STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING ______ B. WING ______	08/26/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 08/24/2021 through 08/25/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/24/2021 through 8/25/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 82 at the time of the survey. The survey sample consisted of 28 resident reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a call bell within reach for one of 28 residents in the survey sample, Resident #8. The facility staff failed to maintain Resident #8's call bell within reach on 8/24/21. Resident #8 was lying in bed and the resident's call bell was	F 558	F558 1. Call bell placement was immediately verified for placement within reach for resident #8 after discussion with Surveyors on 8/25/21. CNA #1 received education on providing call bell in reach as outlined in the care plan. 2. All residents who reside at Falls Run	9/10/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/10/2021

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

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F 558	Continued From page 1 on the floor under the bed. The findings include: Resident #8 was admitted to the facility on 2/16/17. Resident #8's diagnoses included but were not limited to diabetes, major depressive disorder and a history of falling. Resident #8's quarterly minimum data set assessment with an assessment reference date of 5/17/21, coded the resident's cognition as moderately impaired. Section G coded Resident #8 as requiring limited assistance of two or more staff with bed mobility and as requiring extensive assistance of one staff with transfers. On 8/24/21 at 12:04 p.m. and 12:47 p.m., Resident #8 was observed lying in bed watching television. The resident's call bell was under the bed and out of the resident's reach. On 8/24/21 at 12:47 p.m., CNA (certified nursing assistant) #1 walked into Resident #8's room, served a lunch tray, exited the room, obtained tea, walked back into the room, placed the tea on the table then exited the room. CNA #1 did not pick the call bell up from under the bed. On 8/25/21 at 10:08 a.m., an interview was conducted with CNA #1. CNA #1 stated call bells should be kept within residents' reach and CNAs round at least every two hours to make sure call bells are in place. CNA #1 stated she checks call bells each time she is in a resident's room. CNA #1 stated Resident #8 does sometimes use the call bell but it may become unclipped from the sheet and fall off the bed if the resident gets up. CNA #1 stated she could not remember if she observed Resident #8's call bell while serving lunch on 8/24/21.	F 558	Nursing and Rehabilitation have the potential to be affected. The Administrator or designee conducted a quality review of current residents for placement of call bell within residents reach on 09/01/21. 3. Reasonable accommodation of needs/preferences and following plan of care will be reviewed on hire and at least annually for all CNA's. All CNA's will be educated on Reasonable accommodation of needs/preferences and following plan of care by DON/Designee. 4. UM/Designee will audit new admissions and current residents weekly 5x/ week for 4 weeks, then 3x/ week for 8 weeks for periodic review of call bell placement. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. 5. Date of Compliance: September 22, 2021.	

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F 558	Continued From page 2 On 8/25/21 at 1:04 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Resident Communication System and Call light policy" documented, "It is the policy of the facility to provide residents with a means of communicating with staff. A call system is installed in each resident room and toilet/bath areas. The facility responds to resident needs and requests." No further information was presented prior to exit.	F 558		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		9/10/21

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discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

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F 623	Continued From page 4 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. 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, facility document review, and clinical record review, the facility staff to provide evidence of written notification to the resident and or RP (responsible party) for hospital	F 623	F623 1. Resident # 67 was most recently readmitted to facility on 08/23/21 with no	

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discharges for four of 28 residents in the survey sample, Residents #67, #14, #35, and #44.

The findings include:

1. The facility staff failed to evidence written notification to the RP [responsible party] of Resident #67's discharge to the hospital on 8/19/21.

Resident #67 was admitted to the facility on 11/24/14, and most recently readmitted with diagnoses including a periorbital (around the eye) fracture, arthritis, and blindness. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/2/21, Resident #67 was coded as being moderately impaired for making daily decisions, having scored 11 out of 15 on the BIMS (brief interview for mental status).

A review of Resident #67's clinical record revealed the following note: "8/19/2021 11:06 a.m. Nursing Note Text: Order received from [name of Nurse Practitioner] to send resident to ER (emergency room) for HTN (hypertension) post fall, and the resident's needs can no longer be met in the facility. Res (resident) has been notified that she is going to ER and the reason she is going. Res is unable to voice understanding. Bed hold and care plan goals sent with resident. Resident's RP (responsible party) [name of RP] also notified of the above and of all the documents that accompanied the resident."

A copy of the written notice to the resident/RP regarding this discharge was requested. On 8/25/21 at 7:30 a.m., the facility staff provided a packet of materials regarding the discharge. The

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further discharges at this time. Resident #14 was readmitted to facility on 06/24/21 with emergent discharge to hospital on 08/30/21. Copy retained of written notice of transfer letter sent to RP and scanned into residents EMR. Resident #35 was readmitted to facility on 06/19/21 with no further discharges at this time. Resident #44 was readmitted to facility on 08/16/21 and discharged home on 09/01/21. OSM #2 received education on providing resident and/or resident representative with written notification of a hospital transfer.

2. All residents who reside at Falls Run Nursing and Rehabilitation and have a facility initiated discharge have the potential to be affected. The Administrator or designee conducted a quality review of current residents who discharged to the hospital in the last 30 days for documentation to support written notification was provided to resident and/or resident representative.

3. Social Services department has been educated on required written notification for resident and/or resident representative for notification of hospital transfers by Administrator/Designee.

4. SW/Designee will audit all discharges to hospital for 12 weeks for required documentation of written notification of hospital transfers to resident and/or responsible representative. Audit results will be presented monthly for three months to the Quality Assurance

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F 623	Continued From page 6 packet did not contain any evidence that the resident/RP were notified in writing about the discharge. On 8/25/21 at 12:22 p.m., OSM (other staff member) #2, social services director, was interviewed. She stated she does send written notification to the resident/RP. However, OSM #2 stated she could not provide evidence of the notification because she does not keep copies of the letter. She stated she gets receipts for certified mail. On 8/25/21 at 12:28 p.m., OSM #3, social worker, was interviewed. She stated she does not have evidence of written notification of Resident #67's hospital discharge to the RP. When asked if she was aware of the need to have evidence of the notification, OSM #3 stated she did not. On 8/25/21 at 1:10 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. A review of the facility policy, "Discharge/Transfer Letter Policy," revealed, in part: "The Administrator or designee will complete the appropriate discharge letter utilizing State Specific forms...Social Service or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor, if applicable. Copies will be sent to Department of Health...and filed in the business file and/or scanned into [electronic health record] with certified receipt, if applicable." No further information was provided prior to exit.	F 623	Performance Improvement committee for review and recommendation. 5. Date of Compliance: September 22, 2021.	

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F 623	Continued From page 7 2. The facility staff failed to provide Resident # 14 and the resident's representative written notification of a facility-initiated transfer on 05/19/2021 and 06/22/2021 for Resident # 14. Resident # 14 was admitted to the facility with diagnoses that included but were not limited to: rectal bleeding and diabetes. Resident # 14's most recent MDS [minimum data set], a quarterly assessment with an ARD (assessment reference date) of 05/30/2021, coded Resident # 14 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. The facility's "Progress Note" for Resident # 14 dated 05/19/2021 at 3:05 p.m., documented in part, "Resident currently transferred to [Name of Hospital] for evaluation of possible GI [gastrointestinal (stomach and intestines)] bleed." The facility's "Progress Note" for Resident # 14 dated 06/22/2021 at 12:31 p.m., documented in part, "Resident noted to have blood in her stool x 2 [times two] and has been loosing [Sic.] weight, GI [gastrointestinal] appointment in July, labs [laboratory tests] obtained 6/21/21 MD [medical doctor] suggest resident go to hospital but resident refused. Education provided to resident and resident agreed to go to ER [emergency room] for eval [evaluation]." Review of the clinical record and the EHR (electronic health record) for Resident # 14 failed to evidence that a written notification of discharge was provided to the resident and resident's representative for the facility-initiated transfer on 05/19/2021 and 06/22/2021 for Resident # 14.	F 623		

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On 08/25/21 at 12:22 p.m., an interview was conducted with OSM [other staff member] # 2, social services director and OSM # 3, social worker. When asked about providing evidence that a written notification to a resident and a resident's representative of a facility initiated transfer OSM # 3 stated, "I don't keep copies of the letter, I get receipts for certified mail. I need to work on streamlining that. There is no written information to the resident unless they are their own RP [responsible party]. When asked if they had a certified mail receipt for Resident # 14's facility initiated transfers on 05/18/221 and 06/22/2021, OSM # 3 stated no.

On 08/25/2021 at approximately 1:00 p.m., ASM [administrative staff member] #1, the administrator and ASM # 2, director of nursing, were made aware of the above concern.

No further information was presented prior to exit.

3. The facility staff failed to provide Resident # 35 and Resident # 35's representative written notification of a facility-initiated transfer on 05/26/2021 for Resident # 35.

Resident # 35 was admitted to the facility with diagnoses that included but were not limited to: diabetes and muscle weakness. Resident # 35's most recent MDS [minimum data set] assessment, a significant change assessment with an ARD (assessment reference date) of 06/25/2021, coded Resident # 35 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions.

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The facility's progress note for Resident # 35 dated 05/26/2021 at 12:40 p.m. documented in part, "Order received from [Name of Doctor] to send [Resident # 35] to E.R. [emergency room] for CT [computerized tomography (x-ray images)] of abdomen ...[Name of Transportation Company] picked up resident at 12:12 p.m. to transfer him to [Name of Hospital]."

Review of the clinical record and the EHR (electronic health record) for Resident # 35 failed to evidence that a written notification of discharge was provided to the resident and resident's representative for the facility-initiated transfer on 05/26/2021 for Resident # 35.

On 08/25/21 at 12:22 p.m., an interview was conducted with OSM [other staff member] # 2, social services director and OSM # 3, social worker. When asked about providing evidence that a written notification to a resident and a resident's representative of a facility initiated transfer OSM # 3 stated, "I don't keep copies of the letter, I get receipts for certified mail. I need to work on streamlining that. There is no written information to the resident unless they are their own RP [responsible party]. When asked if they had a certified mail receipt for Resident # 14's facility initiated transfers on 05/18/221 and 06/22/2021, OSM # 3 stated no.

On 08/25/2021 at approximately 1:00 p.m., ASM [administrative staff member] #1, the administrator and ASM # 2, director of nursing, were made aware of the above concern.

No further information was presented prior to exit.
4. The facility staff failed to provide Resident # 44 and Resident # 44's representative written

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notification of a facility-initiated transfer on 05/26/2021 for Resident # 44.

Resident #44 was admitted to the facility on 5/20/21. Resident #44's diagnoses included but were not limited to: congestive heart failure 'CHF' (circulatory congestion and retention of salt and water by the kidneys) (1), atrial fibrillation (rapid, random contractions of the atria of the heart) (2) and chronic kidney disease (decreased function of the kidneys) (3).

Resident #44's most recent MDS (minimum data set) assessment, a discharge return not anticipated assessment, with an assessment reference date of 8/10/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. Section O-Special Treatments and Procedures: coded the resident as dialysis 'yes'.

A review of the eINTERACT (interventions to reduce acute care transfers) Transfer Form V5 dated 8/10/21, documented in part, "Transfer to hospital. Resident sent to the emergency room related to shortness of breath and oxygen saturation dropping from 91% to 71% on room air. Alert but lethargic. Respirations 26. Color pale."

A review of the nursing progress note dated 8/10/21 at 5:30 PM, documented in part, "Order received from Dr. Clay to send resident to ER [emergency room] for SOB, low oxygenation, and AMS. Resident and a POA notified of the reason that she was going. Resident agreed, and verbalized understanding. Care plan goals sent with resident."

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On 8/24/21 at 4:45 PM, evidence of the provision of written notice to the resident/RP (responsible party) and ombudsman for the transfer of Resident #44 to the hospital on 8/10/21, was requested via written request for documents to the facility. Documents provided included: ombudsman notification and the above nursing progress note dated 8/10/21 at 5:30 PM. The facility staff failed to provide any evidence or documentation that Resident # 44 and Resident # 44's representative were provided written notification of Resident #44's facility-initiated transfer on 05/26/2021.

An interview was conducted on 8/25/21 at 12:22 PM with OSM (other staff member) #2, social services director. When asked the process to provide written notification of transfer, OSM #2 stated, "I do not keep copies of the letter, I get receipts for certified mail. I need to work on streamlining that process. There is no written information to resident unless they are their own RP (responsible party)."

An interview was conducted on 8/25/21 at 12:28 PM with OSM #3, the social worker. When asked if she had written evidence of documentation provided to Resident #44, who is her own RP, OSM #3 stated, "No, I do not have any evidence for her." OSM #3 stated, "I am aware that we need to send the letters out, but I did not realize we needed to have evidence of that."

On 8/25/21 at 1:00 PM, ASM (administrative staff member) #1, the executive administrator and ASM #2, the director of nursing were made aware of the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 12 A review of the facility's policy "Discharge and Transfer" policy revised 10/5/17, which documents in part, "Social Services or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor, if applicable. Copies will be sent to the Department of Health Ombudsman Office and filed in the business file and/or scanned into PCC (point click care) documents tab with administrator/designee signature, with the certified receipt if applicable." No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 133. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 54. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 119.	F 623		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	F 655		9/10/21

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F 655	Continued From page 13 necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (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). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined the facility staff failed to develop a baseline care plan for one of 28 current residents in the survey sample, Resident #430. The facility failed to develop a baseline care plan to address the physician prescribed anticoagulant	F 655	F655 1. Baseline care plan was updated to include the use of anticoagulant for Resident #430 on 08/24/21. 2. All residents who receive anticoagulant	

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F 655 Continued From page 14

medication Warfarin and monitoring for the medication for Resident #430 upon admission.

The findings include:

Resident #430 was admitted to the facility on 8/13/21. Resident #430's diagnoses included but were not limited to: congestive heart failure 'CHF' (circulatory congestion and retention of salt and water by the kidneys) (1), heart block (conduction disorder of the heart whereby electrical impulses are slowed either partially or completely) (2), pacemaker (electrical device used to maintain a normal heart rhythm by stimulating the heart muscle to contract) (3) and chronic kidney disease (decreased function of the kidneys) (4).

Resident #430's most recent MDS (minimum data set) assessment, a 5 day Medicare assessment, with an assessment reference date of 8/19/21, coded the resident as scoring 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status: coded the resident as supervision with eating; extensive assistance with transfer, bed mobility, dressing, hygiene, bathing and locomotion. Walking did not occur. MDS Section H- Bowel and Bladder: coded the resident as occasionally incontinent for bowel and always incontinent for bladder.

A review of Resident #430's physician orders dated 8/13/21, documented in part, "Warfarin Sodium (anticoagulant) (5) 2.5 milligram tablet, give 1 tablet by mouth one time a day every Monday, Wednesday, Friday for blood thinner. Warfarin 5 milligram tablet, give 1 tablet by mouth one time a day every Tuesday, Thursday,

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medication have the potential to be affected. RN #2, ASM #2 and RN #1 educated on Baseline Care Plan completion in regards to high risk medications.

3. Licensed nurses will be educated on baseline care plan development and completeness by DON/Designee. The DON or designee conducted a quality review of all current residents who were admitted in the last 21 days for development and completeness of the Baseline Care Plan.

4. MDS/Designee will audit all new admissions for baseline care plan development and completeness 5x/ week for 4 weeks, then 3x/ week for 8 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: September 22, 2021

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F 655	Continued From page 15 Saturday Sunday for blood thinner." A review of the MAR (medication administration record) documented administration of Warfarin 5 milligram and Warfarin 2.5 milligram as ordered from 8/14/21-8/25/21. Warfarin was held per physician orders on 8/19/21, 8/23/21 and 8/24/21. Review of Resident #430's baseline care plan dated 8/13/21, failed to document or address the administration of and monitoring for the prescribed anticoagulant medication. The baseline care plan, documented in part, "FOCUS-The resident has a pacemaker related to dysrhythmia. The resident has a diagnosis of congestive heart failure. INTERVENTIONS-Assess/document/report to physician as needed any signs or symptoms of infection at incision site: redness, drainage and warmth. Monitor/document/report to physician as needed any signs or symptoms of congestive heart failure. Oxygen therapy and give medications as ordered." A review of the baseline care plan checklist dated 8/20/21, documented in part, "Once the baseline care plan is completed, the resident and their representative will receive at least a summary of the baseline care plan that includes the following: (check off below items that were shared with resident/resident representative): a list of the resident's medications, therapy orders and dietary instructions given with explanation to resident/resident representative (print out orders and/or MARs 'medication administration record'). There was a check mark by a list of the resident's medications. A review of the nursing progress noted dated	F 655		

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F 655	Continued From page 16 8/16/20 at 12:44 PM, documented in part, "Most Recent Admission: 08/13/2021 12:44 PM. Check List: Summary of resident's medication, therapy orders, and dietary instructions shared. Social service needs and recommendations shared with resident/resident representative. PASARR recommendations shared with resident/resident representative. Baseline care plan given to resident/resident representative. Name of Resident and/or Representative Receiving 48 hour baseline care plan: Self and daughter Received on: 08/20/2021." An interview was conducted on 8/25/21 at 9:40 AM with RN (registered nurse) #2, the unit manager. When asked if anticoagulants should be on the care plan, RN #2 stated, "Yes, anticoagulants should be on the care plan." RN #2 was shown the provided printed baseline care plan for Resident #430. RN #2 stated, "Yes, this is the baseline care plan. I do not see it here [on Resident #430's baseline care plan]. Let me look up the comprehensive care plan, which will be done once he is here for 21 days." RN #2 stated, Oh here it is anticoagulant." When asked if Warfarin a high risk medication should it be addressed/included in the baseline care plan, RN #2 stated, "Well, the care plan is to provide what care is needed for the resident." An interview was conducted on 8/25/21 at 9:53 AM with ASM (administrative staff member) #2, the director of nursing. When asked if anticoagulants should be included in the baseline care plan, ASM #2 stated, "No, anticoagulants are not included in the baseline care plan. We just focus on falls, pressure/skin, nutrition, and ADL's (activities of daily living) and there is one other focus for the baseline care plan.	F 655		

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Anticoagulants would be addressed in the comprehensive care plan. Purpose of the baseline care plan is to give a basis of care for the resident."

An interview was conducted on 8/25/21 at 10:27 AM with RN #1, the MDS coordinator. When asked the purpose of the baseline care plan, RN #1 stated, "Baseline care plan includes the basic items and a resident's orders. We do try to make sure everything is on the baseline care plan and we definitely make sure it is on the comprehensive care plan."

On 8/25/21 at 1:00 PM AM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above findings.

The facility's "Interim/Baseline Care Planning" policy dated 8/11/20, documents in part, "Within 48 hours of admission, the facility will develop and implement and interim/baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident until a comprehensive assessment can be completed, leading to a comprehensive care plan. The baseline care plan will include the minimum healthcare information necessary to care for a resident including but not limited to: initial goals based on admission orders, physician orders, dietary orders, therapy/rehab [rehabilitation] services, social services and resident goals."

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the

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F 655	Continued From page 18 Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 133. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 259. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 427. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 119.(5) 2019 Lippincott Pocket Drug Guide for Nurses, Wolters Kluwer, page 406.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		9/10/21

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provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for one of 28 residents in the survey sample, Resident #8.

The facility staff failed to implemented Resident #8's comprehensive care plan for maintaining the resident's call bell within reach.

The findings include:

Resident #8 was admitted to the facility on 2/16/17. Resident #8's diagnoses included but were not limited to diabetes, major depressive disorder and a history of falling. Resident #8's quarterly minimum data set with an assessment reference date of 5/17/21, coded the resident's

F 656

F656

1. Resident #8's call bell placement was verified per the plan of care. CNA #1 educated on following the plan of care.

2. All residents who reside at Falls Run Nursing and Rehabilitation have the potential to be affected. DON/designee conducted a quality review of all current residents care plan in relation to call bell placement.

3. Nursing staff will be educated on following the resident specific plan of care by DON/Designee.

4. DON/Designee will audit call bells within reach per the care plan, 5x/ week

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F 656	Continued From page 20 cognition as moderately impaired. Section G coded Resident #8 as requiring limited assistance of two or more staff with bed mobility and as requiring extensive assistance of one staff with transfers. Resident #8's comprehensive care plan dated 2/16/17 documented, "Self-care deficit. Resident has dx (diagnosis) Muscle Weakness, Gait Abnormality, CAD (coronary artery disease), Psychotic Disorder and Dementia. Keep call bell in reach..." On 8/24/21 at 12:04 p.m. and 12:47 p.m., Resident #8 was observed lying in bed watching television. The resident's call bell was under the bed and out of the resident's reach. On 8/24/21 at 12:47 p.m., CNA (certified nursing assistant) walked into Resident #8's room, served a lunch tray, exited the room, obtained tea, walked back into the room, placed the tea on the table then exited the room. CNA #1 did not pick up the call bell from under the bed. On 8/25/21 at 10:08 a.m., an interview was conducted with CNA #1. CNA #1 stated call bells should be kept within residents' reach and CNAs round at least every two hours to make sure call bells are in place. CNA #1 stated she checks call bells each time she is in a resident's room. CNA #1 stated Resident #8 does sometimes use the call bell but it may become unclipped from the sheet and fall off the bed if the resident gets up. CNA #1 stated she could not remember if she observed Resident #8's call bell while serving lunch on 8/24/21. On 8/25/21 at 10:25 a.m., an interview was conducted with RN (registered nurse) #1. RN #1	F 656	for 4 weeks, then 3x/ week for 8 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: September 22, 2021.	

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F 656	Continued From page 21	F 656		

stated the purpose of the care plan is to plan the resident's care. RN #1 stated that in order to implement a resident's care, nurses and CNAs would have to read and follow the care plan but many care planned items are present in physician's orders for nurses and the task panel for CNAs.

Review of Resident #8's physician's orders and task panel failed to reveal documentation regarding maintaining call bells within reach.

On 8/25/21 at 1:04 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Comprehensive Care Planning" documented, "D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented."

No further information was presented prior to exit.

A review of the facility's policy "Discharge and Transfer" policy revised 10/5/17, which documents in part, "Social Services or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor, if applicable. Copies will be sent to the Department of Health Ombudsman Office and filed in the business file and/or scanned into PCC (point click care) documents tab with administrator/designee signature, with the certified receipt if applicable."

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the

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F 656	Continued From page 22 Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 133. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 54. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 119.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide respiratory services in a sanitary manner for two of 28 residents in the survey sample, Resident #130 and Resident #72. 1. Resident #130's nebulizer mask and medication delivery tank was observed on separate occasions uncovered when not in use and the residents oxygen tubing was observed uncovered and wrapped around the top of an oxygen tank on the back of the resident's wheelchair. 2. The facility staff failed to store oxygen	F 695	F695 1. Oxygen tubing for Resident #72 was replaced and stored in bag on 08/25/21. Nebulizer setup for Resident #130 was removed from room due to non-use and oxygen tubing for Resident #130 was replaced and stored in bag on 08/25/21. 2. All residents who require respiratory services at Falls Run Nursing and Rehabilitation have the potential to be affected. 3. Licensed nurses will be educated on respiratory equipment storage by	9/10/21

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F 695	Continued From page 23 equipment in a sanitary manner for Resident #72. Nasal cannula tubing was observed uncovered and wrapped around the top of the tank that was not in use, located on the back of Resident #72's wheelchair. The findings include: 1. Resident #130 was admitted to the facility on 8/22/2021 with diagnoses that included but were not limited to: high blood pressure, chronic obstructive pulmonary disease (COPD -general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1), pneumonia (An infection in one or both of the lungs.) (2), and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria)(3). The "[Name of corporation] Admission/Readmission Evaluation" dated 8/22/2021 documented in part, "7. LOC (level of consciousness): alert and oriented X4 (person, place, time and situation). 16. One person assist for all ADLs (activities of daily living) except eating. The form documented the use of oxygen via a nasal cannula. The physician order dated, 8/23/2021, documented, "Oxygen @ (at) 3 LPM (liters per minute) via nasal cannula every shift for sob (shortness of breath). Ipratropium - Albuterol Solution (used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary	F 695	DON/Designee. The DON or designee conducted a quality review of all current residents who utilize respiratory services. 4. DON/Designee will audit respiratory equipment storage 5x/ week for 4 weeks, then 3x/ week for 8 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: September 22, 2021.	

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disease) (4) 0.5 - 2.5 MG/3 ML (milligrams per milliliter) 3 ML inhale orally every 6 hours as needed for wheezing."

On 8/24/2021 at 11:00 a.m., observation of Resident #130's room, revealed a nebulizer machine sitting on Resident #130's nightstand. The nebulizer mask and the medication delivery container was not covered. Two other observations were made on 08/24/2021 2:21 p.m. and 8/25/2021 at 8:12 a.m., and revealed the nebulizer delivery container and mask were uncovered.

On 08/25/2021 at 10:20 a.m. an interview and observation of Resident #130's nebulizer was conducted with LPN (licensed practical nurse) #2. LPN #2 was shown the nebulizer equipment that was uncovered. LPN #2 stated, "It [nebulizer mask and medication delivery container] should be covered." Observation was made at this time of Resident #130 in wheelchair with an O2 (oxygen) tank on the back of the wheelchair. There was oxygen tubing wrapped around the tank top. When asked why the tubing was wrapped around the top of the tank, LPN #2 stated that it should be in a bag also and there should be another bag on the concentrator to store the tubing when it's not in use while the resident is hooked up to the tank. LPN #2 stated she needed three bags, one for nebulizer, one for tubing on the tank and one for the tubing on the oxygen concentrator.

An interview was conducted with RN (registered nurse) #2, on 08/25/2021 10:29 a.m. When asked about nebulizer equipment storage when not in use, RN #2 stated it should be in a bag. When asked about oxygen tubing storage when

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not in use, RN #2 stated, it should be in a bag. When asked if oxygen tubing should be wrapped around the top of an oxygen tank on the back of a wheelchair, RN #2 stated, no.

The baseline care plan dated, 8/23/2021, documented in part, "Focus: The resident has altered respiratory status/difficulty breathing r/t (related to) dx (diagnosis) pneumonia, pleural effusion and acute hypoxic respiratory failure." The "Interventions" documented in part, "Administer medication/puffers as ordered. Monitor for effectiveness and side effects. Change O2 tubing per facility protocol. Provide oxygen as ordered."

The facility policy, "Oxygen Administration (all routes) Policy," documented in part, "3. When oxygen not in use, store oxygen tubing and nasal cannula or mask in separate, labeled plastic bag."

According to Fundamentals of Nursing, 6th edition, Potter and Perry, 2005, page 780, Box 33-2 "Sites for and causes of nosocomial infections....Respiratory Tract - Contaminated respiratory therapy equipment".

ASM (administrative staff member) #1, administrator, and ASM #2, the director of nursing, were made aware of the above concern on 8/25/2021 at 1:02 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(2) This information was obtained from the

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following website:
https://medlineplus.gov/pneumonia.html
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.
(4) This information was obtained from the following website:
https://medlineplus.gov/druginfo/meds/a601063.html

2. The facility staff failed to store oxygen equipment in a sanitary manner for Resident #72. Nasal cannula tubing was observed uncovered and wrapped around the top of the tank that was not in use, located on the back of Resident #72's wheelchair.

Resident #72 was admitted to the facility on 8/2/21 with the diagnoses of but not limited to benign prostatic hyperplasia (an enlarged prostate) (1), high blood pressure, atrial fibrillation (2), sepsis,(your body's overactive and extreme response to an infection) (3), spinal stenosis, (Spinal stenosis causes narrowing in your spine. The narrowing puts pressure on your nerves and spinal cord and can cause pain.)(4)

The Medicare, admission/5-day MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 8/8/21 coded the resident as moderately impaired to make daily cognitive decisions. Resident #72 was coded as requiring extensive assistance for bathing, hygiene, toileting, dressing, transfers, and bed mobility; supervision for ambulation and eating; and as incontinent of bowel.

Observation was made of Resident #72 on

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8/25/2021 at 08:06 a.m. The resident was up in the wheelchair with oxygen on via a nasal cannula connected an oxygen concentrator that was running. Observation of the oxygen concentrator flow meter revealed the oxygen flow rate was set at 2 LPM (liters per minute). An oxygen tank was observed on the back of the wheelchair, not in use with nasal cannula tubing wrapped around the top of the tank, uncovered.

The physician orders dated, 8/10/2021, "Oxygen @ (at) 2 LPM (liters per minute) via nasal cannula as needed."

The comprehensive care plan for Resident #72, dated, 8/11/2021, documented in part, "Focus: The resident has impaired cardiovascular status r/t (related to) high blood pressure, blood loss, and heart disease." The "Interventions" documented in part, "Oxygen as ordered by the physician."

An interview was conducted with LPN (licensed practical nurse) #1 on 8/25/2021 at 10:12 a.m. When the tubing wrapped around the oxygen tank located on the back of Resident #72's wheelchair was described to LPN #1, she stated the tubing should be stored in a bag when not in use.

An interview was conducted with RN (registered nurse) #2, on 08/25/2021 10:29 a.m. When asked if oxygen tubing should be wrapped around the top of an oxygen tank on the back of a wheelchair, RN #2 stated, no.

ASM (administrative staff member) #1, administrator, and ASM #2, the director of nursing, were made aware of the above concern

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F 695	Continued From page 28 on 8/25/2021 at 1:02 p.m. No further information was provided prior to exit. References: (1) This information was obtained from the following website: https://medlineplus.gov/enlargedprostatebph.html (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (3) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=Sepsis&_ga=2.155403059.908502701.1629920181-1530802455.1629920181 (4) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=Spinal+stenosis+	F 695		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on employee record review and staff interview, it was determined that the facility staff failed to perform an annual performance review	F 730	F730 1. PRN CNA #2 was contacted on	9/10/21

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F 730	Continued From page 29 for one of five CNA (certified nursing assistant) records reviewed. The findings include: On 8/24/2021 at 4:15 p.m., a review of the facility's CNA annual training and performance review was conducted. Review of five CNA transcripts revealed one of five CNAs selected for review did not have an annual performance review. Review of CNA #2's transcript documented a hire date of 6/1/2018. Further review of the transcript documents provided dated 6/1/2020 through 6/1/2021 failed to evidence documentation of an annual performance review. On 8/24/2021 at approximately 4:45 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the annual performance review for CNA #2. ASM #1 stated that CNA #2's annual performance review had not been completed. ASM #1 stated that CNA #2 only worked prn (as needed) and they were not sure when they had last worked. A request was made to ASM #1 for documentation verifying CNA #2's schedule since their anniversary date of 6/1/2021. On 8/25/2021 at approximately 7:30 a.m., ASM #1, the administrator provided the document "Time Card Report 06/01/2021-08/24/2021" for CNA #2. It documented CNA #2 working the night shift (10:59 p.m.- 6:03 a.m.) on 7/15/2021. On 8/25/2021 at approximately 11:35 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM	F 730	(8/30/21) with no reply to schedule date to come to facility for evaluation completion. Letter sent to PRN CNA #2 on 09/01/21 to request she come to facility to receive evaluation. 2. All staff at Falls Run Nursing and Rehabilitation have the potential to be affected. The DON or designee conducted a quality review of all staff members to ensure annual reviews are up to date. 3. Department Heads and HR will be educated on following / completing annual employee evaluation on or before employee’s anniversary date. 4. HR/Designee will audit performance evaluations for timely completion 5x/ week for 4 weeks, then 3x/ week for 8 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: September 22, 2021.	

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#2 stated that a member of the nursing team conducted the CNA performance reviews. ASM #2 stated that human resources notified them during a staff member's anniversary month that the evaluation was due by the end of the month. ASM #2 stated that they conducted the review or delegated to the unit manager if they were more familiar with the staff member. ASM #2 stated that staff who worked as needed were harder to catch up with than full time staff and they had not been able to do CNA #2's performance review because they had only worked one time since their anniversary date. ASM #2 stated that they performed the reviews face to face and they come in early to catch the night shift staff before they left to do the evaluations. ASM #2 stated that the performance evaluations were used to determine education needs if there were issues with the staff member.

On 8/25/2021 at approximately 9:15 a.m., a request was made to ASM #1 for the facility policy for employee performance reviews.

On 8/25/2021 at approximately 10:00 a.m., ASM #1 stated that the facility did not have a written policy for the employee performance reviews. ASM #1 provided a document titled, "Performance Management" which documented in part, "Performance appraisals will generally be conducted after 90 days of employment and annually thereafter based on your date of hire...The performance appraisal provides a systematic and regular opportunity for you to discuss your work with your department head and to find out how you are developing and where you stand in relation to what is expected of you..."

On 8/25/2021 at approximately 1:00 p.m., ASM

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F 730	Continued From page 31 (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concern. No further information was presented prior to exit.	F 730		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review it was determined the facility staff failed to ensure one the drug regime for one of 28 residents in the survey sample, Resident #72, was free of unnecessary pain medications.	F 757	F757 1. Physician's orders for resident #72 were reviewed and clarified with facility MD on 09/01/21. Licensed nurses x 2 were educated on following parameters in	9/10/21

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The facility staff administered Tylenol prescribed for Resident #72, for pain scale ratings above below the physician ordered parameters of 1-4 and administered Tramadol HCL for a pain rating 4, for which the physician prescribed Tylenol.

The findings include:

Resident #72 was admitted to the facility on 8/2/21 with the diagnoses of but not limited to benign prostatic hyperplasia (an enlarged prostate) (1), high blood pressure, atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria)(2), sepsis,(your body's overactive and extreme response to an infection) (3), spinal stenosis, (Spinal stenosis causes narrowing in your spine. The narrowing puts pressure on your nerves and spinal cord and can cause pain.)(4)

The Medicare, admission/5-day MDS (minimum data set) with an ARD (assessment reference date) of 8/8/21 coded the resident as being moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance for bathing, hygiene, toileting, dressing, transfers, and bed mobility; supervision for ambulation and eating; was incontinent of bowel.

The physician order dated, 8/9/2021, documented, "Acetaminophen Tablet (Tylenol) (used to treat mild to moderate pain) (5) 325 mg (milligrams) Give 2 tablet by mouth every 8 hours

F 757

physician's orders. Medication error report was completed for administration on 08/15/21.

2. All residents who reside at Falls Run Nursing and Rehabilitation and receive pain medication have the potential to be affected. The DON or designee conducted a quality review of all current residents who are receiving PRN pain medication for administration of medication per physician order.

3. Licensed nurses will be educated on administering medications per physicians order by DON/Designee.

4. DON/Designee will audit five residents a week for proper administration of PRN pain medication per physician orders for 12 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: September 22, 2021.

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as needed for pain scale 1-4." The physician order dated, 8/2/2021, documented, "Tramadol HCL (hydrochloride)(centrally acting synthetic opioid analgesic used to relieve moderate to moderately severe pain) (6) Tablet 50 mg, Give 1 tablet by mouth every 6 hours as needed for pain."

The August 2021 MAR (medication administration record) documented the above orders for Acetaminophen and Tramadol. The Acetaminophen was documented as administered on 8/15/2021 at 3:08 p.m. for a pain level of "5." The Tramadol was documented as administered on 8/6/2021 at 4:28 a.m. for a pain level of "4."

The comprehensive care plan dated, 8/12/2021, documented in part, "Focus: Altercation in musculoskeletal status r/t (related to) dx (diagnosis) Spondylosis with lumbar radiculopathy, spinal stenosis." The "Interventions" documented in part, "Give med (medication) as ordered by the physician. Monitor and document for side effects and effectiveness."

An interview was conducted with LPN (licensed practical nurse) #1, on 8/25/2021 at 10:09 a.m. The physician orders above were reviewed with LPN #1. When asked if the Tylenol should have been given for a pain level of "5," LPN #1 stated, no, it shouldn't have been given. When asked if the Tramadol should have been given for a pain scale of "4," LPN #1 stated, no the Tylenol should have been given

An interview was conducted on 8/25/2021 at 10:15 a.m. with RN (registered nurse) #2, the unit manager. The above orders for Tylenol and

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Tramadol were reviewed with RN #2. When asked if the Tylenol should have been given for a pain level of "5," RN #2 stated, no the order says for pain level of 1-4. When asked if the resident should have received the Tramadol for a pain level of "4," RN #2 stated, no, the Tylenol should have been given for that level of pain.

ASM (administrative staff member) #1, administrator, and ASM #2, the director of nursing, were made aware of the above concern on 8/25/2021 at 1:02 p.m.

The facility policy, "General Dose Preparation and Medication Administration" documented in part, "verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident. Confirm that the MAR reflects the most recent medication order."

References:
(1) This information was obtained from the following website:
https://medlineplus.gov/enlargedprostatebph.html
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.
(3) This information was obtained from the following website:
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=Sepsis&_ga=2.155403059.908502701.1629920181-1530802455.1629920181
(4) This information was obtained from the following website:
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 35 meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=Spinal+stenosis+ (5) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html (6) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=tramadol	F 757		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to ensure food storage in a safe	F 812	F812 1. Food storage for expired milk and	9/10/21

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	495407	A. BUILDING ______ B. WING ______	08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812

Continued From page 36

manner, and failed to clean the kitchen stove. The walk-in refrigerator contained expired milk cartons and pudding. The stove top contained areas of built-up grease that was burned on to the grates, elements, and stove top surface. The stove top also contained ashy material that scraped up easily with a gloved finger.

The findings include:

On 8/24/21 at 10:50 a.m., observation was made of the facility kitchen. The walk-in refrigerator contained approximately 1 1/2 quarts of a dark brown, thick substance labeled "nutritional pudding." The label had an expiration date of 8/23/21. The walk in refrigerator also contained 19 individual cartons of milk, all with expiration dates of 8/22/21.

The stove top contained areas of crusty, black debris, which flaked off easily. Some of the debris had the appearance of ash. The loose debris was easily wiped away with a gloved finger. The stove top and grates contained areas of built-up grease.

OSM (other staff member) #1, dietary manager was interviewed during this observation. She stated the milk and pudding were available for resident use, and should have been thrown out on their expiration dates. She stated the debris and grease build-up on the stove were from the current day's use, and would be cleaned at night. She stated the stove top is cleaned every evening after supper, and the grates are soaked in the large sinks and cleaned every night.

On 8/25/21 at 7:47 a.m., observation was again made of the stove top. There were no changes from the previous day's observation.

F 812

house nutritional pudding immediately disposed of during survey. Kitchen stove was cleaned and sanitized on 8/25/21.

2. All residents who reside at Falls Run Nursing and Rehabilitation have the potential to be affected. The Administrator or designee conducted a quality review of food storage area to ensure food is stored in a safe and sanitary manner.

3. Dietary staff will be educated on proper food storage and sanitation by Dietary Manager/Designee.

4. Dietary Manager/Designee will audit food storage area 5x week for 4 weeks and then 3x week for 8 weeks for food storage in a safe and sanitary manner. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation.

5. Date of Compliance: September 22, 2021.

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F 812	Continued From page 37 OSM #1 was interviewed at this time, and stated the stove top was dirty. She stated: "Like I told you yesterday, we usually clean it every night." She stated she did not clean it last night because "I don't have any staff." She stated she needs five people to work in the evenings, and "it was just me last night." She stated she just did not get to the stove to clean it. When asked if the stove should have been cleaned of the loose debris and grease build-up, even if it was between a weekly scheduled cleaning, she said it should be. She stated the refrigerator should be checked each evening, and all expired foods should be thrown away. On /25/21 at 1:10 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. A review of the facility policy, "Freezers and Refrigerators," revealed, in part: "Food and Nutrition Services Director and staff will be responsible for ensuring food items in refrigerators and freezers are not expired or past perish dates." A review of the facility policy, "Kitchen Sanitation and Cleaning Schedule," revealed, in part: "Cleaning and sanitation tasks for the kitchen will be outlined in a written cleaning schedule...." A review of the accompanying Closing Checklist for the Evening Cook revealed no daily tasks related to cleaning of the stove. The checklist documented: "Wednesday: Take apart stove top & run through dish machine." No further information was provided prior to exit.	F 812		

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		9/10/21

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F 880	Continued From page 39 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement infection control practices for one of eight residents in the medication administration observation, Resident #281. The facility staff failed to administer medication in a sanitary manner to Resident #281 on 8/25/21. LPN (Licensed practical nurse) #1 touched and administered a dropped pill to Resident #281 with	F 880	F880 1. Resident #281 assessed for any change in condition on 8/26/21. Med Pass observation was completed with LPN #1 on 8/26/21. 2. All residents who need assistance with medication administration at Falls Run Nursing and Rehabilitation have the potential to be affected. The DON or	

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F 880	Continued From page 40 gloved hands that were worn while touching the medication cart and vital sign machine. The findings include: Resident #281 was admitted to the facility on 8/12/21. Resident #281's diagnoses included but were not limited to heart failure, muscle weakness and high blood pressure. Resident #281's admission minimum data set assessment with an assessment reference date of 8/18/21, coded the resident as being cognitively intact. On 8/25/21 at 8:34 a.m. LPN #1 was observed preparing Resident #281's medications with gloved hands. LPN #1 touched the medication cart with gloved hands then touched the vital sign machine with gloved hands while obtaining Resident #281's vital signs. After obtaining Resident #281's vital signs, LPN #1 administered medications to the resident. The resident dropped one pill on a blanket covering her. LPN #1 picked up the pill with the same gloves, placed the pill into the medicine cup and administered the pill to Resident #281. On 8/25/21 at 9:52 a.m., LPN #1 was asked what should be done if a resident drops a pill on his or her bed. LPN #1 stated the pill should be thrown away if it's on the bed for infection control reasons but she did not discard Resident #281's pill because it landed on the resident. LPN #1 was made aware that she was observed touching the medication cart and vital sign machine with the same gloves used to pick up the dropped pill then the pill was administered to Resident #281. LPN #1 stated she wasn't thinking and she was solely using the gloves for Resident #281. LPN #1 stated she did not know if this practice was	F 880	designee will complete a quality review of all current licensed nurses for medication administration competency. 3. Licensed nurses will be educated on Infection Control as it relates to medication administration by DON/Designee. 4. DON/Designee will perform med pass observations with questions to the observed nurse to reinforce proper infection control standards with licensed nurses 5x/ week for 4 weeks, then 3x/ week for 8 weeks for proper administration and infection control. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. 5. Date of Compliance: September 22, 2021.	

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F 880	Continued From page 41 sanitary. On 8/25/21 at 1:04 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility pharmacy policy titled, "6.0 General Dose Preparation and Medication Administration" documented, "3.4 Facility staff should not touch the medication when opening a bottle or unit dose package. 3.5 If a medication which is not in a protective container is dropped, facility staff should discard it according to facility policy." No further information was presented prior to exit.	F 880		