughout the physician's order. On 9/5/19 at 5:00 p.m member) #1, the adm DON (director of nursing) member) #1, the adm DON (director of nursing) where we will be the physician's order.	to see my assignments. I dication administration atment administration eeds to be done. This is a so many people in and out sked if she was aware of ician-ordered rate, LPN #5 to check on that. I am not here. I would need to ked the order for Resident tated, "It should be three apanied the surveyor to and observed Resident asked what flowrate the PN #5 stated, "Three and a down." She adjusted the three liters per minute. LPN ke on that this morning. But by. When he came back, he someone must have moved to the concentrator. I when the concentrator and he had a sinterviewed. She stated, ding checks the oxygen rate to econcentrators and he had a soften as the day. She stated the enurses check all the rates the er ate should be against the enurse sked to provide the had a sked to provide the	F 69	95		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495407	B. WING _			C 09/06/2019
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406		33,00,2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	Continued From pag	e 57	F 6	95		
	facility did not have a administration. On 9/6/19 at approxiprovided a copy of the practice regarding of standard is from the Practice, 10th edition the standard revealed "Performance phase prescribed liters per oxygen is flowing the No further information (1) COPD is "a gene nonreversible lung dombination of employenchitis." Barron's for the Non-Medical Rothenberg and Chapter 2. The facility staff for	mately 10:30 a.m., ASM #2 me facility's standard of xygen administration. The Lippincott Manual of Nursing n, pages 239-240. A review of ed, in part, the following: e3. Set the flow rate at the minute. Feel to determine if rough the tips of the cannula." en was provided prior to exit. eral term for chronic, isease that is usually a hysema and chronic Dictionary of Medical Terms Reader, 5th edition, apman, page 124. ailed to administer oxygen at				
	by the physician for Resident #57 was ac 09/15/2011 with a re with diagnoses, that to shortness of breach Resident #57's most set), a quarterly asso (assessment reference)	dmitted to the facility admission on 01/03/2019 included but were not limited th and atrial fibrillation (1). recent MDS (minimum data essment with an ARD ince date) of 07/12/19, coded				
	assessment for men of 0 - 15, 15- being of	ring a 15 on the staff tal status (BIMS) of a score cognitively intact for making tion O of the MDS failed to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495407	B. WING			1	00/2040
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 40 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	1 09/	06/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	conducted with Resid stated that she uses I the day and wears it dasked how long she it Resident #57 stated, Resident #57 was obcannula in her nose or room. Observation or revealed the oxygen L/Min (liters/minute). Additional observation and on 09/05/19 at 8: concentrator flow med (liter/minute). The order summary indocumented, "O2 (ox minute) as needed for Order Date: 05/22/20 The eMAR (medication dated 7/1/2019-7/31/2 and 9/1/2019-9/30/20 documented, "O2 at 3 Start Date- 05/22/201 The comprehensive caltered respiratory state (related to) hx (history (congestive heart failurantery disease) (4), and Date Initiated 01/15/207/19/2018." Under 's conservation of the comprehensive of the compre	rion of Resident #57 rapy while a resident. a.m., an interview was lent #57. Resident #57 her oxygen frequently during levery night in bed. When has been using oxygen, "About a year now." served wearing an oxygen luring the interview in her of the oxygen concentrator flowrate to be set on 2 1/2 a.m. revealed the oxygen ter was set on 2 1/2 L/Min beport dated 9/05/2019 ygen) at 3L/Min (liters per or SOB (shortness of breath). con administration record) 2019, 8/1/2019-8/31/2019, con administration reco	F	695			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495407	B. WING _			1	C 06/2019
NAME OF PI	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 00.	00/2010
E4110 DI	IN AUTONIO AND DELLA	D OFWED		140 I	BRIMLEY DRIVE		
FALLS RU	IN NURSING AND REHA	BCENTER		FRE	EDERICKSBURG, VA 22406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page	e 59	F 6	895			
F 695	ordered. Monitor for effects. Date Initiated 01/15/2018. Provide Initiated: 01/15/2018, Provide Initiated: 01/15/2018, On 9/05/19 at 3:57 p. conducted with LPN 7 #57 wears oxygen, Ll oxygen on a regular his ordered as needed Resident #57 wears is she is in her room. We process for setting the #8 stated that you must concentrator and then number that is ordered the location of the line number and the silve flow meter, LPN #8 staligned in the center observed the flowmed located in Resident # was not administering #57 stated that the oxiliter/minute line. LPN look at it from standing but when you are eye incorrect. When asket	effectiveness and side d 01/15/2018, Revision on oxygen as ordered. Dated Revision on 01/15/2018." m., an interview was #8. When asked if Resident PN #8 stated that she wears pasis. LPN #8 stated that it for shortness of breath, but the frequently, especially when when asked to describe the efflowrate of oxygen, LPN ast get eye level to the enturn the knob to the correct end. When asked to describe the effining the oxygen reball located inside of the stated that the line should be of the silver ball. LPN #8 ter on the concentrator 57's room and agreed that it g 3L/Min as ordered. LPN and the stated that when young it looks like it is on three	F	695			
	On 9/05/19 at 4:50 p. conducted with LPN asked if Resident #57 stated, "Yes, she use asked the process for oxygen on the conthat you get down to	m., an interview was #2, the unit manager. When wears oxygen, LPN #2 s it when in bed." When r setting the flowmeter rate ncentrator, LPN #2 stated eye level with the gauge and d number. LPN #2 stated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495407	B. WING		C 09/06/2019	
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	1 00	700/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 695	Resident #57 was see had set it back to the LPN #2 stated that s resident was changir checked frequently. On 09/05/19 at 4:57 written list to ASM (a #1, the administrator oxygen administration oxygen administration and prinstructions for use for used for Resident #5 The manufacturer in Respironics, EverFlor documented, "Chapte 6. Adjust the flow to turning the knob on the ball is centered of specific flow rate." On 09/06/19 at approached the director of nursin "Lippincott Manual of Edition. Procedure (Administering Oxyge #2 stated that nursin of practice. Lippincott Manual of Edition documents in 10-12. Administering 10-12.	rmed her that the oxygen for at at 2 1/2 L/Min and that she is prescribed rate of 3 L/Min. The was concerned that the ing it because it was being p.m., a request was made by dministrative staff member) for the facility policy on n. a.m., ASM #1 stated that the is policy on oxygen rovided the manufacturer for the oxygen concentrator 7. Structions for use "Philips is prescribed setting by the top of the flow meter until in the line marking the oximately 9:30 a.m., ASM #2, g provided a copy of Nursing Practice 10th	F 69	5		

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495407	B. WING _			C 09/06/2019	
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406		00/00/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 695	Continued From pag	ge 61	F 6	995			
	(administrative staff	SM #2, the director of nursing					
	No further information was provided prior to exit. Reference:						
	A trial fibrillation A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.						
	germs, such as back cause pneumonia. Y by inhaling a liquid of was obtained from the	or both of the lungs. Many seria, viruses, and fungi, can fou can also get pneumonia or chemical. This information he website:					
	blood to meet the bo does not mean that about to stop workin not able to pump blo affect one or both si	the heart can't pump enough ody's needs. Heart failure your heart has stopped or is g. It means that your heart is bood the way it should. It can des of the heart. This ained from the website:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		495407	B. WING		09/06/2019		
	ROVIDER OR SUPPLIER JN NURSING AND REH	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 695	rydisease.html. 5. Anxiety Fear. This informat website: https://www.nlm.nih #summary. 3. The facility staff for resident #spirometer (1). Resident #67 was a 8/16/19. Resident #were not limited to and surgical afterca circulatory system. MDS (minimum data assessment with an date) of 8/30/19, cocognitively intact. Review of Resident reveal a physician's spirometer. Reside initiated on 8/16/19 regarding an incentity on 9/4/19 at 3:50 p. observed in bed. All observed in a bag of the property of the propert	ion was obtained from the .gov/medlineplus/anxiety.html ailed to obtain a physician's 67's use of an incentive dmitted to the facility on 667's diagnoses included but lifficulty swallowing, tremor re following surgery on the Resident #67's most recent a set), a 14 day Medicare ARD (assessment reference ded the resident as being #67's clinical record failed to order for an incentive nt #67's baseline care plan failed to reveal documentation ve spirometer. m., Resident #67 was n incentive spirometer was	F 69	5			
	reveal a physician's spirometer. Reside initiated on 8/16/19 regarding an incention on 9/4/19 at 3:50 p. observed in bed. All observed in a bag of the spirometer. Reside	order for an incentive nt #67's baseline care plan failed to reveal documentation ve spirometer. m., Resident #67 was n incentive spirometer was n the nightstand. m., Resident #67 was					

PRINTED: 10/08/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495407	B. WING	P. WING		C	
	ROVIDER OR SUPPLIER	L	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	<u>l 09/</u>	06/2019
FALLS RU	N NURSING AND REHA	BCENIER		F	FREDERICKSBURG, VA 22406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	LPN #1 was asked wiresident using an incestated, "They should Educated why they are there is a goal attached there should be a phy #1 stated, "Uh huh." stated, "So the nursestake place. That's out When asked what inforder should contain, the goal, the reason to the contain the goal, the reason to the goal the goal the goal that goal	licensed practical nurse) #1. hat should be done for a entive spirometer. LPN #1 be taught how to use it. re using it and make sure ed to it." When asked if visician's order in place, LPN When asked why, LPN #1 s are aware that needs to r documentation proving it." formation the physician's LPN #1 stated "Frequency, hey are using it." 1., ASM (administrative staff hinistrator) and ASM #2 (the here made aware of the 1., ASM #1 stated the facility for incentive spirometers. facility standard of practice anual of Nursing Practice handard of practice hand documented, "1. Set the handicator at the desired goal hard or exceed" but did not formation regarding 1. was presented prior to exit. 1. Someter is a device used to hands healthy after surgery or	F	695			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495407	B. WING	B. WING		C 09/06/2019	
	ROVIDER OR SUPPLIER N NURSING AND REHA	L		14	TREET ADDRESS, CITY, STATE, ZIP CODE 40 BRIMLEY DRIVE REDERICKSBURG, VA 22406	<u> 09/</u>	06/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	and healthy while you problems, like pneum obtained from the wel https://medlineplus.go 00451.htm	s your lungs well-inflated I heal and helps prevent lung onia. This information was		695			
F 700 SS=D	alternatives prior to in a bed or side rail is us correct installation, us		F	700			9/23/19
	entrapment from bed §483.25(n)(2) Review bed rails with the resi representative and obto installation. §483.25(n)(3) Ensure are appropriate for the §483.25(n)(4) Follow recommendations and and maintaining bed in This REQUIREMENT by: Based on observation document review and was determined that to implement bed rail residue.	that the bed's dimensions e resident's size and weight. the manufacturers' d specifications for installing			F700 1. Bed rail assessment for resident #61 and #222 were completed on 09/05/19 2. All residents who reside at Falls Run Nursing and Rehabilitation have the	•	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
495407	7 B. WING			C 09/06/2019	
•		STREET ADDRESS, CITY, STATE, ZIP CODI		3.33.23.3	
AD CENTED		140 BRIMLEY DRIVE			
TALLO NON NONCINO AND NEMAD GENTEN		FREDERICKSBURG, VA 22406			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
ge 65	F 70	00			
ty staff failed to assess desident #222 for the use of failed to review risks and led rails, and failed to obtain or the resident's use of bed alled to evidence that issessed for the use of bed to review the risks and informed consent for the drails. dmitted to the facility on a failed to failed to the facility on a failed to failed to failed to failed to failed to failed to order for the bed rails. #61's clinical record failed to order for the bed rails. #61's clinical record failed to order for the bed rails. #61's clinical record failed to benefits were reviewed with the representative) and failed to	F 70	potential to be affected. The Edesignee conducted a quality current residents who utilize be completion of bed rail assess consent for usage. 3. Licensed nurses have been on the use of bed rails, assess consent for use as outlined in policy by DON/Designee. 4. DON/Designee will audit neadmissions for side rail assess consent as indicated 5x/ week weeks, then 3x/ week for 8 we proper documentation. Audit represented monthly for three the Quality Assurance Perforn Improvement committee for recommendation.	review of all ped rails for ment, and in educated sment, and the bed rail ew sments and of for 4 eeks for results will e months to mance eview and		
	A95407 AB CENTER STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	A BUILDING 495407 B. WING STATEMENT OF DEFICIENCIES BOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) For the sesse desident #222 for the use of failed to review risks and over arils, and failed to obtain on the resident's use of bed From the use of the bed rails. From the use of the use of the bed rails. From the use of the use of the bed rails. From the use of the use of the use of the bed rails, failed to use of the bed rails, failed to use of the bed rails, failed to use of the us	A BUILDING 495407 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406 STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) GROSS-REFERENCED TO THE DEFICIENCY) ge 65 thy staff failed to assess leaded the #222 for the use of failed to review risks and led rails, and failed to obtain for the resident's use of bed to review the risks and informed consent for the d rails. dimitted to the facility on 51's diagnoses included but neart failure, seizures and ck. Resident #61's most um data set), an admission ARD (assessment reference ded the resident's cognition irred. Section G coded quiring extensive assistance of th bed mobility. a.m., and 9/5/19 at 9:43 a.m., abserved lying in bed. Both b bars) were in the upright sident was in bed. #61's clinical record failed to order for the bed rails, did to review the resident was e of the bed rails, failed to benefits were reviewed with e representative) and failed to issent was obtained prior to the	A BUILDING A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406 FREDERICKSBURG, VA 22406 PREPRY TAG PROPRY TAG PREPRY TAG PROPRY T	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495407	B. WING _			C 09/06/2019	
	NAME OF PROVIDER OR SUPPLIER FALLS RUN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406		00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 700	regarding the use of On 9/5/19 at 2:30 p. member) #1 (the adrail assessment con 9/5/19. A note attack documented, "Used enablers. No longe assessment and grace on 9/5/19 at 2:50 p. conducted with LPN LPN #1 was asked residents using bed would identify what that may assist. As would help them, whole the mobility, turning strengthening and staff assess the resiralls, LPN #1 stated basically it's not goin type of injury so we #1 was asked if the side rails are explain informed consent is "Yeah. If not necession of the side rails are explain informed consent is "Yeah. If not necession of the facility revealed, in part, the adjustable metal or the bed. They are a shapes, and sizes resident and sizes residents."	miled to document information f bed rails. m., ASM (administrative staff ministrator) presented a bed apleted for Resident #61 on the dot to the assessment grab bars on admit for rusing due to decline. New ab bars removed today." m., an interview was I (licensed practical nurse) #1. what should be completed for rails. LPN #1 stated, "So we diagnosis they would have sess their diagnosis, why that that is it going to help them do;	F7				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED		
		495407	B. WING		C 09/06/2019	
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	1 03/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 700	the manufacturer and along the side of a bill will attempt to use applied to installing a side or rail is used, the facility risks associated with including the risk of einstallation. b. Assessusing a bed rail and or if applicable, the mobility of bed rails prior. No further informed consuse of bed rails prior. No further information 2. The facility staff fafor the use of bed rail risks and benefits for to obtain informed consusts of bed rails. Resident #222 was as 8/19/19. Diagnoses is cancer of the esophate obstructive pulmonal recent MDS (minimulassessment with an adate) of 8/26/19, Reshaving mild cognitive decisions, having social BIMS (brief interview coded as requiring the one staff member for transferring from bed. On the following date was observed sitting p.m. and 3:59 p.m., 9	igned as part of the bed by d may be installed on or used ed. Procedure: 1. The facility propriate alternatives prior bed rail. 2. If a bed or side by will: a. Assess the potential the use of bed rails, entrapment, prior to bed rail is the risk versus benefits of review them with the resident esident's representative. c. sent for the installation and to the installation." In was presented prior to exit. illed to assess Resident #222 Is, and staff failed to review use of bed rails, and failed onsent for the resident's use admitted to the facility on include, but not limited to agus and COPD (chronic by disease) (1). On the most im data set), an admission ARD (assessment reference is ident #222 was coded as a simpairment for making daily ored 11 out of 15 on the for mental status). He was the extensive assistance of the bed mobility and for	F 70			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495407			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495407	B. WING _			C 09/06/2019	
	NAME OF PROVIDER OR SUPPLIER FALLS RUN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP COL 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406		3575572010	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 700	Continued From pag	ge 68	F 7	700			
	bars (side rails) were the bed. The side ra observation.	e attached to both sides of ils were up at each					
	interviewed. When a stated, "They are up	m., Resident #222 was asked about the side rails, he all the time when I'm in the elp position myself. I hold on I some support."					
	revealed no evidence any alternatives prior There was no evider use of side rails, no was provided the ris side rails, and no evidence.	t #222's clinical record e that the facility attempted r to installing the side rails. nce of an assessment for the evidence that Resident #222 k and benefits for the use of idence of informed consent at the RR (responsible ne use of side rails.					
		ician orders for Resident any orders for use of the					
	8/20/19 failed to rev	t #222's care plan dated eal any information related to e of side rails for bed mobility					
	member) #1, the ad DON (director of nur above concerns, and documentation evide been attempted for I installing the side ra evidencing that Res	m., ASM (administrative staff dministrator, and ASM #2, the rising) were informed of the dasked to present any encing that alternatives had Resident #222 prior to ills. Any documentation ident #222 had been e of side rails, was informed					

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	PLE CONSTRUCTION G	COMPLETED		
		495407 B. WING			09/	06/2019
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	1 00.	5072010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPRIED TO THE APPROPROPRIED TO THE APPROPRIED	D BE	(X5) COMPLETION DATE
F 700	and evidence that Re (responsible party) had for the use of side raid on 9/6/19 at 8:15 a.m. nurse) #3 was interving Resident #222's use LPN #3 stated, "Yes, turning and mobility in On 9/6/19 at 8:54 a.m. surveyor with a docur Corporation] Bed Raid The document included Risk Potential, and Country that the devices as grab to the devices as gr	ts of the use of the side rails, esident #222 or the RR ad given informed consent Is a., LPN (licensed practical ewed. When asked about of the side rails (grab bars), he uses them to help with a the bed." a., ASM #2 presented the ment, "[Name of Il Assessment dated 9/5/19. ed the headings, Rationale, onsent. When asked why dated 9/5/19 when the limitted on 8/19/19, ASM #2 is a concern. The nurses see bars, not side rails. That is essment or anything on the ing a 100% audit, and at need updating. We are non it." In was provided prior to exit. The term for chronic, seease that is usually a ysema and chronic Dictionary of Medical Terms Reader, 5th edition,	F 70			
	Rothenberg and Cha Food Procurement,S CFR(s): 483.60(i)(1)(§483.60(i) Food safe The facility must -	tore/Prepare/Serve-Sanitary 2)	F 8 ²	12		9/23/19

[` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495407	B. WING		09/06/2019		
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406	09/06/2019		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 812	Continued From pag		F 812	2			
	approved or conside state or local author (i) This may include from local producers and local laws or require (ii) This provision do facilities from using gardens, subject to safe growing and fo (iii) This provision do from consuming foo \$483.60(i)(2) - Store serve food in accord standards for food so This REQUIREMENT by: Based on observation document review, it facility staff failed to manner in the main freezer a box of froz beans were observed exposing the food to the findings included on 9/4/19 at 11:11 A kitchen was conducted to the finding was identified bag inside was not sexposed to environre	food items obtained directly is, subject to applicable State gulations. The series of prohibit or prevent produce grown in facility compliance with applicable od-handling practices. The series of preclude residents of the state of the environment. The series of the series of the environment of the sealed. The food was		F812 1. Food storage for 2 items was immediately corrected 09/04/19. 2. All residents who reside at Falls Ru Nursing and Rehabilitation have the potential to be affected. The Administ or designee conducted a quality revier food storage area to ensure food is sin a safe and sanitary manner. 3. Dietary staff have been educated or proper food storage by Dietary Manager/Designee. An audit was conducted of dietary/kitchen to assure items were properly stored in a sanitary manner. 4. Dietary Manager/Designee will aud food storage area three times a week 12 weeks for food storage in a safe a sanitary manner. Audit results will be presented monthly for three months to	erator ew of tored on e all erry lit for		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495407	B. WING				00/2040
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406			06/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	freezer, with the lid n bag inside was not so exposed to environm On 9/4/19 at approximated it should be seen on 9/4/19 at approximated the Dietary Manager, A review of the facility Foods" documented, freezer shall be cove On 9/5/19 at the end approximately 5:00 F	ot securely closed and the ealed. The food was ent of the freezer. mately 11:15 AM, OSM #3 ealed. mately 11:17 AM, OSM #2, was notified of the concern. y policy, "Storage of Frozen "11. Food stored in the red, labeled and dated." of day meeting at PM, ASM #1 (Administrative dministrator, was notified of	F8	312	Quality Assurance Performance Improvement committee for review and recommendation. 5. Date of Compliance: October 1, 201 Preparation and submission of this PO is required by state and federal law. Th POC does not constitute an admission purposes of general liability, profession malpractice or any other court proceed	9. C is for al	