STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0404	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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 3/14/2023 through 3/16/2023. Corrections are required with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. 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 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-150. (B.3.) Resident rights. Cross reference to F585. 12VAC5-371-220. (B.) Nursing services Cross reference to F695 & F757. 12VAC5-371-300 (B) Pharmaceutical services. Cross reference to F761 12VAC5-371-360 (E) Clinical records. Cross reference to F842. 12VAC5-371-150 (H) Resident rights. Based on staff interview and facility document review, it was determined that the facility staff failed to evidence a sex offender registry check for one of 37 residents. The findings included: The facility failed to provide evidence that they performed a sexual offender registry background	F 001	12VAC5-371-150 (B.3) cross reference to 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	4/14/23

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

Electronically Signed | 03/31/23

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F 001	Continued From page 1 check on Resident #272 on admission per the State of Virginia licensing regulation. The facility event synopsis dated 3/17/22, documented in part, "Incident date: 3/17/22. Residents involved (Resident #272) and (Resident #74). Injuries: (A check mark was documented next to)-No. Incident type: Allegation of abuse/mistreatment. Describe incident: (Resident #272) is suspected of putting his hand in Resident #74's brief without her consent. Residents separated and placed on increased observation. Head to toe and skin assessments completed on Resident #74. Reported incident to Sheriff's office. MD (physician) and RP (responsible party) notified." The "Investigation Summary" dated, 3/23/22, documented in part, "On 3/17/22, Resident #272 was seen exiting Resident #74's room. Staff checked on Resident #74 and saw that her brief was askew with feces wiped on her sheets. Resident #74's hands were checked and revealed no feces. Staff noted that Resident #272 was washing his hands and upon examination, were found to have what appeared to be feces under the nails and in the sink. Police, physician and family were notified. A full head to toe assessment was conducted on female resident and she was placed at nurses' station for close supervision. RP and MD were notified. MD ordered female resident to be transferred to the ER (emergency room) for evaluation. Upon her return she was assessed for any psychosocial needs and plan of care was updated. Staff will continue to monitor for any changes in behavior. She has been seen by psych services with no noted changes to mood or behavior. Male resident was placed on 1:1, RP, MD and police notified. Male resident was	F 001	grievances. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date of Compliance: April 14, 2023. 12VAC5-371-220 (B.) cross reference to 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 12VAC5-371-220 (B.) cross reference to 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	

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F 001	Continued From page 2 arrested and removed from facility by police after confessing to sexual contact with his hands to female resident in question. Residents with a BIMS of 12 and above were interviewed to determine if they had concerns and felt safe in the facility. Residents with a BIMS of 11 and below had skin check completed by licensed nurse. Resident Council meeting was held to review abuse and who to report any concerns to and also reviewed location of Ombudsman information. An Audit of current residents was conducted through the sex offender registry with no findings. New admissions will be run through the sex offender registry per protocol. Current staff were run through the sex offender registry per protocol. Staff were interviewed and asked if they observed unusual behavior by this resident or any other resident. Abuse education with a focus on sexual abuse was done with staff by the Administrator/designee. New hires will receive abuse education upon hire and annually. Conclusion: The preponderance of evidence substantiates an allegation of resident-to-resident abuse." Resident #272 was admitted to the facility on 8/22/2017 with diagnosis 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, indicating 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	F 001	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 12 weeks. QAPI committee will review processes at conclusion of POC audits for improvement. 5. Date of Compliance: April 14, 2023. 12VAC5-371-300 (B) Pharmaceutical services.Cross reference to 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 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. 12VAC5-371-360 (E) Clinical records. Cross reference to 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	

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F 001	Continued From page 3 walking, locomotion, dressing and eating. A review of the annual MDS dated Section E: 0200 A. Physical behavior symptoms exhibited towards others e.g., abusing other sexually. Coded=0 behavior not exhibited. Review of Resident #272's medical record or facility event synopsis did not reveal a copy the Virginia Sex Offender Registry as of the date of the incident 3/17/22. The plan of correction documentation included the Virginia Sex Offender Registry for Resident #272 dated 3/18/22. An interview was conducted on 3/15/23 at 11:50 AM, with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated, we do not have any evidence of the sexual registry for Resident #272 prior to this incident. The registry was on paper in 2017 when he was admitted and the former person in charge of this, had piles of the sexual offender registry. We went through them to find his and could not find it. We pulled one on 3/18/22 and it revealed that "no offenders found". A review of the facility's "Sex Offender Registry" policy, dated 10/2016, revealed "The Facility will ensure all regulations are followed and maintain safety for all residents and staff. A. Upon receiving a referral for admission to the facility, the administrator/designee shall search for the resident's name on the internet-based sex offender and child-victim offender database at: http://www.snopr.gov/. 1.Utilize tracking tool for admission (See exhibit A)." No further information was provided prior to exit.	F 001	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. 12VAC5-371-150 (H) Resident rights. 1. Sexual offender background check was conducted on resident #272 with no derogatory information noted. 2. All residents who reside at Falls Run Nursing and Rehabilitation have the potential to be affected. An audit was conducted on all current residents with no derogatory information noted. 3. Admissions Director trained on conducting SOR registry and placing report in resident record. 4. All new admissions will have SOR report placed in record and reviewed in morning meeting. 5. Date of Compliance: March 18th, 2022.	