STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING ______ B. WING ______	C 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 03/14/23 through 03/16/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No Emergency Preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/14/2023 through 3/16/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Four complaints were investigated during the survey (VA00055861-substantiated without deficiency, VA00056122-unsubstantiated, VA00055263-substantiated with deficiency, VA00057910-unsubstantiated). The Life Safety Code survey/report will follow The census in this 90 certified bed facility was 74 at the time of the survey. The survey sample consisted of 27 current resident reviews and 10 closed record reviews.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other	F 585		4/14/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 03/31/2023

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 585	Continued From page 1 residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process,	F 585		

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F 585	Continued From page 2 receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and	F 585		

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F 585	Continued From page 3 (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to initiate a written grievance for one of 37 residents in the survey sample, Resident #6. The findings include: For Resident #6 (R6), the facility staff failed to initiate a written grievance when the resident reported a missing coat. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/2/23, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact. On 3/14/23 at 3:31 p.m., an interview was conducted with R6. The resident stated someone stole their winter coat in November 2022. R6 stated this was reported to multiple staff and the coat was supposed to be replaced but it had not yet been replaced. A review of R6's clinical record failed to reveal documentation regarding R6's missing coat. A review of the November 2022 and December 2022 grievances failed to reveal documentation regarding R6's missing coat. On 3/16/23 at 9:17 a.m., an interview was	F 585	F585 1. Resident #6□s new coat was previously ordered and given to the resident in facility on 3/21/23. 2. All residents who reside at Falls Run Nursing and Rehabilitation have the potential to be affected. SW/ designee reviewed grievances for past 30 days to ensure appropriate action and documentation. 3. Grievances will be obtained and documented as they arise. Social Services department has been educated on grievance policy by Administrator/Designee. 4. SW will review both new and outstanding grievances in morning meeting to ensure proper documentation weekly 5x/ week for 4 weeks, then 3x/ week for 8 weeks for periodic review of grievances. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date of Compliance: April 14, 2023.	

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F 585	Continued From page 4	F 585		

conducted with OSM (other staff member) #1 (the director of social services). OSM #1 stated missing clothing is a concern/grievance. OSM #1 stated if a resident reports missing clothing, then she writes up a grievance and staff looks through the laundry. OSM #1 stated that if the missing clothing is not found then she talks to the resident to see if they want to be reimbursed for the missing clothing or if they want the clothing replaced. OSM #1 stated R6 did report a missing green coat and the coat was replaced. OSM #1 stated there was no grievance form regarding the missing coat because the replacement coat was purchased for R6 as a Christmas gift.

On 3/16/23 at 9:34 a.m., ASM (administrative staff member) #2 (the director of nursing) provided evidence that a coat was purchased on 12/16/22. ASM #2 stated there probably was not a grievance form regarding R6's missing coat because the reporting of missing clothing is a behavior that R6 presents with, and the staff typically accommodates the resident. ASM #2 stated R6 has lost multiple pairs of white pants and the staff has reimbursed the resident.

On 3/16/23 at approximately 12:00 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 were made aware of the above concern.

The facility policy titled, "Resident Grievances and Concerns Policy" documented, "3. Investigation. The Grievance Committee/Grievance Official shall complete an investigation of the resident's grievance. This may include a review of facility processes, programs and policies, as well as interviews with staff, residents and visitors, as indicated, and any other review deemed

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F 585	Continued From page 5 necessary by the Grievance Committee...5. Grievance Decision. Upon completion of the review, the Grievance Official will complete a written grievance decision that includes the following: a. The date the grievance was received. b. A summary of the statement of the resident's grievance. c. The steps taken to investigate the grievance. d. A summary of the pertinent findings or conclusions regarding the resident's concern(s). e. A statement as to whether the grievance was confirmed or not confirmed. f. Whether any corrective action was or will be taken. g. If corrective action was or will be taken, a summary of the corrective action. If corrective action will not be taken, then an explanation of why such action is not necessary..."	F 585		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		4/14/23

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F 656	Continued From page 6 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to implement the comprehensive care plan for three of 37 residents in the survey sample, Residents #32, #31, and #6. The findings include: 1. For Resident #32 (R32), the facility staff failed to implement the care plan to attempt	F 656	F656 1. Comprehensive care plan for Resident #32 and #6 was reviewed for patient specific non-pharmacological interventions on 3/29/23. Oxygen setting for patient #31 was corrected on 03/15/23. 2. All residents who reside at Falls Run Nursing and Rehabilitation have the potential to be affected. DON/ designee conducted a quality review of care plans and records for residents with PRN pain	

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F 656	Continued From page 7 non-pharmacological interventions as part of the resident's pain management program. A review of R32's physician orders revealed the following order dated 1//17/23: "Oxycodone-Acetaminophen (opioid pain medication) 5-325 mg (milligrams)...Give 1 tablet by mouth every 8 hours as needed for moderate or severe pain. A review of R32's March 2023 MAR (medication administration record) revealed the resident received the Oxycodone-Acetaminophen as ordered on 3/2/23, 3/4/23, 3/6/23, 3/11/23, 3/12/23, and 3/14/23. Further review of the clinical record revealed no evidence that non-pharmacological interventions were offered to R32 prior to the administration of Oxycodone-Acetaminophen on all six of the dates in March 2023. A review of R32's care plan dated 9/6/17 and most recently updated 10/2/17 revealed, in part: "[R32] has diagnosis of chronic pain...Staff to attempt non-pharmacological interventions." On 3/16/23 at 10:33 a.m., RN (registered nurse) #1 was interviewed. She stated prior to administering an as needed pain medication, she attempts to reposition the resident or offer ice packs as non-pharmacological interventions and if those do not help, or if the resident refuses the non-pharmacological interventions, she asks the resident to rate and describe the location of the pain. She stated the facility's EMR (electronic medical record) software prompts the nurse to write a progress note for each as needed medication and she would document the	F 656	medications to identify non-pharmacological interventions and oxygen settings. 3. Licensed nurses have been educated on comprehensive care plan requirements with regard to non-pharmacological interventions and oxygen administration by DON/Designee. 4. MDS/Designee will audit five care plans and records for non-pharmacological interventions 5x/ week for 4 weeks, then 3x/ week for 8 weeks for accurate documentation. DON? Designee will audit respiratory records and settings to ensure accuracy 5x/ week for 4 weeks, then 3x/ week for 8 weeks. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date of Compliance: April 14, 2023.	

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non-pharmacological interventions and the location of the pain in the progress note. She stated non-pharmacological interventions are important because they give the residents an option other than medication and the purpose of the care plan is to show different aspects of how to care for a resident. She stated the care plan lets the facility staff know what the resident needs, and the resident's goals, and typically nurses are mostly responsible for implementing a resident's care plan, although other departments have some specific aspects of the care plan for which they are responsible. She stated all nurses have access to the care plan through the EMR.

On 3/16/23 at 11:47 a.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, "Comprehensive Care Planning," revealed, in part: "All staff must be familiar with each resident's Care Plan and all approaches must be implemented."

No further information was provided prior to exit.
2. For Resident #31 (R31), the facility staff failed to implement the resident's comprehensive care plan for oxygen administration.

R31's comprehensive care plan revised on 5/10/22 documented, "Oxygen as ordered by the physician..." Further review of R31's clinical record revealed a physician's order dated 12/5/22 for oxygen at three liters per minute via nasal cannula every shift.

On 3/14/23 at 12:39 p.m. and 3/15/23 at 8:28 a.m., R31 was observed lying in bed receiving

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F 656	Continued From page 9	F 656		

oxygen via nasal cannula at three and a half liters per minute, as evidenced by the middle of the ball in the oxygen concentrator flowmeter positioned on the three-and-a-half-liter line.

On 3/16/23 at 10:33 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the purpose of the care plan is, "Different aspects of how to care for them, being able to review what they need, what their goals are, things that happened in the past to prevent in the future." RN #1 stated care plan implementation depends on the intervention but typically the nurses are responsible. RN #1 stated nurses can easily access residents' care plans through the computer system. RN #1 stated nurses should know how much oxygen to administer to a resident based on the resident's physician's order.

On 3/16/23 at approximately 12:00 p.m., ASM (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.

3. For Resident #6 (R6), the facility staff failed to implement the comprehensive care plan for pain management.

R6's comprehensive care plan dated 3/7/17 documented, "At risk for pain r/t (related to) multiple health risk factors. Non-pharmacological interventions as appropriate..." Further review of R6's clinical record revealed a physician's order dated 11/23/20 for tramadol 50 mg (milligrams)- one tablet by mouth every eight hours as needed for pain rated six to ten. A review of R6's March

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F 656	Continued From page 10 2023 MAR (medication administration record) revealed the resident was administered as needed tramadol on 3/2/23, 3/4/23, 3/6/23, 3/7/23, 3/9/23 and 3/11/23. Further review of R6's clinical record (including the March 2023 MAR and March 2023 progress notes) failed to reveal non-pharmacological interventions were attempted on 3/2/23, 3/4/23, 3/6/23, 3/7/23, 3/9/23 and 3/11/23. On 3/16/23 at 10:33 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the purpose of the care plan is, "Different aspects of how to care for them, being able to review what they need, what their goals are, things that happened in the past to prevent in the future." RN #1 stated care plan implementation depends on the intervention but typically the nurses are responsible. RN #1 stated nurses can easily access residents' care plans through the computer system. RN #1 stated nurses should attempt non-pharmacological interventions and should not immediately give medications because nurses should give more options. RN #1 stated she documents non-pharmacological interventions in the progress notes. On 3/16/23 at approximately 12:00 p.m., ASM (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 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		

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F 689	Continued From page 11 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide adequate supervision for one of 37 residents in the survey sample, Residents #272. This deficiency is cited as past non-compliance. The findings include: The facility staff failed to have effective interventions implemented to prevent Resident #272 from wandering into other resident rooms. Resident #272 was admitted to the facility on 8/22/2017 with diagnoses that included but were not limited to: diabetes mellitus, hypertension and adult failure to thrive. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/21/22, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, which indicated the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring limited assistance for bed mobility, transfer, hygiene and bathing; supervision for walking, locomotion, dressing and eating. A review of the annual MDS dated Section E: 0200 A. Physical behavior symptoms exhibited towards	F 689	Past noncompliance: no plan of correction required.	

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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 689	Continued From page 12 others e.g., abusing other sexually. Coded=0 behavior not exhibited. A review of the comprehensive care plan dated 9/11/21, revealed, "FOCUS: Resident is at risk for alteration in psychosocial wellbeing related to visitation restrictions, social distancing, and other protective restrictions in facility. Resident enjoys watching Western movies, listening to movies playing doorway bingo and other doorway activities. Impaired cognitive-communication function/impaired thought processes related to mild dementia. INTERVENTIONS: Encourage social activities for additional socialization opportunity. Provide activity items resident requires to complete self-initiated activities. Keep resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Encourage resident to make routine, daily decisions." A review of the social worker (SW) progress noted dated 1/5/22 at 10:19 AM, revealed, "Nurse updated SW that resident is taking advantage and rubbing on a female resident. The SW will speak with resident." OSM (other staff member) #1, the director of social work, wrote this note. A review of the social worker progress (OSM #1) note dated 1/5/22 at 10:38 AM, revealed, "Talked to resident about acting inappropriate to another resident. The resident was not very happy with SW, but said he understood to stay away." A review of the nursing progress note dated 2/13/22 at 6:31PM, revealed, "Resident has been wandering into other resident's rooms. Resident has been redirected multiple times and becomes angry and curses at this writer. Resident said,	F 689		

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FALLS RUN NURSING AND REHABILITATION	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

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F 689	Continued From page 13	F 689		

"There's no damn problem with me going in there. They don't mind. Why are you still here? Why don't [you] go home!"

A review of the nursing progress note dated 3/17/22 at 8:26 PM, revealed, "Resident had an incident with a female resident. Police were notified and resident was placed on one-to-one observation. Resident was interviewed by detectives and removed from facility by police."

A review of the facility's five-point plan dated 3/17/22, revealed, "Root Cause Analysis Results: Unable to determine at this time as no previous sexual behavior documented. Action Items: Head to toe assessment was completed on female resident. RP (responsible party) and physician notified. Resident transferred to ER for evaluation. She will be monitored for any changes in behavior. Male resident was placed on 1:1. RP and police notified. Male was arrested and removed from facility by police officers. Residents with a BIMs of 12 and above were interviewed to determine if they had concerns and felt safe in the facility." Actions completed on 3/17/22.

An interview was conducted on 3/14/23 at 4:23 PM with ASM #1, the administrator and ASM #2, the director of nursing. When asked about Resident #272's behaviors, ASM #1 stated, we were aware that he would go through the halls, that he had been redirected. ASM #2 stated, we do that with multiple residents. We were aware he was sometimes going into other people's rooms. For those he was showing interest in, there was a stop sign put up on those resident rooms. When asked if he would respond to the stop sign, ASM #2 stated, he was redirectable. ASM #1 stated,

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FALLS RUN NURSING AND REHABILITATION	**140 BRIMLEY DRIVE** **FREDERICKSBURG, VA 22406**

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F 689	Continued From page 14 some stop signs were put up. I think I had talked to him a month before the incident (January), and things seemed to have calmed down. When asked to describe actions on 3/17/22, ASM #1 stated, once we realized what had happened, we called the police. We separated them. We put him on 1:1. He acknowledged that he had touched her, and he was arrested. He was sent to the hospital. Survey team conducted multiple interviews of staff on the evening shift. An interview was conducted on 3/14/23 at 5:35 PM with CNA (certified nursing assistant) #2, when asked if she remembered Resident #272, CNA #2 stated, "No I do not remember him." An interview was conducted on 3/14/23 at 5:35 PM with RN (registered nurse) #2, when asked to describe Resident #272's behavior, RN #2 stated, "Mainly I worked downstairs, when I up there working, he liked to wander, he liked to watch TV in the sitting area by the elevator. He would come back to get snacks then go to his room." When asked if he wandered, what actions were put into place? RN #2 stated, "Never remember him going in any other resident's rooms, do not remember any interventions. He was alert and oriented, do not remember any behaviors." An interview was conducted on 3/14/23 at 5:41 PM with CNA #6, when asked if she remembered Resident #272, CNA #6 stated, yes, I used to work with him. He was okay. He was nice. He was chill. Never had a problem with him. Did not have good memory, he could be forgetful. I never witnessed any trouble with being angry toward staff. If he had a problem with someone, he would	F 689		

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F 689	Continued From page 15 tell you and that was with staff only. He did not have any problems with other residents. He would wander into other residents' rooms. He was just peeking. We used stop signs to try to keep him out of resident rooms. We would watch where he focused and put up a stop sign. He used to really peek in Resident #74's room a lot. He would sit and stare into her room. We had a stop sign there. We had no idea, that he had any inclination of sexual behaviors. It is the last thing we would ever have expected. An interview was conducted on 3/15/23 at 8:57 AM with CNA #1, when asked what she remembered about Resident #272's behaviors, CNA #1 stated, took care of him on the 3-11 PM shift, he really needed redirected. Trying to go into other resident rooms. When asked to describe events of 3/17/22, CNA #1 stated, we had just laid Resident #74 down. I was at nurses' station talking with the nurse and saw him (Resident #272) speeding out of Resident #74's room. I went down the hall and heard water running in his bathroom and he was washing his hands in his room. He was in the room right across from Resident #74. He acted like nothing happened. He would be very aggressive verbally; he would curse at me and some other staff but not with residents. I got the nurse and unit manager and explained that something had happened. Resident #74's brief was torn open and feces was smeared all over. I stayed late, and they called the police. This was first time of physical contact by Resident #272 and Resident #74 or any female resident to my knowledge. Resident #272 was alert and aware of his surroundings and what was going on, he may have had a little dementia.	F 689		

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An interview was conducted on 3/15/23 at 9:25 AM with OSM (other staff member) #3, the physical therapist assistant. When asked if he remembered Resident #272, OSM #3 stated, yes, I know him very well. I never thought anything like would happen. He was always very cordial to me. He was never verbally aggressive to me. I almost thought I was dreaming when I heard about this situation. I remember them blocking the door to Resident #74's room, he had been in the room or looking in the room and they put the stop sign up. If I see anything happening, I address it immediately.

An interview was conducted on 3/15/23 at 1:56 PM with RN #3. When asked if she remembered Resident #272, RN #3 stated, yes, he liked to be in his room and in his bed, get up for breakfast, come watch TV and lay down till lunch and go to activities. I never saw him going into any resident rooms. If you tried to redirect him, he would get abrupt with you. I mainly had to redirect him from taking cereal or snacks off of the cart. When asked to describe the events of 3/17/22, RN #3 stated, I was sitting at the nurses' station and CNA #1 was talking with me and I was on the computer and I saw a flash of him going from one side of the hall to the other side. We went down there and you could see, in Resident #74's room, that the sheet was brown and we looked at her, the resident stated I am okay, I am okay, I am alright. She was fidgety. Resident #272 was in the [his] bathroom washing his hands. We told the unit manager and the police were called and we moved the female resident.

An interview was conducted on 3/15/23 at 2:15 PM with RN #1, the unit manager. When asked to describe Resident #272's behavior, RN #1

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F 689	Continued From page 17 stated, 'he was fine with residents, he would get agitated with redirection, he was a wanderer, he was nosey, would look in rooms, cereal and snack cart. He would raise his voice at times with staff when redirected. He was flirtatious, most of females enjoy that. When asked to describe the event on 3/17/22, RN #1 stated, RN #4 called me and she felt that Resident #272 had done something to Resident #74. I told the administrator. I went to Resident #74's room and saw bowel movement on bedsheet, I asked RN #4 what had happened and she stated that she had seen Resident #272 roll quickly from Resident #74's room to his room across the hall. RN #4 went into Resident #272's room and there was bowel movement smeared in the sink. We sent them both to the hospital as soon as the incident happened. When Resident #74 returned from the hospital we had move her room to the first floor. On 3/15/23 at 6:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing (DON), were made aware of the findings. An interview was conducted on 3/16/23 at 9:58 AM with RN #4. When asked to describe the events of 3/17/22, RN #4 stated, one of the aides had told me that Resident #272 was leaving Resident #74's room. In Resident #74's room there was stool smeared across her bed and her [brief] was torn open and stool was on it. I went to Resident #272's room and saw stool on his hands and in the sink where he was washing his hands. We called the police. A review of the facility's "Resident Observation" policy dated 5/28/21 revealed, "To provide	F 689		

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enhanced observation as a temporary safety mechanism during an acute episode where a resident is endangered.
Procedure:
A) Charge nurse will contact DON who, if necessary, will consult with administrative staff and/or Director of Mental Health, if applicable, to determine the appropriate observation/interventions if resident meets one of the following criteria:
1. Resident is a danger to themselves, to include but not limited to: self-harm; suicidal ideation/threat;
2. Resident is acting out behaviorally, to include but not limited to: throwing items; continuous screaming/disruptive behavior;
3. Resident is a danger to others, to include but not limited to: homicidal comments/threats/actions;
4. Immediate risk of elopement.
B) DON will assign a staff member to complete appropriate observation/interventions which may include but are not limited to every 15 or 30 minutes checks or 1:1 monitoring."

A review of the facility's five-point plan dated 3/17/22, revealed, "Root Cause Analysis Results: Unable to determine at this time as no previous sexual behavior documented. Action Items: Head to toe assessment was completed on female resident. RP (responsible party) and physician notified. Resident transferred to ER for evaluation. She will be monitored for any changes in behavior. Male resident was placed on 1:1. RP and police notified. Male was arrested and removed from facility by police officers. Residents with a BIMs of 12 and above were interviewed to determine if they had concerns and felt safe in the facility. Weekly resident interviews

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F 689	Continued From page 19 will be conducted with residents with BIMS of 12 and above by the Social worker/designee for 12 weeks. Skin checks of 10 residents with a BIMS of 11 and below will be conducted by director of nursing/designee for 12 weeks. Weekly staff interviews with 10 staff members to ask if any unusual or concerning behaviors occurred. Staff education regarding abuse 3/17/22-3/21/22. Resident Council meeting on 3/18/22 to discuss abuse and reporting of abuse. Discussion at QAPI (quality assurance process improvement) committee on 3/18/22." Actions completed on 3/21/22. This deficiency is cited as past non-compliance. No further information was provided prior to exit.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		4/14/23

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as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and

(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services for a urinary catheter for one of 37 residents in the survey sample, Resident #53.

The findings include:

For Resident #53 (R53), the facility staff failed to secure the resident's urinary catheter bag in a sanitary manner. A urinary catheter is a tube placed in the body to drain and collect urine from the bladder. (1)

A review of R53's clinical record revealed a physician's order dated 2/12/23 for a urinary catheter.

On 3/15/23 at 8:19 a.m., R53 was observed lying in bed. The resident's urinary catheter bag was secured to the bed frame under the bed and touching the floor.

F 690

F690

1. Bed for resident #53 was raised which corrected catheter care issue.
2. All residents who have and indwelling catheter have the potential to be affected. DON/ designee conducted quality review and rounded on residents with indwelling catheters to ensure proper placement.
3. Licensed nurses will be educated on proper catheter positioning and care by DON/Designee.
4. DON/Designee will audit all residents with indwelling catheters for proper placement 3x/ week for 4 weeks, then 2x/ week for 8 weeks. QAPI committee will review processes at conclusion of POC audits for improvement.
5. Date of Compliance: April 14, 2023

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F 690	Continued From page 21 On 3/16/23 at 10:33 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that if a resident is lying in bed, then their urinary catheter bag should hang on a bar under the bed and should not touch the floor because someone could step on it and because of infection. On 3/16/23 at approximately 12:00 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, "Indwelling Urinary Catheter Care Procedure" documented, "10. Check drainage tubing and bag to ensure that the catheter is draining properly, and no kinks are present. The urinary drainage bag must be placed below the bladder level but not on the floor." No further information was presented prior to exit. Reference: (1) https://medlineplus.gov/ency/article/003981.htm	F 690		
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,	F 695		4/14/23

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F 695	Continued From page 22 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, the facility staff failed to provide respiratory care and services per physician orders, for two of 37 residents in the survey sample, Residents #18 and #31. The findings include: 1. For Resident #18 (R18), the facility staff failed to administer oxygen at the physician prescribed rate of four liters per minute. A review of R18's clinical record revealed a physician's order dated 1/22/23 for oxygen at four liters per minute via nasal cannula every shift. R18's comprehensive care plan revised on 1/24/23 documented, "Oxygen as needed..." On 3/14/23 at 12:40 p.m. and 3/15/23 at 2:31 p.m., R18 was observed lying in bed receiving oxygen via nasal cannula at one and a half liters per minute, as evidenced by the middle of the ball in the oxygen concentrator flowmeter positioned on the one-and-a-half-liter line. On 3/16/23 at 10:33 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated nurses should know how much oxygen to administer to a resident based on the resident's physician's order. RN #1 stated the middle of the ball in the oxygen concentrator flowmeter should be on the four-liter line if the physician's order is for four liters. On 3/16/23 at approximately 12:00 p.m., ASM	F 695	F695 1. Oxygen setting for Resident #18 and resident #31 was corrected on 03/15/23. 2. All residents who require respiratory services at Falls Run Nursing and Rehabilitation have the potential to be affected. DON/ Designee reviewed MD orders and settings for oxygen for current residents. 3. Licensed nurses will be educated on respiratory care and services by DON/Designee. 4. DON/Designee will audit oxygen settings 3x/ week for 4 weeks, then 2x/ week for 8 weeks. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date of Compliance: April 14, 2023	

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

The oxygen concentrator manufacturer's instructions documented, "2. Check the flow meter to make sure that the flow meter ball is centered on the line next to the prescribed number of your flow rate."

The facility policy titled, "Oxygen Administration (all routes) Policy" documented, "Licensed clinicians with demonstrated competence will administer oxygen via the specified route as ordered by a provider."

No further information was presented prior to exit.

2. For Resident #31 (R31), the facility staff failed to administer oxygen at the physician prescribed rate of three liters per minute.

R 31's comprehensive care plan revised on 5/10/22 documented, "Oxygen as ordered by the physician..." Further review of R31's clinical record revealed a physician's order dated 12/5/22 for oxygen at three liters per minute via nasal cannula every shift.

On 3/14/23 at 12:39 p.m. and 3/15/23 at 8:28 a.m., R31 was observed lying in bed receiving oxygen via nasal cannula at three and a half liters per minute, as evidenced by the middle of the ball in the oxygen concentrator flowmeter positioned on the three-and-a-half-liter line.

On 3/16/23 at 10:33 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated nurses should know how much oxygen to

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F 695	Continued From page 24 administer to a resident based on the resident's physician's order. RN #1 stated the middle of the ball in the oxygen concentrator flowmeter should be on the three-liter line if the physician's order is for three liters. On 3/16/23 at approximately 12:00 p.m., ASM (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 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement a complete pain management program for two of 37 residents in the survey sample, Residents #32 and #6. The findings include: 1. For Resident #32 (R32), the facility staff failed to offer non-pharmacological interventions and assess for the location of a resident's pain prior to administering an as needed pain medication on multiple occasions in March 2023. A review of R32's physician orders revealed the	F 697	F697 1. Comprehensive care plan for Resident #32 and #6 was reviewed for patient specific non-pharmacological interventions on 3/29/23. 2. All residents on pain management who reside at Falls Run Nursing and Rehabilitation have the potential to be affected. DON/ designee conducted a quality review of care plans and records for residents with PRN pain medications to identify residents requiring non-pharmacological interventions. 3. Licensed nurses have been educated on pain management protocol by	4/14/23

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F 697	Continued From page 25 following order dated 1/17/23: "Oxycodone-Acetaminophen (opioid pain medication) 5-325 mg (milligrams)...Give 1 tablet by mouth every 8 hours as needed for moderate or severe pain. A review of R32's March 2023 MAR (medication administration record) revealed the resident received the Oxycodone-Acetaminophen as ordered on 3/2/23, 3/4/23, 3/6/23, 3/11/23, 3/12/23, and 3/14/23. Further review of the clinical record revealed no evidence that non-pharmacological interventions were offered to R32 prior to the administration of Oxycodone-Acetaminophen on all six of these dates in March 2023. The record revealed no evidence that the resident's pain location was assessed or documented on 3/2/23, 3/11/23, 3/12/23, and 3/14/23. On 3/16/23 at 10:33 a.m., RN (registered nurse) #1 was interviewed. She stated prior to administering an as needed pain medication, she attempts to reposition the resident or offer ice packs as non-pharmacological interventions and if those do not help, or if the resident refuses the non-pharmacological interventions, she asks the resident to rate and describe the location of the pain. She stated the facility's EMR (electronic medical record) software prompts the nurse to write a progress note for each as needed medication and she would document the non-pharmacological interventions and the location of the pain in the progress note. She stated non-pharmacological interventions are important because they give the residents an option other than medication. After reviewing R32's March 2023 progress notes and MAR,	F 697	DON/Designee. 4. DON/Designee will audit five resident records for non-pharmacological interventions and appropriate assessments 5x/ week for 4 weeks, then 3x/ week for 8 weeks for accurate documentation. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date of Compliance: April 14, 2023.	

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F 697	Continued From page 26	F 697		

RN#1 agreed that there was no documentation of non-pharmacological interventions at each administration, and a lack of documentation of the location of the resident's pain on four occasions.

On 3/16/23 at 11:47 a.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, "Pain Management Protocol," revealed, in part:
"Non-pharmacological intervention[s] will be attempted prior to the administration of PRN pain medications. When it is determined the resident's pain will need pharmacological interventions: Documentation of administration of medications will be located in the electronic medication record (eMAR)...The effectiveness of the medication(s) will be identified on the eMAR."

No further information was provided prior to exit.
2. For Resident #6 (R6), the facility staff failed to initiate a complete pain assessment on 3/6/23 when the as needed pain medication tramadol was administered, and failed to attempt non-pharmacological interventions on 3/2/23, 3/4/23, 3/6/23, 3/7/23, 3/9/23 and 3/11/23 when as needed tramadol was administered.

R6's comprehensive care plan dated 3/7/17 documented, "At risk for pain r/t (related to) multiple health risk factors. Non-pharmacological interventions as appropriate..." Further review of R6's clinical record revealed a physician's order dated 11/23/20 for tramadol 50 mg (milligrams)- one tablet by mouth every eight hours as needed for pain rated six to ten. A review of R6's March

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F 697	Continued From page 27 2023 MAR (medication administration record) revealed the resident was administered as needed tramadol on 3/2/23, 3/4/23, 3/6/23, 3/7/23, 3/9/23 and 3/11/23. Further review of R6's clinical record (including the March 2023 MAR and March 2023 progress notes) failed to reveal a complete pain assessment, including the location of pain, was completed on 3/6/23 and failed to reveal non-pharmacological interventions were attempted on 3/2/23, 3/4/23, 3/6/23, 3/7/23, 3/9/23 and 3/11/23. On 3/16/23 at 10:33 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that if a resident complains of pain, then she asks where the pain is located and if the pain is in their back or legs, she will try repositioning and ice packs before medication administration, if the resident allows this. RN #1 stated nurses should not immediately give medications because nurses should give more options. RN #1 stated she documents the location of pain and non-pharmacological interventions in the progress notes. On 3/16/23 at approximately 12:00 p.m., ASM (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 697		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		4/14/23

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F 757	Continued From page 28 §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 and clinical record review, the facility staff failed to ensure a resident was free from an unnecessary medication for one of 37 residents in the survey sample, Resident #6. The findings include: For Resident #6 (R6), the facility staff administered the as needed pain medication, tramadol, outside of the physician's order for pain rated between six to ten on a scale of one to ten (one being least and ten being most) on multiple dates in January 2023 and February 2023. The staff administered tramadol for a pain rating less than six. A review of R6's clinical record revealed a physician's order dated 11/23/20 for tramadol 50	F 757	F757 1. Physician's orders for resident #6 were reviewed. Licensed nurses x 4 were educated on following parameters in physician's orders. 2. All residents who reside at Falls Run Nursing and Rehabilitation and receive pain medication have the potential to be affected. The DON/ 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 physician's order by DON/Designee. 4. DON/Designee will audit five residents a week for proper administration of PRN pain medication per physician orders for	

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F 757	Continued From page 29 mg (milligrams)- one tablet by mouth every eight hours as needed for pain rated six to ten. A review of R6's January 2023 and February 2023 MARs (medication administration records) revealed the resident was administered as needed tramadol for pain rated less than six on the following dates: 1/3/23 (pain rated as two) 2/4/23 (pain rated as four) 2/20/23 (pain rated as zero) 2/23/23 (pain rated as zero) 2/28/23 (pain rated as three) 2/28/23 (pain rated as five) On 3/16/23 at 10:33 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the pain rating documented on R6's MAR beside as needed tramadol administration is the resident's initial pain rating. RN #1 stated if a resident complains of pain, then nurses should check the physician's orders to see what medication should be given based on the resident's pain rating. RN #1 stated that for R6, tramadol should only be given for a pain rated between six to ten. RN #1 stated R6 should have been administered Tylenol (per physician's order) instead of tramadol on the above dates. On 3/16/23 at approximately 12:00 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; "Pain Management Protocol" failed to document information regarding the above concern. No further information was presented prior to exit.	F 757	12 weeks. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date of Compliance: April 14, 2023.	
F 761 SS=D	Label/Store Drugs and Biologicals	F 761		4/14/23

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F 761	Continued From page 30 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to properly store medications for one of 37 residents in the survey sample, Resident #59. The findings include: For Resident #59 (R59), the facility staff failed to	F 761	F761 1. Medication for resident #59 was sent home with family on 3/15/23. 2. All residents who reside at Falls Run Nursing and Rehabilitation have the potential to be affected. DON/ designee conducted a quality review and rounded on residents to ensure proper storage of medications. 3. Licensed nurses will be educated on	

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F 761	Continued From page 31 secure a bottle of Vitamin D 10000 IU (international units) and one bottle of multivitamins in the resident room. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/21/2023, the resident scored 10 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. On 3/14/2023 at 1:46 p.m., an observation was made of Resident #59's (R59) room. R59 was not in the room at the time however their family member was in the room. R59's family member stated that the resident was in therapy. Observation of R59's room revealed two bottles of medication on top of the nightstand beside the bed. One bottle was labeled Vitamin D 10000 IU and one bottle of multivitamins were observed. On 3/14/2023 at 3:30 p.m., R59 was observed in bed asleep. The bottle of Vitamin D 10000 IU and the bottle of multivitamins remained on top of the nightstand beside the bed. On 3/15/2023 at 8:15 a.m., R59 was observed sitting in the wheelchair in their room. The bottle of Vitamin D 10000 IU and bottle of multivitamins remained on top of the nightstand beside the bed. When asked about the medications, R59 stated that they did not know why they were there. R59 stated that the nurse had brought them down the day before and left them and they were not sure why. R59 stated that they normally took Vitamin D and a multivitamin every day but had not taken any from the bottles and was going to ask the nurse about them when they came in.	F 761	proper storage of medications by DON/Designee. 4. DON/Designee will audit 5 resident rooms per week x 12 weeks for proper medication storage. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date of compliance: April 14, 2023.	

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F 761	Continued From page 32	F 761		

The physician orders for R59 documented in part, "Multivitamin Oral Tablet (Multiple Vitamin) Give 1 tablet by mouth one time a day for supplement. Order Date: 02/16/2023. Start Date: 02/17/2023." The physician orders further documented, "Cholecalciferol Oral Tablet 50 MCG (2000 UT) (Cholecalciferol) Give 1 tablet by mouth one time a day for supplement. Order Date: 02/16/2023. Start Date: 02/17/2023."

A resident self-administration of medication assessment for R59 dated 2/22/2023 documented R59 being a candidate for self-administration of medications.

On 3/15/2023 at 1:57 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that medications needed to be secured by keeping them locked up. LPN #4 stated that the medications in R59's room were brought in by the family and they could not keep them on the medication cart because they were not prescribed. LPN #4 stated that when family members brought medications in they were given to the unit manager to be locked up and not left in the room. LPN #4 stated that they had given the Vitamin D and Multivitamin back to the family member to take home on 3/14/2023 and they had left them in the room. LPN #4 stated that they had observed the bottles on the nightstand when they went into the room this morning and they should not have been left there because it was a safety issue. LPN #4 stated that they would remove the medication and follow up with the family to ensure that they would take the medication home.

The facility policy, "Storage and Expiration Dating

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F 761	Continued From page 33 of Medications, Biologicals" dated 12/01/07 documented in part, "...Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors...Facility should store bedside medications or biologicals in a locked compartment within the resident's room..." On 3/15/2023 at 5:06 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		4/14/23

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F 842	Continued From page 34 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 842		

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F 842	Continued From page 35 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 37 residents in the survey sample, Resident #26. The findings include: For Resident #26 (R26), the facility staff failed to maintain an accurate ADL (activities of daily living) documentation record for February 2023. On the most recent MDS (minimum data set), a five day admission assessment with an ARD (assessment reference date) of 2/8/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) indicating they were cognitively intact for making daily decisions. Section G documented R26 required extensive assistance of one person for bed mobility and limited assistance of one person for transfers, toileting and personal hygiene. The comprehensive care plan for R26 documented in part, "At risk for self care deficit severe sepsis and amputation. Date Initiated: 02/05/2023." A review of the ADL documentation for R26 failed to evidence documentation of personal hygiene,	F 842	F842 1. Resident #26 discharged the facility on 03/09/23. 2. All residents who reside at Falls Run Nursing and Rehabilitation have the potential to be affected. DON/ designee conducted a quality review of ADL documentation for current residents to ensure proper documentation. 3. Certified Nurse aides will be educated on complete and accurate ADL documentation requirements. 4. DON/Designee will audit 5 resident records per week x 12 weeks for complete and accurate ADL documentation. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date of compliance: April 14, 2023.	

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mouth care, bladder and bowel continence, barrier cream application, behavior monitoring, skin observations or toilet use on the evening shift (3:00 p.m. to 11:00 p.m.) on 2/13/2023.

On 3/15/2023 at 2:12 p.m., an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 stated that ADL care was documented in the medical record. CNA #3 stated that some of the staff work 12 hour shifts but they still documented the ADL care in eight hour shifts in the medical record. CNA #3 stated that if the ADL documentation was left blank they could not say that the care was not provided, but that it was not documented.

On 3/16/2023 at 11:30 a.m., an interview was conducted with CNA #5. CNA #5 stated that they documented ADL care in the computer and had to complete the documentation before they could leave. CNA #5 stated that if the ADL documentation was blank it meant that no one documented anything. CNA #5 stated that if the care was not documented, the record was not complete because it did not show what they did for the resident.

The facility policy, "Medical Records Storage and Retention Policy" dated April 2008 failed to evidence guidance regarding maintaining a complete and accurate medical record.

On 3/16/2023 at 11:47 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING ______ B. WING ______	C **03/16/2023**

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

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