#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/13/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495038 B. WING 04/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS HEALTH AND REHAB CENTER MANASSAS, VA 20109 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 F 281 An unannounced Medicare/Medicaid standard survey was conducted 4/4/17 through 4/6/17. 1. Resident #12's physician One complaint was investigated during the was notified that the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long accucheck order with Term Care requirements. The Life Safety Code sliding scale insulin survey/report will follow. coverage was not confirmed by the nurse The census in this 120 certified bed facility was 114 at the time of the survey. The survey sample and blood sugars had not consisted of 20 current Resident reviews been obtained as (Residents # 1 through # 20) and five closed record reviews (Residents # 21 through # 25). ordered, order was F 281 483.21(b)(3)(i) SERVICES PROVIDED MEET F 281 clarified and re-entered SS=D PROFESSIONAL STANDARDS into electronic medical record. Nurse confirming (b)(3) Comprehensive Care Plans the order will receive The services provided or arranged by the facility, educational coaching on as outlined by the comprehensive care plan, mustcompletion of data entry for accucheck orders with (i) Meet professional standards of quality. sliding scale coverage. (2) This REQUIREMENT is not met as evidenced by: The licensed nurse Based on staff interview, facility policy review and working with Resident #5 clinical record review, it was determined that on 1/17/17 who failed to facility staff failed to follow professional standards of practice for two of 25 residents in the survey document assessment of sample, Resident #12 and Resident #5. pressure injury and treatment is no longer 1. The facility staff failed to clarify a physician's order for sliding scale humulin-r (regular insulin employed in the Center. with short duration of action (2)) insulin for Resident #5's pressure Resident #12. Resident #12's sliding scale order for humulin-r insulin did not contain the sliding injury remains resolved.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

scale doses to be given based on blood sugar

Almistration

(X6) DATE

419/17

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIER	HAB CENTER		8575	ET ADDRESS, CITY, STATE, ZIP CODE RIXLEW LANE ASSAS, VA 20109	04	<del>!</del> /06/2017
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	assessment of a prothe physician order Resident #5.  The findings included 1. Resident #12 was 3/2/17 and readmitted that included but we anemia, high blood and depression.  The most recent ME day assessment, with reference date) of 3/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2	ailed to document an essure injury and document for a treatment applied for second and the second and the second are admitted to the facility on ed on 3/17/17 with diagnoses re not limited to: diabetes, pressure, difficulty swallowing assure, difficulty swallowing assured to make daily decisions, ded as requiring assistance wities of daily living.  July 10 daily living assistance with sliding scale coverage and the side of the status of daily living.  July 11 daily 12 daily 13 daily 14 daily 16 daily 16 daily 16 daily 16 daily 17 daily 17 daily 18 daily 1	F 28		2. Current residents will have body audits completed to verify skin integrity; any areas identified nurse will verify an appropriate treatment in place per MD orders and documented and notification of MD/RP. Current residents will have sliding scale order reviewed for order entry accuracy.  3. Licensed Nurses will be educated on assessment and documentation of altered skin integrity. UM's and supervisory nurses will be educated on Center's protocol for monitoring dashboard for alerts to altered skin integrity and verification of		
r	Review of Resident: ecord did not eviden since 3/13/17.	#12's blood sugar summary ce any blood sugar results			assessment/treatments/ MD & RP notification. Completion of data entry		
F 4	Review of the nurse's 4/5/17 did not eviden	notes from 3/29/17 through ce documentation of blood		-	for accucheck orders with sliding scale coverage.	7 00 au	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		(X3)	(X3) DATE SURVEY COMPLETED	
		495038	B. WING	}			C <b>04/06/2017</b>
	PROVIDER OR SUPPLIER  SAS HEALTH AND RE	HAB CENTER		8	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 RIXLEW LANE MANASSAS, VA 20109		0.410012011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
	sugar results.  Review of the care of documented, "Focu fluctuation requiring management. Intervigence diabetic management Perform blood sugar clinically indicated. Foutside of established An interview was cop.m., with RN (registrunit manager and RI followed when physistated, "Any time you have scheduled time embedded into the coreview Resident #12 looked at the order stell you this order is really you this order is really you the scheduled time and put in the sliding doctor) to re-clarify it the physician entered for the insulin to be go insulin dosages writted be seen by the pharmentered into the MAR should have clarified 'This order wasn't put the MAR."  On 4/5/17 at 3:45 p.m. care of a diabetic on only sician orders was	plan created on 3/3/17 s. Has diabetes/blood sugar medical and/or dietary rentions/Tasks. Administer nt medication as ordered. It checks as ordered or Report significant values ed protocol or parameters."  Inducted on 4/5/17 at 2:50 dered nurse) #5, the interim N #6, regarding the process cians write orders. RN #5 a put in an order you have to es, the sliding scale has to be order." RN #5 was asked to be reder." RN #5 stated, "I can not written in there (the that order out and re-order it scale and get him (the "RN #5 stated that when all the order there was no time iven and therefore it would not nacist and would not get and therefore it would not nacist and would not get the order. RN #6 stated, it in right, it won't show up in the insulin and following	F	281	4. 1) The Don or Designee will randomly audit 5 electronic medical records for documentation of risk for development of wound treatment/intervention is place weekly x 4 weeks and then Monthly x 2. The DON will review findings and report to QAPI Committee for any further recommendation.  2) The DON and designee will conduct a review of resident with new accucheck orders weekly x 4 weeks and monthly x 2 months for residents to verify accuracy of data entry for orders with specific parameters. The DON or designee will review findings and report to QAPI Committee for any further recommendation.  5. Date of compliance:	n	
( r	auministrative staff n nursing.	nember) #2, the director of			5. Date of compliance : 10,2017	May	} :

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER SAS HEALTH AND RE	HAB CENTER		857	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109	1		
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	p.m. with ASM #2, the was asked about the follow when an order ASM #2 stated that order into the comp confirms the order. was confirming, AS (the orders) for accept and the five rights of ASM #2 stated that the policies as requistandard nursing produced at the findings at the An interview was confirmed order for sliding scale about the process senters an order into #7 stated, "When the order we have to compare was included in constated, "What's involunderstanding. Why follow up with the panecessary." LPN #7 sliding scale order for the order was correctly to be clarified. It does (the amount of insult blood sugar results)	conducted on 4/5/17 at 4:15 the director of nurses. ASM #2 the process the staff nurses the process the staff nurse when a physician wrote an outer system the nurse When asked what the nurse M #2 stated, "You verify them uracy, scheduling, timing, date of medication administration." they (the facility) did not have the ested as nurse's used the facility used, AMS the process. When asked what the address the facility used, AMS the process the facility used, AMS the pro	F 2	81				
		on was provided prior to exit.  damentals of Nursing, 6th					10 TO	
	mir ottor i ciry, i um	damontale of Huleling, our					: [	

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		HAND HUMAN SERVICES			FORM	D: 04/13/201 MAPPROVEI
STATEMENT	T OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	E .	PLE CONSTRUCTION  G	OMB NC (X3) DA	). 0938-039° TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER  SAS HEALTH AND RE	EHAB CENTER	8	STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	<u> </u>	100/2011
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	"When medications compares the medic computer orders with orders." On page 8 administration of ora accuracy and computer printout with medication order."  (1) Accuchecks State decades ago, self-medication order."  (1) Accuchecks State decades ago, self-medicated ago, self-medicated as an adjustion order of the patients-particularly become full partners professionals in strivic control. This information of the professional order of the professional order of the physician order for applied for Resident #5 was admired the physician order	a noted standard of practice is: a are first ordered, the nurse ication recording form or ith the prescriber's written 852, regarding the ral medications, "Check oleteness of each MAR or with prescriber's written  Since its introduction three monitoring of blood glucose er-stick blood samples, test meters has aided diabetes ipally by enabling those treated with insulin-to a along with health wing for excellent glycemic ation was obtained from: n.nih.gov/pmc/articles/PMC28  Llar) Humulin R U-100 is unct to diet and exercise to ontrol in adults and children 2 diabetes mellitus. Humulin nsulin with a short duration of tion was obtained from: .nih.gov/dailymed/drugInfo.cf 038c-4ec5-a231-a51ec5cc29  ailed to document an essure injury and document for a treatment that was	F 281			

limited to: dementia, schizophrenia, high blood

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PRO IDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIEF		<u> </u>	85	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE ANASSAS, VA 20109	04	/06/2017
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	The most recent Massessment) a qual assessment refere resident as having memory difficulties being severely impedicisions. Resident extensive assistant of her activities of the staff for these accoded as being free bowel and bladder. Conditions, the resistage 3 pressure a	rosis, diabetes, anemia.	F2	281			
	The nurse's notes volumes of 1/1	vere reviewed. There was no 7/17.					
	for 1/17/17 docume	of daily living) documentation nted, "oa" indicating an open ating buttocks. A "Y" nurse was notified.					
 	member) #1, the ad director of nursing a nurse consultant, pr actions the facility to	m. ASM (administrative staff ministrator, ASM #2, the and ASM #3, the corporate esented a "Timeline" of the book in the prevention and sure ulcer for Resident #5.				A CALL	
(		ented the CNA ne ADL record for 1/17/17. activity of daily living) record					

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MANASS	SAS HEALTH AND RE	TIAD OFATTED		8575 RIXLEW LANE	OODL	
WIMINAGE	)A3 IICALIII AND N.L.	HAB CENTER		MANASSAS, VA 20109		
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	open area" on 1/3/1 indicating "yes" the states. ASM # CNA (#4) who docur informed me that the crack' and not on the documentation does descriptive documentation does descriptive documentation would hat CNA stated when I in day there was a 'pate dressing is our proto assesses the wound nurse documented the prior to placing a wor #2 stated, "There is a nurse for this. The number of the cold interviewed the CNA was the same area the	ocumented in part an "OA - 17 and 1/17/17, and a "Y" nurse was notified on each of \$\frac{4}{2}\$ stated, "I interviewed the imented this on 1/17/17. She be open area was in the 'butt he buttock. The CNA	F 26	81		
. 1	wound care nurse as	ssessment of this area was 42 stated, "We were not				

During an interview was ASM #1, the administrator, on 4/6/17 at 8:37 a.m. ASM #1 stated, "The piece that we don't have is the documentation of 1/17/17 that the nurse assessed the area and implemented a treatment.

The facility policy, "Pressure Ulcer Prevention and Care Program" documented in part, "Pressure ulcers can develop anywhere there is pressure. The obvious areas include: Sacrum and coccyx...The CNA is to verbally report ALL unusual resident observations/changes to their licensed nurse, including the skin observations

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		(X3) DA	(X3) DATE SURVEY COMPLETED	
******************************		495038	B. WING	·		C 04/06/2017	
	PROVIDER OR SUPPLIER  SAS HEALTH AND RE			85	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE ANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 282 SS=E	in the EMR on the Enurse will: observe the CNA, obtain phy Responsible Party, indicated, documenthe Interdisciplinary report, and update the treflect the treatmentare implemented."  No further information 483.21(b)(3)(ii) SER PERSONS/PER CAR (b)(3) Comprehension The services provide as outlined by the comustance with each care. This REQUIREMENT by:  Based on observation document review and was determined that follow the care plan from the services and the survey sample, Resident #8 and Res	en document what they report Body Audit. The licensed the area/condition reported by visician's orders, notify the provide treatment(s) the problem thoroughly in Notes, include in the 24 hour he resident's Care Plan to vipreventative measures that on was provided prior to exit. VICES BY QUALIFIED RE PLAN  We Care Plans and or arranged by the facility, imprehensive care plan,  Lalified persons in he resident's written plan of a staff interview, facility declinical record review, it the facility staff failed to or four of 25 residents in the dent #10, Resident #12, ident #9.	F 2		F 282  1. (1) Resident #10's physician was notified that Clonidine ordentry did not reflect recordings blood pressure; the physician reviewed current blood pressur readings in the MAR and PRN Clonidine was discontinued. Nurse entering the original Clonidine order will receive educational coaching on order entry for PRN BP medications. Resident # 10's care plan has been reviewed and nursing staf will be re-educated on following resident's individualized plan of care for monitoring vital signs at medication administration.	of ee	

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STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	/Y2\ MULTI	IDLE CONCEDUCTION	OIMB NO. 0938-039		
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	PROVIDER OR SUPPLIER SAS HEALTH AND RE	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109			
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F 282	Continued From pa	ge 8	F 282	() · · · · · · · · · · · · · · · · · ·			
	comprehensive care of non-pharmacolog	ailed to follow Resident #8's e plan for the implementation pical interventions for pain.		notified that the accucheck with sliding scale insulin cowas not confirmed by the nand blood sugars had not b	verage iurse		
	4. The facility staff facility staff facility comprehensive care of fall mats for Residual	plan for the implementation		obtained as ordered, order clarified and re-entered into	der was		
	1/30/16 and readmit diagnoses that inclustroke, high blood produced by diabetes. The most reset), an annual asse (assessment references ident as having a (brief interview for more ident was cognitive decisions. The resident minimal assistance for dress needed moderate states.	admitted to the facility on ted on 3/31/16 with ded but were not limited to: essure, depression and ecent MDS (minimum data ssment, with an ARD ace date) of 2/8/17 coded the 14 out of 15 on the BIMS ental status) indicating the rely intact to make daily ent was coded as needing rom staff for activities of daily sing which the resident aff assistance.		electronic medical record. confirming the order will re educational coaching on completion of data entry fo accucheck orders with slidir scale coverage. Resident # care plan has been reviewe nursing staff will be re-educ on following resident's individualized plan of care f blood sugar monitoring and medication management of sugars.	ceive  r ng 12's d and cated or		
	Review of Resident #10's care plan created on 2/12/16 and revised on 3/6/17 documented, "Focus. (Resident #10's initials) has altered cardiovascular status which may impacts (sic) day to day function R/t (related to) hypertension (high blood pressure)Interventions/Tasks. Administer medications as ordered. Vital Signs per MD (medical doctor) orders and as indicated by s/s/ (signs and symptoms). Notify physician of significant deviations/abnormalities."  Review of the physician's orders dated April 2017 documented, "CloNIDIne HCL (indicated in the			(3) Resident #8 will be reassessed for pain and finding be reviewed by the interdisciplinary team and his plan of care will be revised a indicated. Nursing staff will be educated on implementation non-pharmacological	s s oe re-		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	(X3) DA	(X3) DATE SURVEY COMPLETED	
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NAME OF BROWINGS OR CURRUSES	495038	B. WING			/06/2017
NAME OF PROVIDER OR SUPPLIER  MANASSAS HEALTH AND RE		;	STREET ADDRESS, CITY, STATE, ZIP CODE 3575 RIXLEW LANE MANASSAS, VA 20109		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
milligram) Give 1 to as needed for systed pressure - when the blood (2)) b/p (blood Start Date. 11/15/20 Review of the April 2 administration record HCL Tablet 0.1 MG mouth every 12 hour (blood pressure) great 11/15/2016." Under were two boxes. On pressure)" and the coneeded)." There was evidenced of the bloomedication was administration was administration was administration. Review of the reside record documented on 4/1/17 and a blood 4/3/17.  Review of the April 2 evidence documentate having blood pressure. An interview was corp.m. with RN (registed who used the resider "We do, physical the the health care field with the health care field with the masked why residence who used the resider."	ension (1)) Tablet 0.1 MG ablet by mouth every 12 hours blic (top number of blood e heart beats while pumping d pressure) greater than 160. D16."  2017 MAR (medication rd) documented, "CloNIDIne (milligram) Give 1 tablet by ars as needed for systolic b/p eater than 160. Start Date. each day of the month there e box was titled, "BP (blood other box was titled "PRN (as as no documentation od pressure or if the ninistered.  ent's blood pressure summary a blood pressure of 130/70 and pressure of 115/72 on  017 nurse's notes did not ation regarding the resident res taken twice a day.  Inducted on 4/5/17 at 12:55 ared nurse) #7. When asked are plans, RN #7 stated, arapy, the doctor, everyone in who are helping the patient." Indents have care plans, RN sure the patient has goals."	F 282	1	e nd t's ces. ill zed he to ata	

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	SAS HEALTH AND RE	HAB CENTER		8	575 RIXLEW LANE MANASSAS, VA 20109		
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F 282	Continued From page 10 An interview was conducted on 4/5/17 at 1:10			282			
	p.m. with RN #5, the	#5, the interim unit manager. When ed the care plans, RN #5 stated,			A review of 24 hour report fo		
	"All the nurses need	I to be aware of the care			past 72 hours to verify nurses a	re	
	plan." When asked	why residents had care plans,			implementing non-		2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
	RN #5 stated, "To m	ake sure our residents are sing, it's huge." When asked if			pharmacological interventions		
	staff were expected	to follow the care plan, RN #5			per resident's individualized pla	n	and the second s
	stated, "Yes. The ca on the care plan for	re plan interventions are put a reason and we follow the			of care.		
	care plan. If (the interventions) aren't working we				A review of residents with		
	re-assess and chang	ge the care plan."		1	safety device orders will be		
	An interview was cor	nducted on 4/5/17 at 4:15			completed to ensure safety		
	p.m. with ASM (adm	inistrative staff member) #2.			•		
	the director of nursin	ig. When asked why			devices are in place and nursing		
	residents had care p	lans, ASM #2 stated, "To rour patients." When asked			staff are following the resident's		
	who used the care p	lan, ASM #2 stated, "Every			individualized plan of care,		
	department has som When asked if staff v	e part of the care plan." were expected to follow the			3. The Nurse Educator or		
	resident's care plan,	ASM #2 stated, "Yes." ASM			designee will educate nursing		O. Address
	#2 was made aware	of the findings at that time.			staff on following the residents		
1	Review of the facility	's policy titled			individualized plan of care and		
	"COMPREHENSIVE				data entry of new orders. The		
		nted, "POLICY. The facility			Nurse Educator will educate UM	, <sub>-</sub>	!
	must develop a comp	prehensive care plan for				5	
	each resident that inc				and supervisory staff on Center		i
	objectives and timeta	ables to meet a resident's			protocol for verifying complete		
	needs that are identif	mental and psychosocial fied in the comprehensive			and accurate medication orders		
		DURE. 6. Duties and			4.The DON and designee will		
	responsibility of the C				review of resident with blood		
1	not limited to h. Revi	nary Team include but are ewing care plans to assure			pressure orders weekly x 4 weeks	s	
1	that: I. They represen	it the resident's medical and			and monthly x 2 months for		
	nursing assessment;	v. They reflect standards of			,	,	
(	current professional s	standards."			residents to verify accuracy of	i	

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Event ID: 3CQ311

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/13/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495038 B. WING 04/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS HEALTH AND REHAB CENTER MANASSAS, VA 20109 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 282 Continued From page 11 F 282 No further information was provided prior to exit. data entry for orders with specific According to Fundamentals of Nursing Lippincott parameters. The DON or designee Williams and Wilkins 2007 pages 65-77 will review findings and report to documented, "A written care plan serves as a communication tool among health care team QAPI Committee for any further members that helps ensure continuity of recommendation. care...The nursing care plan is a vital source of information about the patient's problems, needs, The DON and designee will and goals. It contains detailed instructions for achieving the goals established for the patient review of 24 hour report for and is used to direct care...expect to review. implementation of nonrevise and update the care plan regularly, when pharmacological interventions there are changes in condition, treatments, and with new orders..." weekly x 4 weeks and monthly x 2 months for resident's interventions per resident's (1) Clonidine -- Clonidine hydrochloride is indicated in the treatment of hypertension. individualized plan of care. The Clonidine hydrochloride may be employed alone DON or designee will review or concomitantly with other antihypertensive findings and report to QAPI agents. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/druglnfo.cf Committee for any further m?setid=438dece9-95d4-40f2-84b4-9e2c6d88e7 recommendation. 60 (2) Systolic blood pressure- This information was 5. Date of compliance: May obtained from the website: https://www.nhlbi.nih.gov/health/health-topics/topi 10,2017

2. Resident #12 was admitted to the facility on 3/2/17 and readmitted on 3/17/17 with diagnoses that included but were not limited to: diabetes, anemia, high blood pressure, difficulty swallowing

cs/hbp/

DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES  & MEDICAID SERVICES			FOR	D: 04/13/201 M APPROVEI
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(X3) D	O. 0938-039 ATE SURVEY DMPLETED
NAME OF	DROVIDER OF CURRUES	495038	B. WING			C 4/06/2017
	PROVIDER OR SUPPLIER  SAS HEALTH AND RE	HAB CENTER		STREET ADDRESS, CITY, STA 8575 RIXLEW LANE MANASSAS, VA 20109	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE EIENCY)	(X5) COMPLETION DATE
F 282	Continued From page	ge 12	F 2	282	enterente entre proprieta de la companya de la comp	
	day assessment, wireference date) of 3, having scored an 11 interview for mental was moderately imp. The resident was cofrom staff for all active. Review of the physic documented, "accurate meals)/hs (bedtime) with humulin-r (regul duration of action (2) Review of the April 2 administration record documentation of the Review of Resident # record did not evident since 3/13/17.  Review of the nurse's 4/5/17 did not evident sugar results.  Review of the care ple documented, "Focus, luctuation requiring rean agement. Intervestiabetic management erform blood sugar stinically indicated. Resident and perform blood sugar stinically indicated.	cian's orders dated 3/29/17 hecks (1) ac (before with sliding scale coverage ar insulin - with a short )."  017 MAR (medication d) did not evidence				

An interview was conducted on 4/5/17 at 12:55 p.m. with RN (registered nurse) #7. When asked

#### PRINTED: 04/13/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495038 B. WING 04/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS HEALTH AND REHAB CENTER MANASSAS, VA 20109 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID m (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 282 Continued From page 13 F 282 who used the residents' care plans, RN #7 stated. "We do, physical therapy, the doctor. Everyone in the health care field who are helping the patient." When asked why residents have care plans, RN #7 stated, "To make sure the patient has goals." When asked if staff were expected to follow the care plan, RN #7 stated, "Yes, you have goals to help get them out of here." An interview was conducted on 4/5/17 at 1:10 p.m. with RN #5, the interim unit manager. When asked who used the care plans, RN #5 stated. "All the nurses need to be aware of the care plan." When asked why residents had care plans. RN #5 stated, "To make sure our residents are safe. It's part of nursing, it's huge." When asked if staff were expected to follow the care plan, RN #5 stated, "Yes. The care plan interventions are put on the care plan for a reason and we follow the care plan. If (the interventions) aren't working we re-assess and change the care plan." An interview was conducted on 4/5/17 at 4:15 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked why residents had care plans, ASM #2 stated, "To know how to care for our patients." When asked who used the care plan, ASM #2 stated, "Every department has some part of the care plan." When asked if staff were expected to follow the resident's care plan, ASM #2 stated, "Yes." ASM

#2 was made aware of the findings at that time.

No further information was provided prior to exit.

(1) Accuchecks -- Since its introduction three decades ago, self-monitoring of blood glucose (MSG) using finger-stick blood samples, test strips, and portable meters has aided diabetes

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				FOF	ED: 04/13/201 RM APPROVEI
STATEMEN"	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		ISTRUCTION	OMB N	O. 0938-039 DATE SURVEY COMPLETED
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	SAS HEALTH AND RE	HAB CENTER		8575 RI	TADDRESS, CITY, STATE, ZIP CO IXLEW LANE SSAS, VA 20109	ODE	
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	become full partners professionals in striv control. This informa https://www.ncbi.nlm 45057/  (2) Humulin - r Hu an adjunct to diet an glycemic control in a and type 2 diabetes human insulin with a This information was https://dailymed.nlm.m?setid=b519bd83-1f  3. The facility staff facomprehensive care of non-pharmacological Resident # 8 was add 03/15/16 with diagnonot limited to: atrial figastroesophageal remellitus (3), arthritis, respiratory failure (5) (7), and retention of the set), an annual assess (assessment referencesident # 8 as scori interview for mental set 15, 15 being cogniti-	ipally by enabling those treated with insulin-to is along with health ving for excellent glycemic ation was obtained from: in.nih.gov/pmc/articles/PMC28  Imulin R U-100 is indicated as ind exercise to improve adults and children with type 1 mellitus. Humulin R U-100 is in short duration of action. Is obtained from: Inih.gov/dailymed/drugInfo.cf 038c-4ec5-a231-a51ec5cc29  Inited to follow Resident #8's plan for the implementation ical interventions for pain.  Imitted to the facility on ited interventions for pain.  Inited to the facility on ited interventions for pain.  Inited to the facility on ited interventions for pain.  Inited to the facility on ited interventions for pain.  Inited to the facility on ited interventions for pain.  Inited to the facility on ited interventions for pain.  Inited to the facility on ited interventions for pain.  Inited to the facility on ited interventions for pain.  Inited to the facility on ited interventions for pain.  Inited to the facility on ited interventions for pain.  Inited to the facility on ited interventions for pain.  Inited to the facility on ited interventions for pain.  Inited to the facility on ited interventions for pain.  Inited to the facility on ited interventions for pain.  Inited to follow Resident #8's plan for the implementation ited interventions for pain.	F 2	82			

activities of daily living.

extensive assistance of one staff member for

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	# 8 dated 04/04/13 the physician on 0 Review Date: 04/2 documented, "Oxy (milligrams). Give [gastrostomy tube needed for pain m 05/23/2016." "Ace 650 MG via G-Tub mild pain. Order E The care plan for F documented, "Foc (related to) arthritis "Interventions/Task resident with altern non-pharmacologic	an's Order Sheet) For Resident 7 and electronically signed by 2/25/17 documented, "Next 26/2017." The POS further 7 (codone (8) 5 (five) MG 1 (one) tablet via (by) G-Tube (9)] every 6 (six) hours as oderate to severe. Order Date: taminophen Liquid (10). Give e every 6 hours as needed for	F 282			
:	Resident # 8 dated "Oxycodone 5 (five (one) tablet via (by every 6 (six) hours to severe. Order D"Acetaminophen Li G-Tube every 6 horder Date: 05/23/2 Further review of the revealed acetamino on 01/15/17 at 1:12 a.m. and 4:26 p.m. on 01/01/17 at 9:00 01/03/17 at 9:03 p.i 01/05/17 at 10:01 p and 9:08 p.m., 01/0	quid. Give 650 MG via urs as needed for mild pain.				9

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/13/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495038 B. WING 04/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MANASSAS HEALTH AND REHAB CENTER 8575 RIXLEW LANE MANASSAS, VA 20109 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 282 Continued From page 16 F 282 10:58 a.m., and 8:49 p.m., 01/11/17 at 10:30 a.m., and 6:35 p.m., 01/12/17 at 9:42 a.m. and 9:07 p.m., 01/13/17 at 9:02 p.m., 01/14/17 at 9:44 a.m., 01/16/17 at 4:13 p.m., 01/17/17 at 9:02 p.m., 01/18/17 at 6:49 p.m., 01/19/17 at 9:18 p.m., 01/21/17 at 9:01 p.m., 01/22/17 at 9:04 p.m., 01/24/17 at 9:01 p.m., 01/25/17 at 8:05 p.m., 01/26/17 at 8:37 p.m., 01/27/17 at 3:10 p.m. and 9:14 p.m., 01/28/17 at11:50 a.m., 01/29/17 at 9:24 a.m. and 8:42 p.m., 01/30/17 at 3:30 p.m. and 9:38 p.m. and on 01/31/17 8:36 p.m. The MAR (medication administration record) for Resident # 8 dated "February 2017 documented: "Oxycodone 5 (five) MG (milligrams). Give 1 (one) tablet via (by) G-Tube [gastrostomy tube] every 6 (six) hours as needed for pain moderate to severe. Order Date: 05/23/2016." "Acetaminophen Liquid. Give 650 MG via G-Tube every 6 hours as needed for mild pain. Order Date: 05/23/2016." Further review of the MAR dated February 2017 revealed acetaminophen liquid was administered on 02/01/17 at 9:52 a.m. and 02/26/17 at 9:22

a.m. Oxycodone was administered on 02/01/17 at 5:26 p.m., 02/02/17 at 8:44 p.m., 02/05/17 at 11:34 a.m. and 9:38 p.m., 02/07/17 at 5:42 p.m., 02/08/17 at 9:01 p.m., 02/09/17 at 8:31 p.m., 02/10/17 at 9:32 p.m., 02/11/17 at 11:54 a.m., 02/13/17 at 9:51 a.m. and 9:02 p.m., 02/14/17 at 9:42 p.m., 02/15/17 at 4:03 p.m., 02/16/17 at 11:08 a.m. and 8:53 p.m., 02/18/17 at 5:15 p.m., 02/19/17 at 5:25 p.m., 02/21/17 at 9:05 p.m., 02/22/17 at 8:42 p.m., 02/23/17 at 8:40 p.m., 02/26/17 at 2:09 p.m., 02/27/17 at 1:19 p.m. and

7:36 p.m. and on 02/28/17 at 8:11 p.m.

The MAR (medication administration record) for Resident # 8 dated "March 2017 documented:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	, C.	495038	B. WING			į.	/06/2017
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	(one) tablet via (by every 6 (six) hours to severe. Order I Further review of t revealed oxycodor 9:04 p.m., 03/02/1 p.m. and 9:07 p.m. 03/06/17 at 9:18 p. 03/08/17 at 9:24 p. 03/10/17 at 8:48 p. 03/14/17 at 5:15 p. 03/16/17 at 9:02 p. 03/19/17 at 3:34 p. 9:17 p.m. and on 0  The MAR (medicat Resident # 8 dated "Oxycodone 5 (five (one) tablet via (by every 6 (six) hours to severe. Order D Further review of the revealed oxycodone 7:51 a.m. and on 0. The "Progress Note 01/01/2017 through and failed to eviden non-pharmacologic administration of acoxycodone.  On 4/5/17 at 3:20 p conducted with LPN 6. When asked to cadministering PRN stated, "Assess the	e) MG (milligrams). Give 1  y) G-Tube [gastrostomy tube] s as needed for pain moderate Date: 05/23/2016." he MAR dated March 2017 ne administered on 03/01/17 at 7 at 8:40 p.m., 03/04/17 at 1:50 ., 03/05/17 at 9:02 p.m., .m., 03/07/17 at 4:04 p.m., .m., 03/09/17 at 8:48 p.m., .m., 03/13/17 at 8:59 p.m., .m., 03/15/17 at 9:03 p.m., .m., 03/15/17 at 1:00 p.m. and 3/28/17 at 10:31 a.m. ion administration record) for "April 2017 documented: ) MG (milligrams). Give 1 ) G-Tube [gastrostomy tube] as needed for pain moderate	F 2	282			

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			ŀ	PRINTED	: 04/13/201
		& MEDICAID SERVICES			(	MR NO OM RMC	APPROVEI . 0938-039
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MANAS	SAS HEALTH AND RE	HAB CENTER		8	575 RIXLEW LANE		
()(A) (D)	STIMMADY CTA	TEMENT OF DEFICIENCIES			MANASSAS, VA 20109		
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F 282	Continued From page	ge 18	F 2	82			
		as given the last dose. Use	1 2	OZ.			
	: non-pharmacologica	al interventions. After 30					
	minutes to an nour i	would check the resident to n was effective and document					
	in the progress note	s." When asked to describe					
	the purpose of a res	ident's care plan, LPN # 6					
	resident " I PN # 6 w	how to take care of the has asked to review the care					in the second se
	plan dated 03/24/16	, the MARs dated January,					
	February, March and	d April 2017 and the progress					
	# 8. When asked to	7 through 4/4/17 for Resident show the documentation that					
	the care plan was fo	llowed to implement					
	non-pharmacologica	I interventions prior to the					
	to Resident # 8. I PN	codone and acetaminophen I # 6 was unable to provide		;			
	any evidence of the					j	
	On 4/E/17 of 4:10 = =			;		-	
	On 4/5/17 at 4:10 p.r conducted with ASM	# 2, the director of nursing					
	regarding a resident'	s care plan and the					
٠,	implementation of no	on-pharmacological					
		the administration of PRN M (administrative staff					
	member) # 2 stated,	"The care plan should be					
	followed."					1044	
	On 4/5/17 at 5:15 p.n	n. ASM (administrative staff				-	
	member) # 1, the adr	ministrator and ASM # 2, the					
	director of nursing, w above findings.	ere made aware of the				100	
	above muliys.					1	
	No further information	n was provided prior to exit.					
	References:	;					

the website:

1. A problem with the speed or rhythm of the heartbeat. This information was obtained from

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCT	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495038	B. WING			1	C <b>/06/2017</b>
	PROVIDER OR SUPPLIER			STREET ADDRES 8575 RIXLEW L MANASSAS,			00/2017
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F 282	on.html.  2. Stomach contenthe esophagus and was obtained from https://www.nlm.nih  3. A chronic diseas regulate the amour information was obhttps://www.nlm.nih 001214.htm.  4. Fear. This information website: https://www.nlm.nih #summary.  5. When not enouglungs into your blood obtained from the whitps://www.nlm.nih ilure.html.  6. A swallowing discobtained from the wood obtained from th	ts to leak back, or reflux, into lirritate it. This information the website: n.gov/medlineplus/gerd.html.  e in which the body cannot of sugar in the blood. This tained from the website: n.gov/medlineplus/ency/article/mation was obtained from the n.gov/medlineplus/anxiety.html  h oxygen passes from your od. This information was vebsite: n.gov/medlineplus/respiratoryfa	F 2	82	DEFICIENCY		
	amount of potassiu normal. This inform website:	evel is a condition in which the m in the blood is lower than nation was obtained from the gov/ency/article/000479.htm.					
	information was ob	noderate to severe pain. This tained from the website: gov/druginfo/meds/a682132.h					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		(X3) DAT	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			857	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109	1 04	700/2017
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F 282	placement of a feet the stomach wall. It stomach. This info website: https://medlineplus.  10. Used to relieve headaches, muscle colds and sore thro and reactions to vareduce fever. Aceta to relieve the pain o caused by the breal	eeding tube insertion is the ding tube through the skin and a goes directly into the rmation was obtained from the gov/ency/article/002937.htm.  mild to moderate pain from aches, menstrual periods, ats, toothaches, backaches, ccinations (shots), and to minophen may also be used of osteoarthritis (arthritis kdown of the lining of the	F 2	282			
	antipyretics (fever re the way the body se body. This informat website: https:	hen is in a class of analgesics (pain relievers) and educers). It works by changing enses pain and by cooling the cion was obtained from the gov/druginfo/meds/a681004.h					
	4. The facility staff facomprehensive care of fall mats for Resid	plan for the implementation					
	04/14/14 with diagno not limited to: anemi	admitted to the facility on oses that included but were a (1), hypertension (2), , dementia (4), anxiety (5), and depression.					
		recent MDS (minimum data					

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#### PRINTED: 04/13/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495038 B. WING 04/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS HEALTH AND REHAB CENTER MANASSAS, VA 20109 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) F 282 Continued From page 21 F 282 (assessment reference date) of 01/12/17, coded Resident # 9 as scoring a six on the brief interview for mental status (BIMS) of a score of 0 - 15, six being severely impaired of cognition for making daily decisions. Resident # 9 was coded as requiring extensive assistance of one staff member for activities of daily living. On 04/04/17 at 3:40 p.m. an observation of Resident # 9 revealed she was lying in her bed and the fall mats were folded under the bed. On 04/04/17 at 4:20 p.m. an observation of Resident # 9 revealed she was lying in her bed and the fall mats were folded under the bed. On 04/04/17 at 5:00 p.m. an observation of Resident # 9 revealed she was lying in her bed and the fall mats were folded under the bed. On 04/05/17 at 8:30 a.m. an observation of Resident # 9 revealed she was lying in her bed and the fall mats were folded under the bed. The care plan for Resident #9 dated 02/17/2014 with a revision date of 01/25/2017 documented. "(Resident #9) is at risk for falls r/t (related to) decreased mobility, cognitive impairment impacting ability to understand own physical limitations." Under "Interventions/Tasks" it documented, "Fall safety mats at bedside when in bed."

The facility's "Fall Risk Assessment" for Resident # 9 dated 01/10/2017 documented, "High Risk."

conducted with ASM # 2, the director of nursing

On 4/5/17 at 4:10 p.m. an interview was

regarding a resident's care plan. ASM

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PRINTED FORM	D: 04/13/2017 A APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	OMB NC (X3) DA	). 0938-0391 TE SURVEY MPLETED
NAME OF	DOOMINED OF CHAPT	495038	B. WING			04	C /06/2017
	PROVIDER OR SUPPLIER SAS HEALTH AND REI	HAB CENTER		85	REET ADDRESS, CITY, STATE, ZIP CODE 175 RIXLEW LANE ANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
	On 4/5/17 at 5:15 p. member) # 1, the acdirector of nursing, vabove findings.  No further information References:  1. Low iron. This information the website: https://www.nlm.nih.g.  2. High blood pressure obtained from the websitined from the website https://www.nlm.nih.gessure.html.  3. A chronic disease regulate the amount of information was obtained https://www.nlm.nih.ge.001214.htm.  4. A loss of brain functions are independent, and behavior betained from the website individual of the control of the second of the control	member) # 2 stated, "The followed."  m. ASM (administrative staff dministrator and ASM # 2, the were made aware of the vere made aware of the vertice on was provided prior to exit.  This information was ebsite: gov/medlineplus/highbloodpr in which the body cannot of sugar in the blood. This ined from the website: gov/medlineplus/ency/article/ etion that occurs with certain emory, thinking, language, for. This information was	F 2	82	JEHCIENCY)		
; ;	5. Fear. This informa website:	tion was obtained from the					

PRINTED: 04/13/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED			
		405000				С ,		
NAME OF	PROVINCE OF STIPPLIER	495038	B. WING		04	/06/2017		
	SAS HEALTH AND RE		STREET ADDRESS, CITY, STATE, ZIP CODE  8575 RIXLEW LANE  MANASSAS, VA 20109					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
F 282	Continued From pa 6. A sudden uncoor	age 23 rdinated muscle movement	F 282	2				
	due to disease or in	njury to the cerebellum in the ation was obtained from the	7 distribute	F 309				
F 309 SS=E	https://medlineplus.	.gov/ency/article/001397.htm. ) PROVIDE CARE/SERVICES ELL BEING	F 309	Resident #8 will be re-assessed				
; ; ; ; ; ; ;	applies to all care ar residents. Each res facility must provide services to attain or practicable physical, well-being, consister comprehensive asset 483.25 Quality of care Quality of care is a frapplies to all treatmet facility residents. Bas assessment of a rest that residents receive accordance with propractice, the comprecare plan, and the rebut not limited to the (k) Pain Management The facility must ensprovided to residents consistent with profest the comprehensive pand the residents' go	andamental principle that and services provided to facility sident must receive and the ethe necessary care and maintain the highest I, mental, and psychosocial ent with the resident's ressment and plan of care.  Are fundamental principle that ent and care provided to ased on the comprehensive sident, the facility must ensure by treatment and care in ofessional standards of ethensive person-centered esidents' choices, including et following:  Int.  Source that pain management is so who require such services, essional standards of practice, person-centered care plan, oals and preferences.		for pain and findings will be reviewed by the interdisciplinar team and his plan of care will be revised as indicated. Nursing stawill be re-educated on implementation of non-pharmacological interventions prior to medication as an adjunct to pain management.  Resident #9 will be re-assessed for pain and findings will be reviewed by the interdisciplinary team and her plan of care will be revised as indicated. Nursing stawill be re-educated on implementation of non-pharmacological interventions prior to medication as an adjunct to pain management.	e aff ct y e			
· (	(I) Dialysis. The facil residents who require	ility must ensure that e dialysis receive such						

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED	
	,	495038	B. WING		04/0	
	PROVIDER OR SUPPLIEF	R		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	04/0	06/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD BE	(X5) COMPLETION DATE
	of practice, the corcare plan, and the preferences. This REQUIREME by: Based on staff into and clinical record the facility staff failthighest level of we in the survey samp #13.  1. The facility staff non-pharmacologic administration of Plandication for Res  2. The facility staff the non-pharmacologic administration of Plandication for Resident administration for Resident for Resident Reside	ent with professional standards imprehensive person-centered e residents' goals and entered eresidents' goals and enview, facility document review review, facility document review review, it was determined that led to maintain residents' ell-being for four of 25 residents ole, Residents #8, #9 #10 and failed to implement cal interventions prior to the PRN (as needed) pain sident #8.  failed to implement cal interventions prior to the PRN (as needed) pain sident #9.  failed to administer Clonidine the physician when Resident depressure was greater than failed to obtain Resident #13's fordered by the physician prior in of the medication Norvasc blood pressure (2)) from 0/17.	F 309		ure r . ults /17 sing	
1	<ol> <li>The facility staff fa</li> </ol>	ailed to implement				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[ ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		!	7. DOLED				С
		495038	B. WING	***************************************		0	4/06/2017
NAME OF I	PROVIDER OR SUPPLIEF	R		S7	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANASS	SAS HEALTH AND R	EHAR CENTER			575 RIXLEW LANE		
MMMAGC	AS TILALITI AND IC	EIMD CENTER		M	IANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	Continued From p	page 25	F 3	309	2. A review of 24 hour report fo	or	
:		ical interventions prior to the			past 72 hours will be completed		
administration pf PRN (as no medication for Resident #8.			A A .		to verify nurses offered and	•	
	medication for ite	sident #o.	L and		documented non-		
		admitted to the facility on			pharmacological interventions	*	,
	03/15/16 with diag not limited to: atria	gnoses that included but were			prior to medication		ris orangement
		I reflux disease (2), diabetes	water party department		administration.		se process and an a transfer and a second
	mellitus (3), arthrit	tis, anxiety (4), depression,	j  -				as made:
		(5), dysphagia (6), hypokalemia			A review of residents with order	^S	4 0 000
	(7), and retention	or urme.			for blood pressure medications		i American de Carlos de Ca
		st recent MDS (minimum data			will be completed to verify		
		sessment with an ARD rence date) of 03/20/17, coded			accuracy of data entry for order	S	THE TO LOUIS COMP.
		assessment reference date) of 03/20/17, coded Resident #8 as scoring a 15 on the brief interview or mental status (BIMS) of a score of 0 - 15, 15			with specific parameters.		and the state of t
	for mental status (				3. The Nurse Educator or		:
		ntact for making daily decisions. coded as requiring extensive	The state of the s		designee will educate licensed		
		staff member for activities of	The state of the s		nurses on non-pharmacological		
	daily living.		number of the second		interventions as an adjunct to		
	The POS (Physici	an's Order Sheet) For Resident			medications for pain		
		and electronically signed by			management, data entry for		}
		02/25/17 documented, "Next	Total Administration of the Control		medications with specific		
		26/2017." The POS further ycodone (8) 5 (five) MG	Account		parameters and reading and		
		e 1 (one) tablet via (by) G-Tube	The state of the s		following physician's orders for		
		e (9)] every 6 (six) hours as	0 P		monitoring vital signs prior to		
		noderate to severe. Order Date: etaminophen Liquid (10). Give	TOTAL MANAGEMENT AND A STATE OF THE STATE OF		medications administration. The	1	
		be every 6 hours as needed for			Nurse Educator or designee will		
	mild pain. Order E				educate UM's and supervisory		P
	The care plan for '	Resident #8 dated 03/24/16			staff on Center protocol for		:
		cus: Potential for Pain r/t			reviewing new orders to ensure		
	(related to) arthritis	s, immobility." Under	2		accurate and complete order		
		ks" it documented, "Assist native positioning as a			entry and reviewing 24 hour		
	resident with alten	halive positioning as a	1		endy and reviewing 24 nour		1

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		TO THE OLIVIOLO			OMB MC	J. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) DA	TE SURVEY MPLETED
		495038	B. WING	·		C 4/ <b>06/201</b> 7
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	ODE 1	100/2017
MANAS	SAS HEALTH AND RE	HAD CENTED		8575 RIXLEW LANE		
WIMINAS	SAS HEALTH AND RE	HAB CENTER		MANASSAS, VA 20109		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	l ID	PROVIDER'S PLAN OF COR	PECTION	454204
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	Continued From pa	ae 26	Ė			
,			F 30	J9 ·		
	03/24/2016."	al intervention. Date Initiated:		report to verify nurses are		
	00/2 1/20 10.			offering non-pharmacolog		
	The MAR (medication Resident # 8 dated	on administration record) for "January 2017 documented:		interventions.	icai	
	"Oxycodone 5 (five)	MG (milligrams). Give 1		4) 1) The DON and designe	e will	
	(one) tablet via (by)	G-Tube [gastrostomy tube] as needed for pain moderate		review of resident with blo	od	
	to severe. Order Da	ate: 05/23/2016 "		pressure orders weekly x 4	weeks	
:	"Acetaminophen Liq	uid. Give 650 MG via		and monthly x 2 months fo		v dia
	G-Tube every 6 hou	rs as needed for mild pain.		residents to verify accuracy		
	Order Date: 05/23/2 Further review of the	MAR dated January 2017		data entry for orders with s		
:	revealed acetamino	phen liquid was administered		parameters. The DON or de	•	
	on 01/15/17 at 1:12	p.m. and 01/17/17 at 9:04 Oxycodone was administered		will review findings and rep	0	
	on 01/01/17 at 9:00	p.m., 01/02/17 at 9:05 p.m.,		QAPI Committee for any fur		
	01/03/17 at 9.03 p.m	n., 01/04/17 at 9:45 p.m., m., 01/06/17 at 12:29 p.m.		recommendation.		
	and 9:08 p.m., 01/07	7/17 at 9:20 p.m., 01/08/17 at at 10:43 p.m., 01/10/17 at		2) The DON and designee w	rill	
ı	10:58 a.m., and 8:49	p.m., 01/11/17 at 10:30		review of 24 hour report for	r	
	a.m., and 6:35 p.m.,	01/12/17 at 9:42 a.m. and		implementation of non-		
	a.m., 01/16/17 at 4:1	at 9:02 p.m., 01/14/17 at 9:44 3 p.m., 01/17/17 at 9:02		pharmacological interventic	ns	
	p.m., 01/18/17 at 6:4	9 p.m., 01/19/17 at 9:18		weekly x 4 weeks and mont	hly x 2	
		1 p.m., 01/22/17 at 9:04		months for resident's		
,	n.m. 01/24/17 at 9.0	1 p.m., 01/25/17 at 8:05 7 p.m., 01/27/17 at 3:10 p.m.		interventions per resident's		
	and 9:14 p.m., 01/28	/17 at11:50 a.m., 01/29/17 at		individualized plan of care. 3	Γhe	
	9:24 a.m. and 8:42 p	.m., 01/30/17 at 3:30 p.m.		DON or designee will review		
	and 9:38 p.m. and or	n 01/31/17 8:36 p.m.		findings and report to QAPI	į	
	The MAR (medication	n administration record) for		Committee for any further	İ	
	Resident # 8 dated "I	Eebruary 2017 documented:		recommendation.	;	
	"Oxycodone 5 (five) I	MG (milligrams). Give 1		recommendation.	o de deservición de la companya de l	
		G-Tube [gastrostomy tube]		5. Date of compliance: May	10.	
	every 6 (six) nours as to severe.  Order Dat	s needed for pain moderate		2017	,	
	Oluci Dal	O. OUIZUIZU IU.		2011	:	1

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Facility ID: VA0003

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495038	B. WING			C 04/06/2017		
	PROVIDER OR SUPPLIER SAS HEALTH AND RI			8575 RIX	ADDRESS, CITY, STATE, ZIP C KLEW LANE SSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 309	G-Tube every 6 ho Order Date: 05/23, Further review of the revealed acetaming on 02/01/17 at 9:52 a.m. Oxycodone with 5:26 p.m., 02/02/11:34 a.m. and 9:30 02/08/17 at 9:01 p. 02/10/17 at 9:32 p. 02/13/17 at 9:51 a. 9:42 p.m., 02/15/11 11:08 a.m. and 8:50 02/19/17 at 5:25 p. 02/22/17 at 8:42 p. 02/26/17 at 2:09 p. 7:36 p.m. and on 00 The MAR (medicate Resident # 8 dated "Oxycodone 5 (five (one) tablet via (by every 6 (six) hours to severe. Order Defended oxycodone 9:04 p.m., 03/02/17 p.m. and 9:07 p.m. 03/06/17 at 9:18 p. 03/16/17 at 9:24 p. 03/16/17 at 5:15 p. 03/16/17 at 9:02 p. 03/19/17 at 3:34 p. 9:17 p.m. and on 00 The MAR (medicate M	iquid. Give 650 MG via purs as needed for mild pain. //2016." he MAR dated February 2017 ophen liquid was administered 2 a.m. and 02/26/17 at 9:22 vas administered on 02/01/17 at 7 at 8:44 p.m., 02/05/17 at 8:6 p.m., 02/07/17 at 5:42 p.m., .m., 02/09/17 at 8:31 p.m., .m., 02/11/17 at 11:54 a.m., .m. and 9:02 p.m., 02/14/17 at 7 at 4:03 p.m., 02/16/17 at 3 p.m., 02/18/17 at 5:15 p.m., m., 02/21/17 at 9:05 p.m., m., 02/21/17 at 8:40 p.m., m., 02/23/17 at 8:40 p.m., m., 02/23/17 at 8:40 p.m., m., 02/27/17 at 1:19 p.m. and 02/28/17 at 8:11 p.m.		09				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495038	B. WING			0.4	C
	PROVIDER OR SUPPLIER			STF 857	REET ADDRESS, CITY, STATE, ZIP CODE S RIXLEW LANE NASSAS, VA 20109	04	/06/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	"Oxycodone 5 (five (one) tablet via (by every 6 (six) hours to severe. Order E Further review of the revealed oxycodon 7:51 a.m. and on 0  The "Progress Note 01/01/2017 through and failed to evider non-pharmacologic administration of acoxycodone.  On 4/4/17 at 2:45 p conducted with RN asked to describe the PRN (as needed) pure determine the level ten, check the physical resident was given administering the more resident in an hour effective." When as should be attempted before administering stated, "I should try medication, reposition packs." When asked documented that not severe the severe administering the more stated, "I should try medication, reposition packs." When asked documented that not severe the severe administering the more stated, "I should try medication, reposition packs." When asked documented that not severe the severe administering the more stated, "I should try medication, reposition packs." When asked documented that not severe the severe administering the more stated, "I should try medication, reposition packs." When asked documented that not severe the severe administering the more stated that not severe the severe	e) MG (milligrams). Give 1 ) G-Tube [gastrostomy tube] as needed for pain moderate bate: 05/23/2016." ne MAR dated April 2017 e administered on 04/02/17 at 4/03/17 at 4:04 p.m.  es" for Resident # 8 dated n 04/04/2017 were reviewed nce documentation of cal interventions prior to the cetaminophen liquid and  .m. an interview was (registered nurse) # 6. When the procedure of administering ain medication, RN # 6 stated, the pain is, what type of pain, of pain on a scale of one to ician's orders and when the the last dose. After the last dose. After the see if the medication was sked if alternative approaches d to alleviate a resident's pain g pain medication, RN # 6 other alternatives to pain oning, massage or cold/hot ed where it would be on-pharmacological attempted, RN # 6 stated, "In	F3	09:			
	conducted with LPN 9. When asked to continuous	m. an interview was (licensed practical nurse) # lescribe the procedure of pain medication. LPN # 9					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DA CO	(X3) DATE SURVEY COMPLETED	
		495038	B. WING		04	C 1/06/2017	
	PROVIDER OR SUPPLIE		1	STREET ADDRESS, CITY, STATE, 8575 RIXLEW LANE MANASSAS, VA 20109		700/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE	
	one to ten, check when the resident 30 minutes to an a to see if the medica asked if alternative attempted to alleve administering pair would try reposition packs." When asked documented that a interventions were the progress notes. On 4/5/17 at 3:20 conducted with LF 6. When asked to administering PR stated, "Assess the one to ten, check when the resident non-pharmacologic minutes to an hour see if the medicate in the progress noreview the MARs of and April 2017 and 01/01/17 through a sked to show the non-pharmacological attempted prior to oxycodone and ac LPN # 6 was unable the documentation. On 4/5/17 at 4:10 conducted with AS	the physician's orders and twas given the last dose. After hour I would check the resident cation was effective." When we approaches should be viate a resident's pain before in medication, LPN # 9 stated, "I pring, massage or cold/hot sked where it would be non-pharmacological extempted, LPN # 9 stated, "In s."  p.m. an interview was PN (licensed practical nurse) # or describe the procedure of N pain medication, LPN # 6 he resident for pain on a scale the physician's orders and was given the last dose. Use ical interventions. After 30 her I would check the resident to ion was effective and document of the s." LPN # 6 was asked to dated January, February, March dother the physician that ical interventions were the administration of cetaminophen to Resident # 8, onle to provide any evidence of	F3	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495038	B. WING			04	C -/06/2017	
NAME OF PROVIDER OR SUPPLIER		1		EET ADDRESS, CITY, STATE, ZIP CODE	1 04	100/2017		
MANASSAS HEALTH AND REHAB CENTER			8575	5 RIXLEW LANE NASSAS, VA 20109				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 309	(administrative starshould try and should the adirector of nursing, above findings.  No further information References:  1. A problem with the heartbeat. This information the website: https://www.nlm.nihon.html.  2. Stomach content the esophagus and was obtained from https://www.nlm.nih  3. A chronic diseas regulate the amour information was obhttps://www.nlm.niho01214.htm.	RN pain medication. ASM ff member) # 2 stated they ald be documented in the out. ASM (administrative staff administrator and ASM # 2, the were made aware of the doministrator and accordance of the were made aware of the accordance of the ormation was obtained from a n.gov/medlineplus/atrialfibrillation of the dirritate it. This information	F3	09				
	https://www.nlm.nih #summary.	n.gov/medlineplus/anxiety.html						
		h oxygen passes from your od. This information was vebsite:						

		AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	04/13/2017 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				). 0938-0391 TE SURVEY MPLETED
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NAME OF	PROVIDER OR SUPPLIER		1	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 04	100/2017
MANASS	SAS HEALTH AND RE	HAB CENTER			75 RIXLEW LANE ANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFIGIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	ilure.html.  6. A swallowing discontained from the whttps://www.nlm.nih.sorders.html.  7. Low potassium leamount of potassium normal. This inform website: https://medlineplus.go	.gov/medlineplus/respiratoryfa order. This information was ebsite: .gov/medlineplus/swallowingdi vel is a condition in which the n in the blood is lower than ation was obtained from the gov/ency/article/000479.htm.	F 30	)9			
	information was obta	oderate to severe pain. This ained from the website: gov/druginfo/meds/a682132.h					
:	placement of a feedi the stomach wall. It g stomach. This inforr website:	ding tube insertion is the ng tube through the skin and goes directly into the mation was obtained from the lov/ency/article/002937.htm.					
	10. Used to relieve n headaches, muscle a colds and sore throa and reactions to vacceduce fever. Acetan to relieve the pain of caused by the break joints). Acetaminophemedications called an antipyretics (fever reather way the body ser	nild to moderate pain from aches, menstrual periods, ts, toothaches, backaches, cinations (shots), and to ninophen may also be used osteoarthritis (arthritis down of the lining of the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495038	B. WING			04	C / <b>06/201</b> 7	
	PROVIDER OR SUPPLIER			857	EET ADDRESS, CITY, STATE, ZIP CODE 5 RIXLEW LANE NASSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 309	Continued From p https://medlineplus tml.	age 32 s.gov/druginfo/meds/a681004.h	F3	809				
:	non-pharmacologi	failed to implement cal interventions prior to the PRN (as needed) pain sident # 9.		:				
	04/14/14 with diag not limited to: aner	readmitted to the facility on noses that included but were mia (1), hypertension (2), 3), dementia (4), anxiety (5), and depression.						
	set), a quarterly as (assessment references Resident # 9 as so interview for mental - 15, six being seven making daily decis	st recent MDS (minimum data sessment with an ARD ence date) of 01/12/17, coded oring a six on the brief at status (BIMS) of a score of 0 erely impaired of cognition for ions. Resident # 9 was coded sive assistance of one staff es of daily living.						
	# 9 dated 04/05/17 the physician on 02 Review Date: 04/20 documented, "Tramadol (7) Table (one) tablet by mod	and electronically signed by 2/25/17 documented, "Next 6/2017." The POS further et 50 MG (milligram). Give 1 ath every 8 (eight) hours as the pain. Order Start Date:						
	Resident # 9 dated	ion administration record) for "January 2017 documented: 0 MG (milligram). Give 1						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		TE SURVEY MPLETED
		495038	B. WING			1 '	C
	PROVIDER OR SUPPLIER		J. WINCE	ST 85	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109	04.	/06/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	needed for modera 06/13/2016." Further review of the revealed tramadol at 10:14 a.m.  The MAR for Reside documented: "Tramadol Tablet 5 (one) tablet by mouneeded for modera 06/13/2016." Further review of the revealed tramadol at 10:20 p.m., 02/04 5:12 a.m., and on 07 the MAR for Reside documented: "Tramadol Tablet 5 (one) tablet by mouneeded for modera 06/13/2016." Further review of the revealed tramadol at 4:59 p.m. and on 07 the "Progress Note 01/11/2017 through and failed to evider non-pharmacologic administration of trailing of the table to describe the producted with RN asked to describe the producted of the table to the table table to the table ta	ath every 8 (eight) hours as atte pain. Order Start Date:  The MAR dated January 2017 was administered on 01/11/17  The start # 9 dated "February 2017  O MG (milligram). Give 1 of the every 8 (eight) hours as the pain. Order Start Date:  The MAR dated February 2017 was administered on 02/01/17 of 1/17 at 9:28 p.m., 02/07/17 at 1/1/17 at 1/2:16 p.m.  Then # 9 dated "March 2017  O MG (milligram). Give 1 of the every 8 (eight) hours as the pain. Order Start Date:  The MAR dated March 2017 was administered on 03/16/17 of 03/29/17 at 2:00 a.m.  The start P dated was administered on 03/16/17 of 03/29/2017 were reviewed ace documentation of all interventions prior to the	The state of the s	309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495038	B. WING		1	C <b>/06/2017</b>
	PROVIDER OR SUPPLIER	R	8	STREET ADDRESS, CITY, STATE, ZIP CODE S575 RIXLEW LANE MANASSAS, VA 20109	1 041	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTY)	D BE	(X5) COMPLETION DATE
F 309	ten, check the phy resident was giver administering the resident in an hou effective." When a should be attempt before administeri stated, "I should tr medication, reposition packs." When ask documented that rinterventions were the progress notes. On 4/4/17 at 2:55 conducted with LP 9. When asked to administering PRN stated, "Assess the one to ten, check to when the resident 30 minutes to an hit o see if the medicasked if alternative attempted to allevi administering pain would try reposition packs." When ask documented that rinterventions were the progress notes. On 4/5/17 at 3:20 pconducted with LP conducted with L	el of pain on a scale of one to ysician's orders and when the in the last dose. After medication I would check the ur to see if the medication was asked if alternative approaches ted to alleviate a resident's paining pain medication, RN # 6 ry other alternatives to pain sitioning, massage or cold/hot ked where it would be non-pharmacological attempted, RN # 6 stated, "In s."  p.m. an interview was PN (licensed practical nurse) # o describe the procedure of N pain medication, LPN # 9 he resident for pain on a scale the physician's orders and was given the last dose. After hour I would check the resident cation was effective." When e approaches should be inate a resident's pain before in medication, LPN # 9 stated, "In oning, massage or cold/hot ked where it would be non-pharmacological attempted, LPN # 9 stated, "In attempted in the last dose.	F 309			
	stated, "Assess the	N pain medication, LPN # 6 e resident for pain on a scale the physician's orders and			a V	

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		AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	04/13/2017 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I .		CONSTRUCTION	(X3) DAT	. 0938-0391 FE SURVEY MPLETED
		495038	B. WING _			1	C / <b>06/201</b> 7
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 04.	700/2017
MANASS	SAS HEALTH AND RE	HAB CENTER			75 RIXLEW LANE ANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	The second secon	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	Continued From page	ge 35	F 30	) )9			
	non-pharmacologica minutes to an hour I see if the medication in the progress note review the MARs da March 2017 and the 01/11/17 through 03 When asked to show non-pharmacologica attempted prior to the to Resident # 9, LPN any evidence of the On 4/5/17 at 4:10 p.i conducted with ASM regarding the implen of non-pharmacologicadministration of PR (administrative staff)	e administration of tramadol I # 6 was unable to provide documentation.					
	On 4/5/17 at 5:15 p.r member) # 1, the ad	n. ASM (administrative staff ministrator and ASM # 2, the ere made aware of the					
1	No further informatio	n was provided prior to exit.					
i	References:	1					
t	he website:	rmation was obtained from ov/medlineplus/anemia.html					
2	2. High blood pressur	re. This information was bsite:					

PRINTED: 04/13/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING C 495038 B. WING 04/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS HEALTH AND REHAB CENTER MANASSAS, VA 20109 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 309 Continued From page 36 F 309 https://www.nlm.nih.gov/medlineplus/highbloodpr essure.html. 3. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 001214.htm. 4. A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. 5. Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. 6. A sudden uncoordinated muscle movement due to disease or injury to the cerebellum in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/001397.htm. 7. Used to relieve moderate to moderately severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.ht ml.

160.

3. The facility staff failed to administer Clonidine (1) as ordered by the physician with Resident #10's systolic blood pressure was greater than

Resident #10 was admitted to the facility on 1/30/16 and readmitted on 3/31/16 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495038	B. WING			l .	C <b>06/2017</b>
	PROVIDER OR SUPPLIE SAS HEALTH AND R	R	<b>I</b>	STI 857	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109	1 04/	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE	(X5) COMPLETION DATE
F 309	diagnoses that inc stroke, high blood diabetes. The moset), an annual as (assessment refer resident as having BIMS (brief intervi- the resident was of decisions. The res- minimal assistanc living except for draneeded moderate Review of Resider 2/12/16 and revise "Focus. (Resident cardiovascular stated day to day function (high blood pressured Administer medical per MD (medical diabetes).	cluded but were not limited to: pressure, depression and st recent MDS (minimum data sessment, with an ARD rence date) of 2/8/17 coded the g scored a 14 out of 15 on the ew for mental status) indicating cognitively intact to make daily sident was coded as needing e from staff for activities of daily ressing which the resident staff assistance.  Int #10's care plan created on ed on 3/6/17 documented, #10's initials) has altered tus which may impacts (sic) In r/t (related to) hypertension Interventions/Tasks. Interventions/Tasks. Interventions as ordered. Vital Signs Indicated symptoms). Notify physician of	F	309			
	documented, "Clol (indicated in the treat Tablet 0.1 MG (mill every 12 hours as number of blood provided provided provided in the treat to the treat treat to the treat tr	sician's orders dated April 2017 NIDIne HCL (hydrochloride) eatment of hypertension (1)) ligram) Give 1 tablet by mouth needed for systolic (top ressure - when the heart beats od (2)) b/p (blood pressure) Start Date. 11/15/2016."  2017 MAR (medication ord) documented, "CloNIDIne of (milligram) Give 1 tablet by urs as needed for systolic b/p reater than 160. Start Date. r each day of the month there					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	į.	X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495038	B. WING	<b>L</b> OTO CONTRACTOR AND				C <b>06/201</b> 7	
	PROVIDER OR SUPPLIER	HAB CENTER		857	REET ADDRESS, CITY, STATE, ZIP CO 5 RIXLEW LANE NASSAS, VA 20109	DE	U-4/	00/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULDE	3E	(X5) COMPLETION DATE	
F 309	pressure)" and the needed)." There wa	ne box was titled, "BP (blood other box was titled "PRN (as as no documentation bod pressure results or if the	F 3	! 309 -					
	summary record do pressures were take pressure of 171/68 Review of the Dece evidence document	#10's blood pressure cumented that blood en once a week. A blood on 12/8/16 was documented. mber 2016 MAR did not ation of the blood pressure or ad been administered.							
	record documented on 11/19/16 was do November 2016 MA	e blood pressure or that the							
	12:15 p.m. with RN of who cared for the rethe process staff foll blood pressure para #8 stated, "You would and if the blood pressures give it." When asked the blood pressures medication would not "There's no reason revere reviewed with F	w was conducted on 4/5/17 at (registered nurse) #8, a nurse sident. When asked about ows when a physician orders meters for a medication, RN d take the blood pressure sure was over 160 you would if there was any time that would not be checked or the begiven, RN #8 stated, not to do it." The findings RN #8. RN #8 stated, "That's m. I'm assuming he's one of					The second secon		

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495038	B. WING				C
NAME OF	PROVIDER OR SUPPLIER		L. Wille	,	STREET ADDRESS, CITY, STATE, ZIP CODE	04	<b>/06/2</b> 017
MANAS	SAS HEALTH AND RE	HAB CENTER		8	B575 RIXLEW LANE WANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPRINCE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	the patients that ge week." When asked doctor's order, RN # An interview was cop.m. with RN (regist unit manager. When staff follows for physparameters on a menurse would check blood pressure was medication." When document the blood would show up in the report), but when give parameter, a spot for MAR)." When asked manage Resident # stated, "If his BP is I We don't want him to stroke." RN #5 was	ge 39 Its his BP checked once a It if that superseded the It stated, "No, I'm so sorry." Inducted on 4/5/17 at 1:10 Itered nurse) #5, the interim In asked about the process Isician ordered blood pressure Iteredications, RN #5 stated, "The Itered nurse would give the Itered if the nurse would give the Itered stated, "Itered would give the Itered give the summary Itered give the summary Itered give the stated, "Itered give the give the give the give the Itered give the give	F	309			
	p.m. with RN #6, the asked about the prophysician ordered bl RN #6 stated, "You of the parameter the m When RN #6 review pressure for 12/8/16 been given." When a why the medication stated, "No."  An interview was cor (administrative staff nursing. The physicial	ood pressure parameters, check the BP first. If it's above ledication should be given." ed Resident #10's blood, she stated, "It should have asked if there was any reason should not be given, RN #6					

AND PLAN OF CORRECTION IDENTIFICA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DA	(X3) DATE SURVEY COMPLETED	
		495038	B. WING			C 04/06/2017	
	PROVIDER OR SUPPLIER	HAB CENTER		8575	EET ADDRESS, CITY, STATE, ZIP COD 5 RIXLEW LANE NASSAS, VA 20109		100/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	ASM #2 stated, "W If we obtain a BP g administer the Clor asked if she expect ASM #2 stated, "Ye following doctor's o On 4/5/17 at 4:15 p no policy on followin followed nursing stated, "Lippincott." #1, the administrate nursing were made	age 40 parameters for a medication, e should see a twice a day BP. reater than 160 we should hidine as ordered." When ted staff to follow the order, is." A request for a policy on orders was made at that time. I.m. ASM #2 stated there was an doctor's orders that staff andard practice. When asked and the facility used, ASM #2 On 4/5/17 at 5:15 p.m. ASM or and ASM #2, the director of aware of the findings. No was provided prior to exit.	F3	09:			
	indicated in the trea Clonidine hydrochlo or concomitantly wit agents. This information https://dailymed.nlm m?setid=438dece9- 60	nidine hydrochloride is tment of hypertension. ride may be employed alone th other antihypertensive ation was obtained from: n.nih.gov/dailymed/drugInfo.cf .95d4-40f2-84b4-9e2c6d88e7					
	obtained from the w	essure- This information was ebsite: a.gov/health/health-topics/topi					
	blood pressures as to the administration	failed to obtain Resident #13's ordered by the physician prior of the medication Norvasc lood pressure (2)) from					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495038	B. WING			-	C
NAME OF PROVIDER OR SUPE	PLIER		STF 857	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109	04,	/06/2017
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL 'OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRED TO THE APPROPRIED TO THE A	D BE	(X5) COMPLETION DATE
9/16/10 with dialimited to: dem impairment (1) pressure and he assessment, a assessment resident as have memory difficulto make daily of was coded as mone or more state of daily living.  The physician of "Norvasc (used 10 MG (milligramorning related HYPERTENSIC SBP (systolic billion of the MAR (med March 2017 does 11 tablet by mouted	vas admitted to the facility on agnoses that included but were not entia, stroke, dysphagia (speech), contractures, high blood istory of falling.  Int MDS (minimum data set) quarterly assessment with an ference date of 3/8/17, coded the ring both short and long term ties and being severely impaired ognitive decisions. The resident equiring extensive assistance of aff members for all of his activities order dated, 8/16/16, documented, to treat high blood pressure (2)) ms); Give 1 tablet by mouth in the late ESSENTIAL (PRIMARY) on (high blood pressure). Hold for cood pressure) < (less than) 100." ication administration record) for cumented, "Norvasc 10 MG; Give th in the morning related to RIMARY) HYPERTENSION. Hold "The MAR documented the ed the medication from 3/1/17 through 3/8/17. There pressures documented from	F	309			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON			(X3) DAT	TE SURVEY MPLETED
		495038	B. WING	;		į.	C
	PROVIDER OR SUPPLIER SAS HEALTH AND RI			ST 85	REET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE ANASSAS, VA 20109	04	/06/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (CROSS-REFERENCE)	D BE	(X5) COMPLETION DATE
	The comprehensive documented in parrisk for complication Cerebrovascular Descriptions of the complication of the complete of t	"There were no parameters cian order.  e care plan dated, 3/22/17 t, "Focus: (Resident #13) is at ns r/t (related to) isease (stroke)." The umented in part, "Give ered by the physician. fects and effectiveness. Vital cility protocol. Document and abnormal findings as  a.m., an interview was I (licensed practical nurse) #2. to review Resident #13's to 3/20/17. LPN #2 was is expected to do when they er like the Norvasc order #2 stated, "You have to take before you give the medicine ssure (systolic) is less than edication, call the doctor and sible party)." When shown R where no blood pressures from 3/9/17 through 3/20/17, et doctors and the DON had a meeting to take the eresident was stable." LPN #2 order was changed and if the if the doctor had not changed PN #2 stated, "I don't know.	F3	809			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS	TRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495038	B. WING			1	C <b>06/2017</b>	
	PROVIDER OR SUPPLIER	HAB CENTER		8575 RIX	ADDRESS, CITY, STATE, ZIP CODE LEW LANE SAS, VA 20109	1 041	00/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
	physician order like Resident #13. LPN take the blood pres medication. If the blood, then the nurse and notify the physi March 2017 was shwhy there were no be from 3/9/17 through don't know. I would the administrator, cadministrative staff corporate nurse and (resident assessme were made aware of at 5: 24 p.m.  No further information (1) Barron's Dictional Non-Medical Reade Chapman, page 178 (2) This information following website:	the Norvasc order for #1 stated, "The nurse has to sure before giving the blood pressure is less than should hold the medication cian and RP." The MAR for own to LPN #1. When asked blood pressures documented 3/20/17. LPN #1 stated, "I have to research that."  direction of nursing, member (ASM) #3, the HASM #4, the corporate RAI in tinstrument) consultant, for the above findings on 4/5/17 on was provided prior to exit.  The arry of Medical Terms for the results, sure of the sure of the results, and the sure of the results, and the sure of the results of the sure of the results. The sure of the sure o	F 3		The licensed nurse working with Resident #5 on 1/17/17 who failed to document assessment of pressure injury and			
SS=D	(b) Skin Integrity -  (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-		. 3		treatment is no longer employed in the Center. Resident #5's pressure injury remains resolved. A Braden assessment is current with preventative measures are in place.			

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498 20 30**7** 



AND PLAN OF CORRECTION I IDENTIFICATION NUMBER: I			E CONSTRUCTION		X3) DATE SURVEY COMPLETED					
			7	1110	Antimontal montana against against an ann an		С			
		495038	B. WING			1	/06/2017			
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE					
MANASS	SAS HEALTH AND RE	EHAB CENTER			575 RIXLEW LANE					
				M	IANASSAS, VA 20109					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETION DATE			
F 314	Continued From pa	- ,	F 3	314	2. Current residents will					
	(i) A resident receiv	ves care, consistent with	· · · · · · · · · · · · · · · · · · ·		have body audits					
,	professional standa	ards of practice, to prevent	İ		completed to verify skin					
	pressure ulcers and	nd does not develop pressure	ĺ		integrity; any areas		And and an and an an an an an an an an an an an an an			
		ndividual's clinical condition they were unavoidable; and	i f		•		Milliode a com on			
	Gernonstrates that	they were unavoluable, and	***		identified nurse will verify					
1		pressure ulcers receives	i		an appropriate treatment		-			
	necessary treatmer	nt and services, consistent with	i		in place per MD orders					
		ards of practice, to promote	!		and documented and					
	from developing.	fection and prevent new ulcers		notification of MD/RP.						
		NT is not met as evidenced			Current residents will be					
	by:				reviewed to ensure up to					
		tion, staff interview, facility			date Braden assessments		i i			
		and clinical record review, it at the facility staff failed to			are completed and					
		ervices for the prevention and			·					
	treatment of a press	sure ulcer for one of 25			preventative measures					
; !	residents in the sur	vey sample, Resident #5.			are in place.					
	The facility staff fail	led to measure and track a			3. Nursing staff will be	İ				
	Stage I pressure uk	cer* documented as redness			educated by the Nurse	İ	P ( )			
	in November 2016,	and failed to measure, stage			Educator or designee on					
	and track an open a	area pressure ulcer identified			pressure injury					
		dent #5's ADL (activities of On 1/23/17 the wound nurse			prevention, altered skin					
		ctical nurse] #3) documented			integrity alerts,					
		ssure sore was present on			assessment of skin	ļ				
	Resident #5's coccy	yx, the wound was evaluated			integrity, notification of	m vy sociolo	· · · · · · · · · · · · · · · · · · ·			
		or on 1/25/17 and documented			MD/RP and	1				
		sure ulcer **. The facility staff lete a quarterly Braden Scale				;				
		sident #5. Resident #5 did not			implementation of					
	have a Braden scale	e assessment completed after			treatment and Centers					
		, when a pressure injury* was			protocol on monitoring	1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
	identified.	:			dashboard for alerts and					
	*Pressure Injury: A	pressure injury is localized			tracking pressure injuries.					
		and underlying soft tissue			<b>3</b> 1	1				

#### PRINTED: 04/13/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ C 495038 B. WING 04/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS HEALTH AND REHAB CENTER MANASSAS, VA 20109 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 314 Continued From page 45 F 314 4. The Don or Designee will usually over a bony prominence or related to a randomly audit 5 medical or other device. The injury can present as intact skin or an open ulcer and may be electronic medical painful. The injury occurs as a result of intense records for and/or prolonged pressure or pressure in documentation of risk for, combination with shear. The tolerance of soft tissue for pressure and shear may also be development of wound affected by microclimate, nutrition, perfusion, treatment/intervention in co-morbidities and condition of the soft tissue. (1) place weekly x 4 weeks \*Stage 1 Pressure Injury: Non-blanchable and then Monthly x 2. erythema of intact skin The DON will review Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly findings and report to pigmented skin. Presence of blanchable **QAPI** Committee for any erythema or changes in sensation, temperature. further recommendation. or firmness may precede visual changes. Color changes do not include purple or maroon 5. May 10,2017 discoloration; these may indicate deep tissue pressure injury. (1) \*\*Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar

The findings include:

obscures the extent of tissue loss this is an

Resident #5 was admitted to the facility on

3/22/12 with diagnoses that included but were not limited to: dementia, schizophrenia, high blood

Unstageable Pressure Injury. (2)

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DA	TE SURVEY
AND FEMA	DF CORNECTION	IDENTIFICATION NUMBER:	A. BUILDING _		CO	MPLETED
		495038	B. WING		04	C 1/06/2017
	PROVIDER OR SUPPLIER		85	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	The most recent M assessment) a qua assessment referer resident as having memory difficulties being severely impadecisions. Resident extensive assistant of her activities of cobathing in which shathe staff for these accoded as being frequine and bladder. If the resident was copressure area that a (centimeters) in lendem in depth.  The MDS prior to the 2/8/17 was completed.	osis, diabetes, anemia, y and depression.  DS (minimum data set arterly assessment, with an ance date of 2/8/17, coded the both short and long term. The resident was coded as aired to make daily cognitive at #5 was coded as requiring are of one staff member for all daily living except eating and e was totally dependent upon activities. The resident was quently incontinent of both an Section M - Skin Conditions, and as having one Stage 3 measured 0.4 cm gth, 0.5 cm in width and 0.2	F 314			
	***Stage 1 Pressure erythema of intact s Intact skin with a loo erythema, which ma pigmented skin. Pre erythema or change or firmness may pre changes do not incli	e Injury: Non-blanchable				
	The "Braden Scale t	for Predicting Pressure Sore				3

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Event ID: 3CQ311

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	TO TOTAL DIOTAL	A MEDICAID SERVICES				JIMR IAC	). 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495038	B. WING			04	C / <b>06/201</b> 7
	PROVIDER OR SUPPLIER SAS HEALTH AND RE	HAB CENTER		85	REET ADDRESS, CITY, STATE, ZIP CODE 675 RIXLEW LANE ANASSAS, VA 20109	1	100/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	Resident #5 was a developing a pressure for Risk and documented Refor developing a pressure Sore Risk and documented Refor developing a pressure a patient/clien pressure ulcers. It may be a capabilities of the particular intensity and tissue tolerance for pressure ulcer developing indicate pressure ulcer developing and 4 for impairment). Total so subscales scored was subscales measure patient that contribute and duration of pressure tolerance for pressure tolerance for pressure tolerance for pressure tolerance for pressure tolerance for pressure tolerance for pressure tolerance for pressure tolerance for pressure tolerance for pressure tolerance for pressure tolerance for pressure tolerance for pressure tolerance for pressure tolerance for pressure to the	dated; 7/3/16 documented 'Moderate Risk" for are ulcer.  "Braden Scale for Predicting Original;" was dated 1/23/17 esident #5 was a "Low Risk" ssure ulcer.  or Predicting Pressure Sore alidated tool that allows alth care providers to reliably t's level of risk for developing reasures functional attent that contribute to either duration of pressure or lower pressure. Lower levels of higher levels of risk for opmentThe Braden Scale g scale made up of six om 1-4 (1 for low level of the highest level or no cores range from 6-23 (one with values of 1-3, only). The functional capabilities of the et o either higher intensity	F3	:14			
	development. (4) A review of "Body Au #5's revealed the foll - 10/5/16, "Skin integ	egrity intact - No." At the					
	documented, "redness	e following was as noted to her buttock area." for the following questions:					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION	(X3) DA	(3) DATE SURVEY COMPLETED	
		495038	B. WING		0.	C 4/ <b>06/201</b> 7	
	PROVIDER OR SUPPLIER  SAS HEALTH AND RE	HAB CENTER		STREET ADDRESS, CITY, STATE, Z 8575 RIXLEW LANE MANASSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 314	Responsible party r - 10/19/16, "Skin in bottom of the form documented: "Wee new skin issue note - 10/26/16, "Skin in - 11/2/16 documented: "Week slight redness noted cream applied, TAR (every) 2 hrs. (hours - 11/9/16, "Skin inte - 11/17/16, "Skin inte - 12/3/16, "Skin inte - 12/11/16, "Skin inte - 12/11/16, "Skin inte - 12/11/16, "Skin inte - 12/11/16, "Skin inte - 12/11/17, "Skin inte - 1/1/17, "Skin integ of the form the follow "Weekly skin assess	Physician notified and notified"was blank. tegrity intact - yes." At the the following was kly skin assessment done noted." tegrity intact - yes." ted, "Skin integrity intact - No." form the following was thy skin assessment done, at on buttocks area, protective P (turn and reposition Q s) maintained." tegrity intact - yes." tegrity intact - yes." tegrity intact - yes." tegrity intact - yes." tegrity intact - yes." tegrity intact - yes." tegrity intact - yes." tegrity intact - yes." tegrity intact - yes." tegrity intact - yes." tegrity intact - yes." tegrity intact - yes." tegrity intact - yes." tegrity intact - yes."	F 3	14			
	yes." At the bottom documented: "Week new skin issue." - 1/23/17, "Skin interbottom of the form the documented: Coccy injury**** 1 cm x (by eschar, 10% slough defined, surrounding	ed, "Skin integrity intact - of the form the following was dy skin assessment done no grity intact - no." At the					

		AND HUMAN SERVICES  MEDICAID SERVICES			•	FORM	: 04/13/2017 1 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ł		E CONSTRUCTION	(X3) DAT	. 0938-0391 TE SURVEY MPLETED
		495038	B. WING	i		l.	C /06/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANASS	SAS HEALTH AND RE	HAB CENTER			575 RIXLEW LANE IANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	full-thickness skin a Full-thickness skin a extent of tissue dam be confirmed becau eschar. If slough or 3 or Stage 4 pressu Stable eschar (i.e. d erythema or fluctuar limb should not be s  A review of the nurse following documente - 10/4/16 at 8:20 p.r buttock area cream TARP (turn and repo son notified via phor notified will have wor tomorrow."  There was no further nurse's notes related The next nurse's not skin was dated 1/23/ documented, "Resid- in buttocks which me bleeding or drainage or symptoms) of infe nss (normal saline so dressing applied. Mi notified. New order f This was written by L nurse) #2.  The next note on 1/2 documented by the we	essure Injury: Obscured and tissue loss and tissue loss in which the nage within the ulcer cannot use it is obscured by slough or eschar is removed, a Stage re injury will be revealed. Iry, adherent, intact without nace) on the heel or ischemic coftened or removed. (5)  e's notes revealed the ed entries:  m. "Redness noted to her applied aid was instructed to osition) q (every) 2 (hours) ne, MD (medical doctor) and nurse evaluate  of documentation in the documentation in the ed to this area of redness.  The related to Resident #5's 17 at 6:52 a.m. The note ent noted with an open area easures 1.8 cm X 2 cm. No anoted on site. No s/s (signs action noted. Area clean with colution), pat dry and foam D and RP (responsible party) for wound consult received."  EN (licensed practical 3/17 at 6:15 p.m. was yound nurse, LPN #3. The	F 3	314			
		his nurse was notified of an					

open area to residents coccyx, upon assessment,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING	COV	(X3) DATE SURVEY COMPLETED		
		495038	B. WING		i	C /06/2017		
	PROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, 8575 RIXLEW LANE MANASSAS, VA 20109		00/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
	cm X 0.2 cm (width eschar (necrotic or slough, no drainage surrounding area no of) pain. Body audi noted. MD notified. (Santyl is a sterile eused to that has a uin necrotic tissue (6 mattress. Wound onotified, braden (sic therapy and RD (regrequested."  The "Pressure Ulce dated 1/23/17, docupressure injury 1 cm eschar, 10% yellow edges defined, surroc/o pain. "Description highlighted. The phwere notified on 1/2  The Wound Consult documented in part, Coccyx. Wound size Granulation Tissue:  The comprehensive dated, 3/27/12 with documented in part (Resident #5) has a development r/t (relative transport of the comprehensive transport of the comprehensive dated, 3/27/12 and a revise Encourage to turn/rehours as tolerated, resident descriptions.)	e pressure injury 1 cm X 1.5 times length time depth), 90% black tissue) 10% yellow e, no odor, edges defined, o redness, no c/o (complaint t done with no further issues N.O. (new order) Santyl enzymatic debriding ointment unique ability to digest collagen )) and foam Q (every) shift, air eleaned and dressed, RP e) reassessed; 16 low risk, gistered dietician) screen  r Report" for Resident #5 mented, "Coccyx unstageable o x 1.5.cm x 0.2 cm, 90% slough, no drainage, no odor, bunding area no redness, no on of healing" - "New" was ysician and responsible party 3/17 at 1:00 p.m.  tant Report, dated 1/25/17, "Stage 3 Pressure Wound e - 0.7 x 0.5 x 0.3cm.	F3					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	TIPLE CONSTRI		(X3) DATE SURVEY COMPLETED	
		495038	B. WING			04	C / <b>06/201</b> 7
	PROVIDER OR SUPPLIER SAS HEALTH AND R			8575 RIXLE	DRESS, CITY, STATE, ZIP ( EW LANE AS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EA	PROVIDER'S PLAN OF CO ACH CORRECTIVE ACTION ISS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 314	breakdown. 7/21/ to MD PRN (as not appearance, color and symptoms) of (times) width X de Resident #5's TAF record) for Januar "Zinc Oxide (a top from being irritated (7)) cream to left to measures." The odocumented as had ay in January 20 documented initiated 1/23/17 for: "Santy topically every day Clean coccyx with Santyl, cover with PRN." This was do administered from month. The TAR for documented, "Air every shift." This common the topically every shift. This common the topical put indicating but nurse was notified An interview was conversing assistant) When asked how skin, CNA #1 stated during morning cachange them and	s and treatment of skin 15 - revised on 12/5/16 - Report seeded) changes in skin status: r, wound healing, s/sx (signs infection, wound size (length X	F				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495038	B. WING	_		į.	06/2017
	PROVIDER OR SUPPLIE			85	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109		00/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	nurse." When ask observed an area "We have a barrie that."  On 4/5/17 at 10:12 conducted with LF the nurse that door Resident #5's coor asked about skin #2 stated, "I check shower days, twice #2 was then asked 1/23/17. When ask found on Resident #2 stated, "It was thought it was shound it was shound on 1/23/17, incontinent cream before breakfast as bed in the afternor bottom. Then we An interview was manager, on 4/5/2 explain the pressure coccyx on 1/23/17 investigate that or reports and get bar wound nurse; on a was asked to read p.m. When asked Resident #5's coordinates."	CNA #1 stated, "I call the ted what she does if she with redness, CNA #1 stated, or cream we use and I'd apply 5 a.m., an interview was PN (licensed practical nurse) #2, cumented the open area on cyx on 1/23/17. LPN #2 was assessments for residents. LPN k them (resident's skin) on their e a week and as needed." LPN d to read her nurse's note dated ked to describe the area she t #5's coccyx on 1/23/17, LPN an open area, round. At first I earing. I notified the wound ted what interventions were in t #5, prior to the pressure injury LPN #2 stated, "We had in place. We would get her up and ensure she went back to on to get a rest, off of her get her up for her dinner meal."  Conducted with LPN #1, the unit 17 at 10:28 a.m. When asked to ure ulcer found on Resident #5's Y, LPN #1 stated, "I'd have to ne, I will have to look at the	F3	314			

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Facility ID: VA0003

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		(X3) DATE SURVEY COMPLETED		
		495038	B. WING			1	C <b>06/2017</b>
	PROVIDER OR SUPPLIER	3		STR 857	EET ADDRESS, CITY, STATE, ZIP CODE 5 RIXLEW LANE NASSAS, VA 20109	1 04/1	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	#3 stated, "It was a with 90% eschar - When asked if she prior to 1/23/17, LF asked if it was unuan unstageable staunusual. It doesn't "She (Resident #5 wheelchair too longuickly." When ask place prior to the p 1/23/17, LPN #3 st wheelchair, a pressasked if a pressure standard mattress "Yes, it is." LPN #3 cream." When ask #5 should have obspressure area beforeschar on 1/23/17, so?" LPN #3 was a Scale assessments and who completed nurses do. I have frequency of the aswrong." LPN #3 ret stated, "The Brade quarterly."  On 4/5/17 at 11:30 manager, returned it happened (the prococyx) it just appeats staff should identify eschar present in the would think so."	ented in her 1/23/17 note, "LPN an unstageable coccyx wound black and 10% yellow slough." was aware of any other areas PN #3 stated, "No." When sual to find a pressure sore at age, LPN #3 stated, "It's very happen often." LPN #3 stated, had been sitting in her g. We got it better, it healed sed what interventions were in ressure sore being found on ated, "We had a cushion in her sure reducing mattress." When a reducing mattress is the at this facility, LPN #3 stated, stated, "We used barrier ed if a CNA caring for Resident served Resident #5's coccyx are it was found with 90% LPN #3 stated, "I would hope asked how often the Braden are completed for residents, at them. LPN #3 stated, "The to double check on that (the sessments) so I don't tell you urned at 11:28 a.m. and an Scale (assessment) is done  a.m. LPN #1, the unit and stated, "I don't know how essure sore on Resident #5's ared." LPN #1 was asked if a pressure sore before it has ne wound, LPN #1 stated, "I	F	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		495038	B. WING	3	04	C -/ <b>06/201</b> 7		
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE 8575 RIXLEW LANE MANASSAS, VA 20109	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
F 314	concerns. On 4/5/17 at 2:25 conducted with ac (ASM) #2, the dire wound nurse. ASI (director of nursin assistant director meeting on 1/23/1 an open area (on the clinical meetin (ASM #2), (LPN # the wound. I (ASI wound bed." Whe certified in wound defer to (LPN #3). asked how long st #3 stated she had years. When aske care, LPN #3 state wound but I am no brought this to our looked at the pres my investigation. ASM #2 stated, "I the day before been the ADLs (activitie identification of an applying barrier crarea was on the control of the care was on the care as the state of the care as was on the care as was as the director of the care as was on the care as was as the director of the care as was on the care as was as a care as was as the care as w	p.m. an interview was a standard was the pool of nursing and LPN #3, the pool of nursing and LPN #3, the pool of nursing. In the clinical pool of nursing. In the clinical pool of nursing. In the clinical pool of nursing. In the clinical pool of nursing. In the clinical pool of nursing. In the clinical pool of nursing. In the clinical pool of nursing. In the clinical pool of nursing. In the clinical pool of nursing. In the clinical pool of nursing. In the clinical pool of nursing. In the clinical pool of nursing. In the clinical pool of nursing in the pool of nursing i	F	314	NOT)			
	on 1/23/17 if she winaccurate, LPN #3 Now that I went the	I why she documented her note was now stating it was stated, "I made a mistake. Tough my certification course, I mistake. Since my course. I						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (2		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495038	B. WING			1	C <b>06/201</b> 7
	PROVIDER OR SUPPLIER  SAS HEALTH AND RE	HAB CENTER	ı	STF <b>857</b>	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109	1 047	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	wound bed, LPN #3 where the edges (o itself. That's where the rolled part of the asked what the woustated, "Pinkish, red an oversight on my specialist notes wer wound doctor docur stage 3 pressure injrealized after my trahave gone back to rhealed on 3/22/17." back, after her train LPN #3 stated, "No #3 stated, "After this I read the doctor's made a mistake in read the doctor's made a mistake in resolving and events with my own eyes at I had to have her exhow many wounds withis wound, ASM #2 wounds, not patients wounds, skin tears at LPN #3 was asked woccyx Pressure sor unstagabel as docur 1/23/17. LPN #3 stage 2 with rolled exhaust a call was placed to	asked if she could see the stated, "What I think I saw if the wound) rolled up on the darkness was, the top of e edges." LPN #3 was again and bed looked like. LPN #3 d." LPN #3 stated, "This was part." The wound care re reviewed with LPN #3. The mented the wound was a jury. LPN #3 stated, "I sining my mistake. I wouldn't review this as the wound When asked if she went ing, to review her wounds, the wound was closed." LPN is was brought to my attention, notes, and reread my notes. I my documentation."  PN #3) doesn't go back and cause this wound was ually healed. I saw the wound and didn't see any black tissue; plain it to me." When asked were in house at the time of a stated, "We had 60 total is and that included surgical and such."  what stage Resident #5's re was, if it was not mented in her note dated ated, "It was a shearing or a diges and darkness."	F3	1314			
	and a message was	left, on 4/5/17 at 4:22 p.m.					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION		E SURVEY IPLETED
		495038	B. WING			1	C <b>06/2017</b>
	PROVIDER OR SUPPLIE			85	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314		conducted with ASM #5 on ASM #5 was asked if he had	F3	314 ·	· .		
	reviewed his note When asked if he Resident #5's coc ASM #5 stated, "I wound in the midli Per the MDS codi	s, ASM #5 stated that he had. could describe the wound on cyx that he saw on 1/25/17, recall it to be a very small ne of the buttocks, coccyx area. ng it was a shearing with					
	pressure. It was a superficial area that is under lateral stress." When asked what stage the wound was, ASM #5 stated, "It was a stage 3 wound. That is based on the location and the extent of the depth of the wound when I saw it." When asked if he saw any black eschar, ASM #5 stated, "I don't recall. There may have been						
	non-viable edges. on non-necrotic tis "Absolutely, it help the edges. If I reca were dry so Santy	al aspect where there were ' When asked if Santyl is used sue, ASM #5 stated, is a lot with the improvement in all, the edges of this wound I was appropriate. My					
	curled under and of beneficial to use the addendum to the re- clarified with the ward written sacrum. There is not much in that area, becaustage 3 pressure is	edges of this wound, they were dry. It would have been he Santyl." There was an hote dated, 1/25/17. This was round doctor. ASM #5 stated, "I had it was actually coccyx. between the bone and fascialse of the depth I had to call it a hjury. If it had just a little bit					
	On 4/5/17 at 5:24 ASM #2, ASM #3, and ASM #4, the F	o.m. ASM #1, the administrator, the corporate nurse consultant, RAI (resident assessment tant, were made aware of the		,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		(X3) DATE SURVEY COMPLETED		
			/ N. BOILL	·1140		1	С
		495038	B. WING			}	06/2017
	PROVIDER OR SUPPLIEI			85	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109		00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	ASM #3 presented listed above and a prevention and tree Resident #5.  ASM #2 stated, "In was noted to have following intervent dietician review pressure reduction standard mattress turning and repositional chair/bed with alter and a standard with alter the standard with	a.m. ASM #1, ASM #2 and d a "Timeline" of documents as actions the facility took in the atment of a pressure ulcer for a November (2016) the resident redness to her buttock. The ions were put in place:  In mattress - verified this is the for the facility tioning rnate periods of rest with barrier cream which is the	F3	314			
	assessment of the stated, "I do not haw as not the director am unable to located."  The timeline documentation on Resident #5's ADL for January 2017 dopen area" on 1/3/indicating "yes" the these dates. ASM (CNA (#4) who documentation docume	the ADL record for 1/17/17.  (activity of daily living) record ocumented in part an "OA - 17 and 1/17/17, and a "Y" nurse was notified on each of #2 stated, "I interviewed the umented this on 1/17/17. She he open area was in the 'butt ne buttock. The CNA is not allow for more entation, it just allows buttock					
	CNA stated when I	nave included the coccyx. This interviewed her, that the next atch' over the area. A foam				:	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		E CONSTRUCTION		E SURVEY PLETED
		495038	B. WING			}	C <b>06/2017</b>
	PROVIDER OR SUPPLIER  SAS HEALTH AND RE	HAB CENTER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE IANASSAS, VA 20109	1 0-11	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	assesses the wound nurse documented prior to placing a word #2 stated, "There is nurse for this. The remployed at the fact interviewed the CNA was the same area cream to since 11/4 wound care nurse a documented, ASM #2 aware of the open a skin audit on 1/19/1 intact." ASM #2 furth documented in the A triggered on our das and the wound nurs Once this was broug what's going on with put in place? We for	ocol until the wound nurse d." When asked where the the assessment of the area bund dressing in place, ASM no documentation by the nurse who did this is no longer ility." ASM #2 stated, "When I A she informed me that this that they had been applying /16." When asked where the ssessment of this area was #2 stated, "We were not area until 1/23/17. But we did a 7 that said her skin was her stated, "When it is ADLs by the CNA, it is shboard. The Unit Manager e then go do an observation. In this resident. What can we allowed our protocol - we cushion and put a new	F	314			
;	identified the area. The place. It wasn't until 1/23/17 that the post clarified. The piece was documentation of 1/	ASM #1, stated, "The CNA The nurse put a treatment in the wound was assessed on ition of the wound was we don't have is the 17/17. We feel it's existed for nave had a care plan in					
	tracked, ASM #2 sta The timeline docume 10/10/16, document we will continue trea	ige 1 pressure injury is ted, "Yes, they should be." ented a physician's note of ing, "Buttock ulcer, Stage 1 tment plan." When asked vas, ASM #2 stated, "During					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
		495038	B. WING	2000			С	
	PROVIDER OR SUPPLIE	R	J B. WING	STF 857	REET ADDRESS, CITY, STATE, ZIP ( 5 RIXLEW LANE NASSAS, VA 20109	CODE	04/06	5/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	E	(X5) COMPLETION DATE
F 314	documentation. We anything else in place are. Risk areas we interventions we have stage 3, this area opened and new in When asked the place are should conticing any excontreatment and should be the wound nurse. It is were any new areas should correspond to the found." ASM #2 stage problem, yes. We not feel it is documentations.	page 59  ye do not have any clinical ye would not have not put lace. We had a mattress, m cushion and incontinence were being treated with the had in place. It's not about a was compromised when it interventions were needed." brocess for a body audit, ASM sident should be disrobed and check any bony prominences, riation and if seen should initiate huld be escalated to (LPN #3, "When asked how this is h (LPN #3), ASM #2 stated, hally communicated to her but body audit if something was tated, "Is there a process had a care plan in place we do mented as harm to the resident. brocess improvement but don't	F3	14:				
	speak with CNA #4 back from her as of the facility policy, 'Care Program' door Assessment: The It Pressure Sore Risl nurse - at the time review, annual re-asignificant change observation will be baths/showers, and	a.m. a message was left to d. There was no return call of exit on 4/6/17.  "Pressure Ulcer Prevention and cumented in part, "Risk Braden Scale for Predicting k is completed by a licensed of admission, at each quarterly assessment and upon any in conditionTotal body done on admission, with d when additional risk factors ate to development of pressure						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495038	B. WING			04/	06/2017
NAME OF	PROVIDER OR SUPPLIE	२	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANAS	SAS HEALTH AND R	FHAB CENTER		8	575 RIXLEW LANE		
				IV	MANASSAS, VA 20109		
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F 314	Continued From p	age 60		! - 314			
	•	e licensed nurse upon initial	, ,	) 1-4			
•	assessment and v	vhen additional risk factors are					
		VA will observe the resident's					
		he bath/shower. Any areas of					-
	concern will be rea	ported to the nurse immediately.					
		ess the area of concern and					
		ctions. Findings will be					
	documented in the	nursing initial assessment and					***************************************
	in the interdisciplin	ary notes. When additional					
		entified, the findings of the total					
		will be documented in the					
	Interdisciplinary no	tes. The CNA will document					
		IR (electronic medical					
		ection: Early detection of					
	pressure ulcers is	the responsibility of all					
		sident care team. The					
		ssistant (CNA) is in an				1	
		to detect possible pressure as they provide direct care to				l	
	the resident on a re	egular basis. The CNA's have					
	the opportunity to	bbserve the resident's skin				:	1
		a 24 hour period. Examples of					
		ne residents are; when bathing					
	and/or dressing the					ļ	
		the resident; when checking				į	
	the resident for inc	ontinence, when cleaning the				100	
		ntinent episodes, or when				- Anna	
		ent. Pressure ulcers can				1	
	develop anywhere	there is pressure. The obvious					
		rum and coccyxThe CNA is					ĺ
		LL unusual resident				į	
		ges to their licensed nurse,				!	
		bservations listed above, and				1 1000	
		at they report in the EMR on				į	
		e licensed nurse will: observe				!	
		reported by the CNA, obtain					
		notify the Responsible Party,				mora se	
		s) indicated, document the				:	
	problem thoroughly	in the Interdisciplinary Notes,				ì	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDE IDENTIFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER SAS HEALTH AND RE			STREET ADDRESS, CITY, STA 8575 RIXLEW LANE MANASSAS, VA 20109		700/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION FE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 323 SS=D	resident's Care Plant treatment/preventate implement."  No further information (1 - 3) This information following website: http://www.npuap.or.clinical-resources/ng (4) This information following website: https://www.nlm.nih.asedocs/current/LNe (5) This information following website: http://www.npuap.or.clinical-resources/ng (6) This information following website: http://www.rxlist.com (7) This information version of the following website: https://www.ncbi.nlm T0012707/	our report, and update the n to reflect the tive measures that are ion was provided prior to exit. Ition was obtained from the rg/resources/educational-and-puap-pressure-injury-stages/was obtained from the rg/resources/educational-and-puap-pressure-injury-stages/was obtained from the rg/resources/educational-and-puap-pressure-injury-stages/was obtained from the rg/resources/educational-and-puap-pressure-injury-stages/was obtained from the rg/santyl-drug.htm	F 31	F 323  1. Resident #9'	s fall mats at bedside s plan of N.A and for Resident	
	from accident hazard (2) Each resident red	rironment remains as free ds as is possible; and ceives adequate supervision ces to prevent accidents.		educational c ensuring safe are in place p individualized care.	ety devices per resident's	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495038	B. WING			04	C 4/06/2017
	PROVIDER OR SUPPLIER  SAS HEALTH AND RE	HAB CENTER		857	REET ADDRESS, CITY, STATE, ZIP CODE 5 RIXLEW LANE NASSAS, VA 20109		HOOLEGI
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREFI TAG	,	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	appropriate alternate bed rail. If a bed or must ensure correct maintenance of bed to the following elem (1) Assess the reside from bed rails prior (2) Review the risks the resident or reside informed consent proceeding (3) Ensure that the based on observation clinical record review facility staff failed to implemented for one sample, Resident #9 The facility staff failed to implemented for one sample, Resident #9 The facility staff failed floor when Resident comprehensive plans. The findings included Resident #9 was ready 14/14/14 with diagnor of limited to: anemic diabetes mellitus (3), cerebral ataxia (6), and Resident #9's most	e facility must attempt to use ives prior to installing a side or side rail is used, the facility installation, use, and rails, including but not limited nents.  ent for risk of entrapment to installation.  and benefits of bed rails with ent representative and obtain ior to installation.  bed's dimensions are esident's size and weight.  T is not met as evidenced ons, staff interview and wit was determined that the ensure fall interventions were of 25 residents in the survey.  d to place fall mats on the #9 was in bed per the of care.  admitted to the facility on uses that included but were a (1), hypertension (2), dementia (4), anxiety (5), indementia (4), anxiety (5), indexedual and a side of a control of	F 3	323	<ol> <li>Round rooms will be conducted to verify residents requiring safety devices are in place according to the resident's individualized plan of care.</li> <li>The Nurse Educator or designee will educate nursing staff on ensuring safety devices are in place per resident's individualized plan of care.</li> <li>The DON and designee will review safety devices weekly x 4 weeks and monthly x 2 months for residents to verify devices are in place according to the resident individualized plan of care. The DON or designee will review findings and report to QAPI Committee for any further recommendation.</li> <li>May 10,2017</li> </ol>		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
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	PROVIDER OR SUPPLIER  SAS HEALTH AND RE	EHAB CENTER		85	FREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE ANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	Resident # 9 as socinterview for menta - 15, six being sever making daily decisi as requiring extens member for activitie On 04/04/17 at 3:40 Resident # 9 reveal and the fall mats we On 04/04/17 at 5:00 Resident # 9 reveal and the fall mats we On 04/04/17 at 5:00 Resident # 9 reveal and the fall mats we On 04/05/17 at 8:30 Resident # 9 reveal and the fall mats we The care plan for Rewith a revision date "(Resident # 9) is at decreased mobility, impacting ability to ulimitations." Under documented, "Fall sed."	ence date) of 01/12/17, coded oring a six on the brief I status (BIMS) of a score of 0 erely impaired of cognition for ons. Resident # 9 was coded ive assistance of one staff	F3	23	RECEIVED		
:		sident # 9 documented, "Fall			VOH/OLC	or or operation and a decision of the second	

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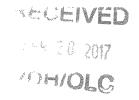
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DAT	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIEI SAS HEALTH AND R	3		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	04.	/06/2017
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	On 4/5/17 at 9:55 conducted with CN 1. When asked winformation regard residents, CNA # When asked about 9, CNA # 1 looked the iPad and state informed of the about in place next to was lying on the bounder the bed. It is On 4/5/17 at 5:15 member) # 1, the adirector of nursing above findings.  No further information References:  1. Low iron. This in the website: https://www.nlm.nil	a.m. an interview was NA (certified nursing assistant) # here she obtained the ling safety devices required for I stated, "It's on the Kardex." It safety devices for Resident # up Resident # 9's Kardex on d, "She has fall mats." When ove observations of the fall mat o Resident # 9's bed when she ed, CNA # 1 stated, "It was should be next to the bed."  D.m. ASM (administrative staff administrator and ASM # 2, the were made aware of the  tion was provided prior to exit.  Information was obtained from angov/medlineplus/anemia.html  sure. This information was	F 32:	3		

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING			(X3) DA	ATE SURVEY OMPLETED
		495038	B. WING				C
	PROVIDER OR SUPPLIER SAS HEALTH AND RE		S 8	575 RIXLE	DRESS, CITY, STATE, ZIP CODE EW LANE AS, VA 20109		4/06/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E	PROVIDER'S PLAN OF CORREC FACH CORRECTIVE ACTION SHO DSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329 SS=D	judgment, and beha obtained from the whitps://medlineplus.  5. Fear. This inform website: https://www.nlm.nih #summary.  6. A sudden uncoor due to disease or in brain. This informat website: https://medlineplus.483.45(d)(e)(1)-(2) IFROM UNNECESS  483.45(d) Unnecess Each resident's drug unnecessary drugs. drug when used  (1) In excessive dostherapy); or  (2) For excessive due (3) Without adequate (4) Without adequate (5) In the presence of which indicate the dediscontinued; or  (6) Any combinations	memory, thinking, language, avior. This information was vebsite: gov/ency/article/000739.htm. nation was obtained from the .gov/medlineplus/anxiety.html  dinated muscle movement jury to the cerebellum in the tion was obtained from the gov/ency/article/001397.htm. DRUG REGIMEN IS FREE ARY DRUGS cary Drugs-General. g regimen must be free from An unnecessary drug is any e (including duplicate drug	F 323	F 329	Resident #13's physicia was notified of blood pressure results not documented on MAR 3/9/17 thru 3/20/17. Thurse revising blood pressure monitoring on MAR will receive educational coaching or verifying data entry for parameters/recording box. Nurses administerion Norvasc 3/9/17 thru 3/20/17 without	he n	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I		DNSTRUCTION		ATE SURVEY DMPLETED
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	PROVIDER OR SUPPLIER SAS HEALTH AND RE	3		STREE 8575 F	ET ADDRESS, CITY, STATE, ZIP CODE RIXLEW LANE ASSAS, VA 20109		100/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPLICATION OF CORRECT PROVIDER OF THE APPLICATION OF THE APPLIC	OULD BE	(X5) COMPLETION DATE
F 329	Continued From pa	age 66	F 33	29	following physician order		i     
,	resident, the facility (1) Residents who h	ehensive assessment of a y must ensure that have not used psychotropic	· Allen and a control of controls		for specific blood parameters will receive educational coaching on reading and following physician's orders.		
drugs are not given thes medication is necessary condition as diagnosed a clinical record;				2	<ol> <li>A review of residents with orders for blood pressure medications will be completed to verify</li> </ol>		
	gradual dose reduction interventions, unless an effort to disconting. This REQUIREMENT by:  Based on staff intermediate and clinical record return the facility staff failer for one of 25 resider	use psychotropic drugs receive ctions, and behavioral se clinically contraindicated, in nue these drugs; NT is not met as evidenced erview, facility document review review, it was determined that ed to ensure the drug regimen ents in the survey sample, as free of unnecessary		3	accuracy of data entry for orders with specific parameters.  3. The Nurse Educator or designee will educate licensed nurses on data entry for medications with specific parameters and reading and following		
	ordered blood press the blood pressure r	ed to obtain the physician sures prior to administering medication Norvasc to 3/9 through 3/20/17.			physician's orders for monitoring vital signs prior to medications administration. The Nurse Educator or designee will		
	9/16/10 with diagnos limited to: dementia,	admitted to the facility on ses that included but were not , stroke, dysphagia (speech ntractures, high blood y of falling.			educate UM's and supervisory staff on Center protocol for reviewing new orders to ensure accurate and		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) E	PATE SURVEY COMPLETED
		495038		_			C 04/06/2017
	PROVIDER OR SUPPLIER SAS HEALTH AND RE	HAB CENTER	I	ST 85	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109		94100/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	assessment, a qua assessment referer resident as having memory difficulties to make daily cogni was coded as requi one or more staff mof daily living.  The physician order "Norvasc (used to the thick thic	DS (minimum data set) rterly assessment with an ance date of 3/8/17, coded the both short and long term and being severely impaired tive decisions. The resident ring extensive assistance of tembers for all of his activities and dated, 8/16/16, documented, reat high blood pressure (2)) Give 1 tablet by mouth in the ESSENTIAL (PRIMARY) high blood pressure). Hold for pressure) < (less than) 100." on administration record) for ented, "Norvasc 10 MG; Give the morning related to ARY) HYPERTENSION. Hold as MAR documented the emedication from 3/1/17 he blood pressure was 17 through 3/8/17. There sures documented from 1/17.	F	3329	complete order entry.  4. The DON and designee will review of resident with blood pressure orders weekly x 4 weeks and monthly x 2 months for residents to verify accuracy of data entry for orders with specific parameters. The DON or designee will review findings and report to QAPI Committee for any further recommendatio  5. May 10.2017	or	
	"Norvasc 10 MG; Gi morning related to E	ve 1 tablet by mouth in the SSENTIAL (PRIMARY) There were no parameters an order.					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495038	B. WING	;		0/	C 4 <b>/06/2017</b>
	PROVIDER OR SUPPLIER SAS HEALTH AND RE	HAB CENTER	<u> </u>	85	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE MANASSAS, VA 20109	04	100/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	medications as ordobserve for side ef signs as ordered/fa advise physician of needed."  On 4/5/17 at 10:15 conducted with LPN LPN #2 was asked Norvasc order prior asked what a nurse see a physician ord shown to her. LPN the blood pressure and if the blood pressure and if the blood pressure and if the RP (respons Resident #13's MAF were documented fi LPN #2 stated, "The (director of nursing) parameters off if the was asked why the order was still valid	amented in part, "Give ered by the physician. fects and effectiveness. Vital cility protocol. Document and abnormal findings as  a.m., an interview was I (licensed practical nurse) #2. to review Resident #13's to 3/20/17. LPN #2 was is expected to do when they er like the Norvasc order #2 stated, "You have to take before you give the medicine sure (systolic) is less than edication, call the doctor and sible party)." When shown R where no blood pressures from 3/9/17 through 3/20/17, et doctors and the DON had a meeting to take the eresident was stable." LPN #2 order was changed and if the lift the doctor had not changed PN #2 stated, "I don't know.	F	3329			
	conducted with LPN #1 was asked to rea order prior to 3/20/1 expected of the nurs physician order like Resident #13. LPN take the blood press medication. If the bl 100, then the nurse	a.m., an interview was #1, the unit manager. LPN ad Resident #13's Norvasc 7. LPN #1 was asked what is se's when they have a the Norvasc order for #1 stated, "The nurse has to sure before giving the ood pressure is less than should hold the medication sian and RP." The MAR for					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CON	ISTRUCTION		TE SURVEY MPLETED
		495038	B. WING			04	C -/06/2017
	PROVIDER OR SUPPLIER	3		STREET 8575 RI	ADDRESS, CITY, STATE, ZIP CODE XLEW LANE SSAS, VA 20109	04	100/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIEM (PROSS-REFERENCE)	ULD BE	(X5) COMPLETION DATE
F 329	why there were no from 3/9/17 through don't know. I would the administrator, administrative staff	age 69 hown to LPN #1. When asked blood pressures documented h 3/20/17. LPN #1 stated, "I d have to research that."  direction of nursing, f member (ASM) #3, the and ASM #4, the corporate RAI	F3	329			
	(resident assessme were made aware of at 5: 24 p.m.	ident assessment instrument) consultant, e made aware of the above findings on 4/5/17 24 p.m.  further information was provided prior to exit.  Barron's Dictionary of Medical Terms for the -Medical Reader, 5th edition, Rothenberg and		FTA	AG 387  1. Physician visit complet	ρ	
	(1) Barron's Diction				for resident #19, Physician visit completo for resident #20,	e	
F 387	following website: https://www.ncbi.nlr T0008948/?report=	m was obtained from the m.nih.gov/pubmedhealth/PMH edetails EQUENCY & TIMELINESS OF	F 3	: 87	physician visit complete for resident #17, Physician visit complete for resident # 9, physici visit complete for	ò	
	(c) Frequency of Ph	nysician Visits		2	resident #11  2. Current resident in the		
	least once every 30	nust be seen by a physician at 0 days for the first 90 days after east once every 60 thereafter.			center are at risk of timely physician visits. A review of last 60 days o		
	occurs not later that visit was required.	is considered timely if it in 10 days after the date the NT is not met as evidenced			physician visits to verify complete and scanned/documented in EMR		
	Based on staff inte	erview, facility document review review, it was determined that		3			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
-		495038	B. WING		04	C <b>//06/2017</b>
	PROVIDER OR SUPPLIER SAS HEALTH AND R			STREET ADDRESS, CITY, STATE, ZII 8575 RIXLEW LANE MANASSAS, VA 20109		100/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	visits for five of 25 Resident # 19, Res Resident #9 and R  1. The facility staff #19 was seen by a between 4/13/16 a days), between 8/2 81 days) and between for 76 days).  2. The facility staff #20 was seen by a between 10/24/16 a 3. The physician fa from 1/9/17 until 3/4 4. The facility staff visits were conduct # 9. The clinical rec visited Resident #9 03/08/17, (77 days 5. The facility staff was seen by a phys a total of 77 days.  The findings include 1. The facility staff #19 was seen by a and 6/23/16 (a perio 8/28/16 and 12/24/16 a days).	iled to ensure timely physician or residents in the survey sample, esident #20, Resident #17, Resident #11.  If failed to ensure that Resident a physician within 60 days and 6/23/16 (a period of 71 28/16 and 12/24/16 (a period of 72 28/16 and 12/24/16 and 3/10/17 (a reen 12/24/16 and 3/10/17 (a reen 12/24/17, a 91 day period.  If failed to ensure that Resident a physician within 60 days and 1/23/17, a 91 day period.  If failed to examine Resident #17 /27/17 (a period of 77 days).  If failed to ensure physician ted every 60 days for Resident cord documented the physician on 12/20/16 then not again till between visits).  If failed to ensure Resident # 11 sician from 12/20/16 to 3/8/17,	ĺ	Coordinator to ens Physicians Visits we made timely. Educe was provided to the attending physician on timely physician on timely physician 4. Don or designee wi complete weekly au 12 weeks to ensure timely physician visi Communication with each physician will be made of outstanding visits and visits upco The DON or designee review findings and report to QAPI Committee for any further recommendations.  5. Date of compliance N 10,2017	ere cation e n group n visits. II udit x its. h pe g oming. e will	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT CON	E SURVEY MPLETED
		495038	B. WING	·		1	C <b>/06/2</b> 017
	PROVIDER OR SUPPLIE			85	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109	1 04/	100/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 387	diagnoses that incidementia, kidney blood pressure.  Resident #19's m set) was a quarte (assessment refe Resident #19 was BIMS (brief interv three out of 15. T that a score of thr cognition is severed A review of Residerevealed, in part, seen by a physicia between 4/13/16 a 12/24/16, and 12/2 On 4/5/17 at 11:05 conducted with Osmedical records dhow often a physic residents. OSM # required to visit a first three months following the initial asked how he ass were timely. OSM each month I run to due for a visit. If t physician via phor grace period. We were doing much	admission date of 9/19/15 with cluded, but were not limited to, failure, depression and high ost recent MDS (minimum data rly assessment with an ARD rence date) of 1/23/17. It coded on the MDS as having a liew for mental status) score of the MDS manual documents ee indicates that the resident's ely impaired.  The physician record that Resident #19 had not been an within a 60 day period and 6/23/16, 8/28/16 and 24/16 and 3/10/17.  To a.m. an interview was SM (other staff member) #4, the irector. OSM #4 was asked cian was required to see the 4 stated, "The physician is resident every 30 days for the and then every 60 days three months." OSM #4 was ured that the physician visits a the stated, "At the beginning of the report to determine who is the visit is late I will notify the ne. The physician has a 10 day have had some problems but better this year." OSM #4 was evidence that Resident #19 was any period on the	F3	387			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				_	**************************************	1	С	
		495038	B. WING			04/	06/2017	
	PROVIDER OR SUPPLIEF			85	REET ADDRESS, CITY, STATE, ZIP CODE 175 RIXLEW LANE ANASSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ž.	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 387	returned and state not done within 60 Resident #19.  On 4/5/17 at 5:10 was conducted with member) #1, the addirector of nursing and ASM #4 the conductive staffindings and a politive staff staf	pximately 4:00 p.m. OSM #4 d that the physician visits were days on the dates provided for p.m. an end of the day meeting h ASM (administrative staff dministrator, ASM #2, the h ASM #3, the corporate nurse proporate MDS coordinator. The f was made aware of the above cy regarding physician visits  welled, in part, the following EDERAL AND STATE The long-term care resident physician at least once every t 90 days after admission, and ays thereafter. 3. "Must be the attending physician must o-face contact with the sician's visit is considered to later than 10 days after the equired."  ion was provided prior to the process.  failed to ensure that Resident physician within 60 days and 1/23/17, a 91 day period.	F	8887	DEFICIENCY			
	11/1/14 with a read diagnoses that incli	admitted to the facility on mission on 4/4/15 with uded, but not limited to, illation (an irregular heart						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	FIPLE CONSTRUCTION NG	(X3) DA	(X3) DATE SURVEY COMPLETED	
		495038	B. WING		04	C	
	PROVIDER OR SUPPLIE	R .		STREET ADDRESS, CITY, STATE, ZIP COD 8575 RIXLEW LANE MANASSAS, VA 20109		/06/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
	Resident #20's me set) was a quarter (assessment refer Resident #20 was BIMS (brief intervinine out of 15. The ascore of nine incognition is model. A review of Resider revealed, in part, the seen by a physicial between 10/24/16. On 4/5/17 at 11:05 conducted with Osmedical records of the how often a physic residents. OSM #required to visit a required to visit a residents. OSM #required to visit a resident for a visit. If the physician via phone grace period. We were doing much the asked to provide eseen within a 60 da aforementioned da On 4/5/17 at approreturned and states.	pressure, diabetes and anxiety.  Dest recent MDS (minimum data and assessment with an ARD rence date) of 3/11/17.  Coded on the MDS as having a sew for mental status) score of the MDS manual documents that dicates that the resident's rately impaired.  Dent #20's clinical record that Resident #20 had not been an within a 60 day period and 1/23/17.  Dent and an interview was asked that was required to see the 4 stated, "The physician is resident every 30 days for the and then every 60 days three months." OSM #4 was three months." OSM #4 was three months." OSM #4 was three wist is late I will notify the expected that Resident #20 was any period on the	F 38	37			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495038	B. WING				1	C 06/2017
	PROVIDER OR SUPPLIE			85	TREET ADDRESS, CITY, STATE, ZIP CO 575 RIXLEW LANE ANASSAS, VA 20109	DE	1 04/	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE .	(X5) COMPLETION DATE
	was conducted with member) #1, the director of nursing and ASM #4 the control was and ASM #4 the control was conducted with the control was conducted with the control was conducted with the control was conducted with the conducted with the conducted was conducted with the conducted was conducted	p.m. an end of the day meeting ith ASM (administrative staff administrator, ASM #2, the g, ASM #3, the corporate nurse orporate MDS coordinator. The ff was made aware of the above	F3	87				
	Resident #17 was 3/7/14. Resident were not limited to pressure and arthurecent MDS (minimassessment with a	ailed to examine Resident #17 d/27/17 (a period of 77 days).  admitted to the facility on #17's diagnoses included but in high cholesterol, high blood ritis. Resident #17's most mum data set), an annual an ARD (assessment reference ded the resident as being						
	reveal the physicia 1/9/17 until 3/27/1 On 4/5/17 at 2:10 conducted with Os medical records er tracking the physician visit has a report he ca what physician visits are leaves a copy of the personal bin on the he also notifies the email when visits a physicians responded.	at #17's clinical record failed to an examined Resident #17 from 7 (a period of 77 days).  p.m., an interview was 6M (other staff member) #4 (the apployee responsible for stan's visits). OSM #4 stated he are upcoming and what are overdue. OSM #4 stated he are report in each physician's an unursing unit. OSM #4 stated a physicians in person or via are overdue. When asked if the d to his notification, OSM #4 ely as I wish but yes they do."						

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495038	B. WING			i	C / <b>06/201</b> 7
	PROVIDER OR SUPPLIE	R	<b>I</b>	STR 857	REET ADDRESS, CITY, STATE, ZIP CODE 5 RIXLEW LANE NASSAS, VA 20109	04,	700/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	that Resident #17 between the dates On 4/5/17 at 3:25 checked with the pinformation regard visits. On 4/5/17 at 5:15 member) #1 (the adirector of nursing above findings.	page 75 ed to provide documentation was examined by the physician is of 1/9/17 and 3/27/17. p.m., OSM #4 stated he ohysician and had no further ding Resident #17's physician p.m., ASM (administrative staff administrator) and ASM #2 (the ) were made aware of the tion was presented prior to exit.	F	387			
	visits were conduct # 9. The clinical revisited Resident #9 03/08/17, (77 days Resident # 9 was rounded of the conduct of the	readmitted to the facility on noses that included but were nia (1), hypertension (2), 3), dementia (4), anxiety (5),					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DAT	E SURVEY MPLETED
		495038	B. WING		небениционностиционности по по по по по по по по по по по по по		C
	PROVIDER OR SUPPLIER	3		STREET ADDRESS, 0 8575 RIXLEW LANI MANASSAS, VA		04/	06/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH COF	ER'S PLAN OF CORRECTIO RRECTIVE ACTION SHOULE ERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	physician visited of 03/08/17, 77 days  On 4/5/17 at 11:10 conducted with OS director of medical often a resident neighysician, OSM # for the first three mafterwards." When afterwards." When physician sees the OSM # 4 stated, "I logs when the physician is late I maked abour Resident # 9 betwee OSM # 4 stated her documentation.  On 4/5/17 at 5:15 member) # 1, the addirector of nursing, above findings.  No further information.  References:  1. Low iron. This in the website: https://www.nlm.nif	ies of daily living. nical record revealed the n 12/20/16 then not again till	F3	87			
	obtained from the v						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONST		(X3) DATE SURVEY COMPLETED	
		495038	B. WING			0/	C 1/06/2017
	PROVIDER OR SUPPLIER SAS HEALTH AND R			8575 RIXI	DDRESS, CITY, STATE, ZIP COLLEW LANE SAS, VA 20109	ODE 1 UZ	106/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (CR	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	regulate the amount information was obthttps://www.nlm.nil 001214.htm.  4. A loss of brain further diseases. It affects judgment, and behobtained from the whittps://medlineplus.  5. Fear. This informates website: https://www.nlm.nil/#summary.  6. A sudden uncoordue to disease or in brain. This informates website: https://medlineplus.  5. The facility staff was seen by a physical atotal of 77 days.  Resident # 11 was a 6/18/12 with diagnolimited to, anemia, I dementia, depression.	se in which the body cannot nt of sugar in the blood. This btained from the website: h.gov/medlineplus/ency/article/unction that occurs with certain memory, thinking, language, avior. This information was	F 3	87			
	set) is a quarterly as	st recent MDS (minimum data ssessment with an ARD					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495038	B. WING				С
	PROVIDER OR SUPPLIER	Luce	B. WINC	ST 85	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109	04	/06/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	3	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 387	Resident # 11 was a understood by othe understand others. scoring a 2 out of a Interview for Mental Cognitive Patterns, severely cognitively  A review of Resident progress notes that 3/8/17, a total of 77 visits. No other phy  During an interview ASM (administrative director of nurses, that a request was made notes that could be a 3/8/17. ASM # 2 was member was resporphysician visits. AS	rs and usually able to Resident # 11 was coded as possible 15 on the Brief Status (BIMS) in Section C, indicating the resident was impaired.  It 11's clinical record revealed were dated 12/20/16 and days between physicians sician notes were provided.  on 4/5/17 at 7:55 a.m. with e staff member) # 2, the his concern was revealed and e for any other physician visits, found between 12/20/16 and his also asked which staff his ble for keeping track of M # 2 stated that it was er staff member) # 4, the	F	387			
	OSM # 4, OSM # 4 v physician was requir facility. OSM # 4 sta resident every 30 da for three months, the days." OSM # 4 was the physician to ensu- required visits. OSM a computer report at the computer progra keeps track and aler are late. OSM # 4 st	on 4/5/17 at 11:10 a.m. with was asked how often a ed to see a resident in the sted, "The physician sees the ys at the time of admission on he sees them every 60 asked how he monitored are that they completed the 1/44 stated that he would run the beginning of each month of [PCC (point click care)] that him if the physician visits stated that he then highlights and then sends an email to overdue. OSM # 4					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
		495038	B. WING_			C
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		06/2017
MANAS	SAS HEALTH AND RE	HAB CENTER		8575 RIXLEW LANE		
				MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 387	Continued From pa	ge 79	F 38	37		
	OSM # 4 further co been less overdue 4 was then asked to	re is a ten day grace period. Immented that there have visits since last year. OSM # to review Resident # 11's te if he could locate any visits and 3/8/17.				
F 425 1	OSM #4, OSM #4 s any other documen Resident # 11 between Resident # 11 between Resident # 11 between Resident # 11 between Resident # 11 between Resident # 11 between Resident # 12 between Resident # 12 between Resident RASM #3, the corporegional RAI (resident consultant, this consultant, this consultant of the survey properties and of the survey properties and the survey propert	ARMACEUTICAL SVC - EDURES, RPH	F 42	1. The medication of been checked to Resident #16's methadone is av 2. Any resident has potential to be a the nurse fails to control and bulk medications time review of 72 hou was done to verify medications not a for administration Medication carts audited to verify meds and bulk medications are a for administration 3. The Nurse Educat designee will re-e nurses on process	verify ailable. the ffected if re-order ely. A r report fy no available n. will be control available n. or or ducate	

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#### PRINTED: 04/13/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495038 B. WING 04/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS HEALTH AND REHAB CENTER MANASSAS, VA 20109 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 425 Continued From page 80 F 425 clinical record review and review of facility ordering meds from documentation the facility staff failed to ensure pharmacy. physician ordered medications were available for administration for one of 25 residents in the 4. The DON or designee will survey sample, (Resident #16). review med cart weekly x 4 weeks them monthly x The facility staff failed to ensure Resident #16's 2 months for 5 residents physician ordered methadone (narcotic pain to verify medications are medication (1)) was available for administration on 3/31/17. available for administration. The DON The findings include: or designee will review Resident #16 was admitted to the facility on findings and report to 2/8/17. Resident #16's diagnoses included but **QAPI** Committee for any were not limited to: multiple sclerosis (2), further fibromyalgia (3) and anxiety. Resident #16's most recent MDS (minimum data set), a quarterly recommendations. assessment with an ARD (assessment reference 5. Date of compliance: May date) of 3/7/17 coded the resident as cognitively 10, 2017 intact scoring 15 out of a possible 15 on the brief interview for mental status. Section J documented Resident #16 received scheduled pain medication and as needed pain medication during the last five days. Section J further documented the resident reported almost constant pain rated as a seven on a scale from zero to ten during the last five days. On 4/4/17 at 5:00 p.m. an interview was conducted with Resident #16. When asked if she

medication was available.

would like to discuss any concerns regarding her life at the facility, Resident #16 stated she felt the facility staff would run out of her pain medication if she didn't pay attention to how much of the

Review of Resident #16's clinical record revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTR		(X3) DATE SURVEY COMPLETED	
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	10 mg (milligrams eight hours for pareight hours for alled to reveal the any other time that 2017 eMAR (electrecord) document mg- two tablets by pain to be administ and 10:00 p.m. The eMAR legend indicated, "9 = Other Anurse's note dat documented, "Pt. responsive. Took except Methadone called for script (pipharmacy. Pt c/othis shift, reposition needed) hydromor medication also krigiven twice this shilving) provided." Anurse's note dated in the called for script (pipharmacy. Pt c/othis shift, reposition needed) hydromor medication also krigiven twice this shilving) provided." Anurse's note that shilving provided." Anurse's note alled for script (pipharmacy. Pt c/othis shift, reposition needed) hydromor medication also krigiven twice this shilving) provided." Anurse's note dated in the call of the call	er dated 2/9/17 for methadone c) - two tablets by mouth every	F 4	25			

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F 425	Continued From pa	ige 82	F	425	1		
	conducted with RN nurse who documer 3/31/17 at 4:35 p.m #16's March 2017 e notes. RN #4 stated to administer to Rescalled the pharmacy didn't have any refill methadone prescrip Resident #16's phys prescription to send stated normally whe can obtain an access obtain the medicatio (immediate) box but stat box. RN #4 sta Dilaudid available to review of the resider revealed the resider needed Dilaudid per at 8:17 a.m. and 3/3 was asked what facien ensure residents did that required prescri wasn't supposed to methadone was sch be re-ordered. RN #4 check when they concount performed to a medications) to see is left and when ther nurses should call the are left on the prescription. RN #4 supervisor talked to	It to the pharmacy. RN #4 It is she has a prescription she It is scode from the pharmacy to It is methadone was not in the It is dealer that the state of the sta					

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	as needed Dilaudid on 3/31/17 was effer On 4/5/17 at 1:20 p. conducted with Res asked if she had ever medications. Resid missed two doses on Resident #16 stated runs out and didn't prinformation. When a Resident #16 stated managed my medical understand how any Further into the constated she remember information. Reside the pharmacy didn't need for a new present medication cards needed a new present medication cards needed a new present medication cards needed a new present medication cards needed a new present medication cards needed a new present medication cards needed a new present medication cards needed a new present medication cards needed a new present medication cards needed a new present medication cards needed a new present medication cards needed a new present medication cards needed a new present medication cards needed a new present medication cards needed a new present pain. Resident # for chronic pain and missing one or both management of her	rviced staff. RN #4 stated the administered to Resident #16 ctive.  m., another interview was ident #16. Resident #16 was er missed any pain ent #16 stated she had f methadone this past week. staff told her the medication provide any further asked how this made her feel, "As a person who has ation for years, I couldn't one could let it run out." versation, Resident #16 ered she was told further nt #16 stated staff told her tell the nurse there was a cription. Resident #16 stated is used to tell her when she ription. When asked if she 3/31/17, Resident #16 stated did didn't completely control f16 stated the methadone is Dilaudid is for acute pain so medications disrupts the	F.	125			
	nursing) was asked t	o provide the education arding the unavailability of				Add very discussions in a se	
	what facility process	n., an interview was #2. ASM #2 was asked was in place to ensure ut of medications that					

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F 425	narcotic medication "re-order" arrow stic pills on the card to in needed to be re-order a five or seven day ASM #2 stated whe pill beside the re-order the medicate ASM #2 stated the pia fax when the refund the nurse should on 4/5/17 at 4:50 pin-service attendance by seven employees "UNAVAILABLE ME emergency supply of in emergencies and maintained in the fathe pharmacy in por PROCEDURE: 1. If not available, the pharmacy at next scheneded prior to the medication) pass tifthe back-up pharmacist is availa 2. Emergency medic kept in the medication units. Unopened be seals when delivered 3. A list of emergency posted so that the in accessible" Review and stat box lists review and stat box	ns. ASM #2 stated the cards contained blue ckers that pointed to one of the ndicate the medication dered from the pharmacy when supply of medication was left. In the nurse administers the der sticker the nurse should ation in the computer system. The pharmacy sends notification ill requires a new prescription and obtain a new prescription.  I.M. ASM #2 presented an are form, dated 4/3/17, signed as that documented, DICATIONS- POLICY: An of medications typically used starter doses of antibiotics is cility in limited quantities by table, sealed containers. The ordered medications are narmacist is notified for eduled delivery time or if next scheduled med me, the pharmacy will contact the cy for the medication. A ble 24 hours a day by phone. Cations and antibiotic kits are no rooms on the nursing exes are sealed with green defrom the pharmacy service. By and stat box contents is a formation is readily and stat box contents is a formation is readily and stat boxes.	F 425			

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F 425	administrator) and the above findings  The facility policy of THE LONG TERM documented, "PUI right to have appromanagement of paramedications as orders."  The facility/pharma OF CONTROLLED "C. Reorders- Skill Medicare certified routine facility protesubstances at least medication being expharmacy) will only there is quantity represcription. i. If nepharmacy) will outrequest for a valid notified that the presuntil a valid prescripharmacy"  No further information website: https://dailymed.nlradruglnfo.cfm?arc (2) "Multiple scleros disease that affects damages the myeli surrounds and protestices."	ASM #2 were made aware of it.  itiled, "PAIN MANAGEMENT IN I CARE SETTING" RPOSE: To protect a Resident's opriate assessment and ain5.e. Administer the dered by the physician on the dered by the physician on the dered by the physician on the dered by the physician on the dered by the physician on the dered by the physician on the development of the exhausted. (1) (Name of the development of the exhausted. (1) (Name of the development of the development of the development of the prescriber with a prescription. The facility will be description cannot be dispensed phion is received by the development of the manification of the manification of the dispensed phion is received by the describer of the manification of the	F 4	25			

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F 428	between your brain symptoms of MS' obtained from the whttps://medlineplus.  (3) "Fibromyalgia is muscle pain and fat fibromyalgia have "Tender points are shoulders, back, hippoints hurt when prinformation was obthttps://medlineplus.  (4) This information website: https://medlineplus.tml(4) This informat website: https://medlineplus.tml  483.45(c)(1)(3)-(5) IREPORT IRREGUL  c) Drug Regimen Refereviewed at least on pharmacist.  (3) A psychotropic d brain activities associand behavior. Thes	and your body, leading to the This information was vebsite: gov/multiplesclerosis.html  a disorder that causes igue. People with render points" on the body. pecific places on the neck, os, arms, and legs. These ressure is put on them." This ained from the website: gov/fibromyalgia.html  In was obtained from the gov/druginfo/meds/a682013.h tion was obtained from the gov/druginfo/meds/a682013.h DRUG REGIMEN REVIEW, AR, ACT ON review  In of each resident must be ce a month by a licensed rug is any drug that affects ciated with mental processes e drugs include, but are not ne following categories:	F 42	F428	Resident #13's physicial was notified that pharmacy recommendation to discontinue blood pressure monitoring was not processed accurate. The Nurse who process the pharmacy recommendation will receive educational coaching on how to process a pharmacy recommendation.	as ely.	

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·	to the attending physician director and director and director minimum, the residual director for facility's medical director attending physician director minimum, the residual director and director facility's medical director and director minimum, the residual director and director and director facility's medical director and director minimum, the residuant director and director and director minimum, the residuant director and director and director and director direc	must report any irregularities ysician and the rector and director of nursing, nust be acted upon.  ude, but are not limited to, any e criteria set forth in paragraph or an unnecessary drug.  s noted by the pharmacist nust be documented on a port that is sent to the and the facility's medical r of nursing and lists, at a ent's name, the relevant drug,	F 4	28:	2. Any resident has the potential to be affect the nurse fails to propharmacy recommendations accurately. A review of current residents with pharmacy recommendations for month of March have been reviewed and verified as being processed completely	of n the		
	(iii) The attending p resident's medical r irregularity has been action has been tak be no change in the physician should do the resident's medic (5) The facility must and procedures for review that include, frames for the differ steps the pharmacis identifies an irregulat to protect the reside This REQUIREMEN by:  Based on staff inter and facility documer	develop and maintain policies the monthly drug regimen but are not limited to, time ent steps in the process and it must take when he or she writy that requires urgent action			accurately.  3. The Nurse Educator or designee will educate UM's and supervisory staff on the Centers protocol for acting upo and processing pharma recommendations.  4. The DON or designee waudit 10 resident charts monthly x 3 months to verify pharmacy recommendations was processed completely accurately. The DON or designee will review	n icy vill s		

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	recommendations survey sample, Resurvey sample, Re 2017 was not acted. The findings included Resident #13 was 9/16/10 with diagn limited to: dementi impairment (1)), confalling.  The most recent M assessment, a quassessment refere resident as having memory difficulties impaired to make of the resident was coded assistance of one of this activities of dail. The clinical record revealed a "Note to Physician/Prescribe pharmacy dated, 1/1/10 documented, "This PARAMETERS for CARVEDILOL order SBP (systolic bloods in review of the last	for negimen review for one of 25 residents in the esident # 13.  commendation done in January d upon until March 2017.  de:  admitted to the facility on oses that included but were not a, stroke, dysphagia (speech ontractures, and history of  IDS (minimum data set) arterly assessment with an nce date of 3/8/17, coded the both short and long term and as being severely daily cognitive decisions. The d as requiring extensive or more staff members for all of y living.  was reviewed. The record	F 4	1428	findings and report to QAPI Committee for any further recommendations  5. Date of compliance: May 10, 2017		
	130 regularly. Plea Parameters for the orders may be disc	se review if the Hold Amlodipine and Carvedilol ontinued at this time." The er Response" documented a				A DESCRIPTION OF THE PROPERTY	

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	by the physician on The "Summary Cop Recommendations Created Between 3 documented, "Residence Regimen Review) of has had overall stall JANUARY, pharma consider discontinu associated with BP Orders. The physic pharmacy recommen NORVASC (AMLOUS state the hold paranthe MAR (medication RECOMMEND REMORDER that state to An interview was copractical nurse) #1, at 11:30 a.m. The two pharmacist were reveasked why the Januwas signed by the pafter the March pharmacist with you."  On 4/5/17 at 1:02 p. surveyor. LPN #1 we followed for process recommendations. pharmacy sends the	"Agree." The form was signed 1/23/17. by of Facility for Recommendations	F 4	.28				
	given to the unit mar	ns) are divided up by unit and hagers or the person the /hen asked why the 1/21/17						

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F 428	upon until March 20 answer why it wasn An interview was constaff member (ASM on 4/5/17 at 1:15 p. process followed for pharmacy recommendations). The pharmacist seeme. I then send the The physicians their recommendations). reviews them (the resummary report." We recommendations for and March 2017, AST responsible was writhrough with the recommendations of the facility policy, "Neolicy," documented all irregularities and	r Resident #13 was not acted #17, LPN #1 stated, "I can't to done."  Inducted with administrative and the end of the end	F	128	DEFICIENCY)		
	to a facility designed Director of Nursing a minimum, the writter resident's name, relethat was identified. within 72 hours of th non-Urgent recomm Attending Physician recommendation(s) the needs of the resinext routine visit to a Attending Physician medical record: a. Wreview, B. What actie	regimen review are provided for the Attending Physician, and Medical Director. a. AT a report will contain the evant drug, and irregularity b. Report will be submitted e actual reviewA. For endations, the Facility and must address the in a timely manner that meets dent - but no later than their assess the resident - and the should document in the that irregularity has been on has been taken to address armacy recommendation					

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F 428	medical record, or EHR (electronic he The administrator, corporate nurse, at (minimum data ass made aware of the 5:24 p.m.	as a tool to document in the a notation may be made in the alth record)."  ASM #2, ASM #3 the and ASM #4 the regional MDS sessment) consultant, were above concern on 4/5/17 at	F 4.	F431	I. RN#7 will receive Associate Counseling a education for failing to ensure med cart was		
SS=D	Non-Medical Readd Chapman, page 17 483.45(b)(2)(3)(g)(l LABEL/STORE DR The facility must pr drugs and biological them under an agre §483.70(g) of this punlicensed personn law permits, but only supervision of a lice (a) Procedures. A findamaceutical sent that assure the accidispensing, and administration.	n) DRUG RECORDS, UGS & BIOLOGICALS  ovide routine and emergency als to its residents, or obtain ement described in eart. The facility may permit all to administer drugs if State y under the general ensed nurse.	F 43		locked when unattended. The PPD vials were discarded from Dogwood Unit Medication Room.  An inspection of the Centers medication card medication rooms and treatment carts will be completed to verify they are locked if unattended Any variances identified will result in associate counseling. An inspection of the Center's Medication Rooms will be	od ts, y d.	
	employ or obtain the pharmacist who (2) Establishes a sy	ation. The facility must e services of a licensed stem of records of receipt and attrolled drugs in sufficient		3.	conducted to verify mult dose vials are dated whe opened.	i-	

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Continued From pa	ge 92	F4	31 <sup>:</sup>			
detail to enable an	accurate reconciliation; and					t v
(3) Determines that that an account of a maintained and per (g) Labeling of Drug Drugs and biological labeled in accordant professional princip appropriate access instructions, and the applicable.  (h) Storage of Drug (1) In accordance with facility must store locked compartment controls, and permit have access to the (2) The facility must permanently affixed controlled drugs listed controlled drugs listed controlled drugs listed control Act of 1976 abuse, except when package drug distrikt quantity stored is midble readily detected. This REQUIREMENT by:  Based on observation document review and was determined that secure medications carts and to label and account of the secure medications carts and to label and the secure medications carts and to label and the secure medications carts and to label and the secure medications carts and to label and the secure medications carts and to label and the secure medications carts and to label and the secure medications carts and to label and the secure medications carts and to label and the secure medications carts and to label and the secure medications carts and to label and the secure medications carts and to label and the secure medications carts and to label and the secure medications carts and to label and the secure medications carts and to label and the secure medications carts and to label and the secure medications carts and to label and the secure medications carts and to label and the secure medications carts and the secure medications carts and the secure medications carts and the secure medications carts and the secure medications carts and the secure medications carts and the secure medications carts and the secure medications carts and the secure medications carts and the secure medications carts and the secure medications carts and the secure medications carts and the secure medications carts and the secure medications carts and the secure medications carts and the secure medications carts and the secure medications carts and the secure medications carts	drug records are in order and all controlled drugs is iodically reconciled.  gs and Biologicals. als used in the facility must be one with currently accepted les, and include the ory and cautionary expiration date when a sexpiration date and biologicals in the sexpiration date when a sexpiration described and biologicals in the sexpiration and and other drugs and biologicals in the sexpiration and and other drugs subject to a sexpiration and and other drugs subject to a sexpiration and and a missing dose can a sexpiration and a missing dose can a sexpiration and a			responsibility to ensumed carts, med room and treatment carts a locked and all meds a secured and educate dating multi — dose vupon opening and expiration dates.  4. The UM or designee vorund weekly x 4 weethen monthly x 2 more to verify med carts, more rooms and treatment carts are locked when unattended; any variances identified woresult in associate counseling. The UM or the carts are unattended.	ure  ns are are e on ials  will eks, nths ned	
	Continued From padetail to enable an  (3) Determines that that an account of a maintained and per  (g) Labeling of Drug Drugs and biological labeled in accordant professional princip appropriate access instructions, and the applicable.  (h) Storage of Drug (1) In accordance with facility must store locked compartment controls, and permit have access to the controlled drugs listed controlled drugs listed controlled drugs listed control Act of 1976 abuse, except when package drug distributed that secure medications carts and to label an opened in one of three details and the secure medications carts and to label and opened in one of three details and to label and opened in one of three details and to label and opened in one of three details and to label and opened in one of three details and to label and opened in one of three details and to label and opened in one of three details and to label and opened in one of three details and to label and opened in one of three details and to label and opened in one of three details and to label and opened in one of three details and to label and opened in one of three details and to label and opened in one of three details and to label and opened in one of three details and the label and opened in one of three details and the label and opened in one of three details and the label and opened in one of three details and the label and the label and opened in one of three details and the label and opened in one of three details and the label and opened in one of three details.	PROVIDER OR SUPPLIER  SAS HEALTH AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 92 detail to enable an accurate reconciliation; and  (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  (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.  (h) Storage of Drugs and Biologicals. (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.  (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	PROVIDER OR SUPPLIER  SAS HEALTH AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 92 detail to enable an accurate reconciliation; and  (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  (g) Labeling of Drugs and Biologicals.  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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 secure medications on one of six medication carts and to label and date medication when opened in one of three facility unit medications	PROVIDER OR SUPPLIER  SAS HEALTH AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 92 detail to enable an accurate reconciliation; and  (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  (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.  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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 unit medication when opened in one of three facility unit medications	PROVIDER OR SUPPLIER  \$ASA HEALTH AND REHAB CENTER  \$SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 92 detail to enable an accurate reconcilidation; and  (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  (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.  (h) Storage of Drugs and Biologicals.  (f) 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.  (2) The facility must store all drugs and biologicals in locked compartments under proper temperature controls, can be permit only authorized personnel to have access to the keys.  (2) The facility must store all facility to see the monthly x 2 more than the facility unit 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 observation, staff interview, facility document review and clinical record review, it was determined that the facility staff reliated to secure medications on one of six medication when opened in one of three facility unit medications.	A BUILDING  495038  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  875 RIXLEW LANE  MANASSAS, VA 20109  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) BY FILL RECULATORY OR LSC IDENTIFYING INFORMATION)  CONTINUED From page 92  detail to enable an accurate reconciliation; and  (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  (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.  (h) Storage of Drugs and Biologicals.  (f) 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.  (2) The facility must store all 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 observation, staff interview, facility document review and clinical record review, it was determined that the facility unitedication carts and to label and date medication when opened in one of three facility unitedications on one of six medication when opened in one of three facility unitedications on one of six medication when opened in one of three facility unitedications on one of six medication when opened in one of three facility unitedications on one of of the redicition when opened in one of three facility unitedications on one of of the redicition when opened in one of three facility unitedications on one of of the redicition when opened in one of three facility unitedications on one of of the redicition when opened in one of three facility unitedications on one of of the redicition when opened in on

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i		STRUCTION		TE SURVEY MPLETED
		495038	B. WING			0.4	C
	PROVIDER OR SUPPLIER		·	STREET 8575 RI	ADDRESS, CITY, STATE, ZIP CODE  XLEW LANE  SSAS, VA 20109		<u>-/06/2017</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	1. The facility staff prior to entering a r 2. In the Dogwood facility staff failed to vials of Aplisol PPD solution (a medicati tuberculosis [lung ir instructions, the medays after being open the findings included to the	failed to lock a medication cart esident's room.  unit medication room, the label an open date on two (purified protein derivative) ion used in the diagnosis of affection]). Per manufacturer's edication must be discarded 30 ened.  Example 10 and 10 the left of was unlocked and the latt of was unlocked and the latt of was unlocked and the latt of was itself was locked. There was in the top right drawer. In the latt of the medication cart at the latt of the medication cart at the latt of lat	F4		dated upon opening. The DON or designee will review findings and report to the QAPI Committee for any further recommendations.  5. Date of compliance: Ma 10, 2017		
	make sure someboomedications." When within his line of sigh	cked, RN #7 stated, "To by doesn't get into the asked if the cart had been at, RN #7 stated, "No."  Inducted on 4/4/17 at 4:20 interim unit manager. When					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		495038	B. WING				С
NAME OF	PROVIDER OR SUPPLIER		B. WING		DEET ADDRESS SITY STATE TO CODE	04/	06/2017
	SAS HEALTH AND R			85	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	make sure there's keep the keys with about the keys in the stated, "Those are open the laundry recloset." When ask medication carts of stated, "No."  On 4/5/17 at 4:15 permember) #2, the deavare of the finding recommendations are storn properly following recommendations medication supply nursing personnel, members authorized PROCEDURE. 2. Consultant Pharma administer medications are allowed access rooms, carts and more attended by personnel. The supplementation of the facility of the facil	RN #5 stated, "We lock them, no medication sitting out and a them (staff)." When asked he medication cart, RN #5 the supervisor's key ring, they com, beauty shop, janitor's ed if there was a key for the r the medication room, RN #5 c.m. ASM (administrative staff irector of nursing was made gs.  ity's policy titled, "GENERAL & MEDICATION STORAGE" .ICY. Medications and red safely, securely and	F	131			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I .		LE CONSTRUCTION	(X3) DAT	E SURVEY
7 11 12 1 12 11 11		IDENTIFICATION NOWBER:	A. BUILE	ING			MPLETED
		495038	B. WING	i		1	C / <b>06/201</b> 7
	PROVIDER OR SUPPLIER  SAS HEALTH AND RE			8:	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE MANASSAS, VA 20109	1 04,	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	two vials of Aplisol F derivative) solution diagnosis of tubercumanufacturer's instruction be discarded 30 day.  On 4/5/17 at 10:55 a dogwood medication medication refrigeration of PPD solution (one full and one vial appropen date was docuboxes that container manufacturer's boxed documented, "Once discarded after 30 dinterview was condunurse) #5. RN #5 with medication expired aread the box that constated the box docuing good for 30 days on asked how staff would have whoever broke the swritten the open date discard the vials.  The manufacturer's "Vials in use more the discarded due to position degradation which more on 4/5/17 at 5:15 p.r. member) #1 (the adrivative) in the control of the	railed to label an open date on PPD (purified protein (a medication used in the allosis [lung infection] (1)). Per ructions, the medication must by after being opened.  a.m., observation of the pater contained two open vials are vial approximately one third proximately one forth full). No amented on the vials or the dath of the vials. The per that contained the vials entered, vial should be ays." At this time an acted with RN (Registered has asked when the lafter being opened. RN #5 and mented the medication was been written on the vials and when the medication ed the date the vials were been written on the vials and leal on the vials should have been written on the vials and leal on the vials should have been written on the vials and leal on the vials should be sible oxidation and	F 4	131:			

PRINTED: 04/13/2017 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER SAS HEALTH AND RE			STREET ADDRESS, CITY, STATE, ZI 8575 RIXLEW LANE MANASSAS, VA 20109		700/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441 SS=D	FOR MEDICATION "POLICY: Medicatic safely, securely and manufacturer's reconsupplier"  No further information website: https://dailymed.nlmgXsl.cfm?setid=1e98871134 483.80(a)(1)(2)(4)(ePREVENT SPREAD  (a) Infection prevent The facility must est and control program a minimum, the following services under the providing services under the decepted national statement and services under the program, whice the program, whice the program, whice the program, whice the program, whice the program, whice the program, whice the program, whice the program, whice the program, whice the program is provided to the program, whice the program is provided to the program, whice the program is provided to the program, whice the program is provided to the program, whice the program is provided to the program is p	led, "GENERAL GUIDELINES STORAGE" documented, ons and biologicals are stored properly following ommendations or those of the on was provided prior to exit.  was obtained from the  .nih.gov/dailymed/fda/fdaDru 1a67c-1694-4523-9548-58f7a  )(f) INFECTION CONTROL, 0, LINENS  ion and control program.  ablish an infection prevention (IPCP) that must include, at wing elements:  venting, identifying, reporting, ontrolling infections and uses for all residents, staff, and other individuals of the contractual upon the facility assessment to \$483.70(e) and following andards (facility assessment)	F 44	F 441 1. RN#3 will rece Associate Cour	nseling on propriate ol g s when ation ds or lication n will be N#3 to nering to ol	
				disposed of prop	erly.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3CQ311

Facility ID: VA0003

If continuation sheet Page 97 of 114



	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DA <sup>-</sup> CO	TE SURVEY
		495038	B. WING			C 1/06/2017
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	<u> </u>	<u>/U0/ZU1/</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	JLD BE	(X5) COMPLETION DATE
F 441	Continued From p	page 97	F 44	41:		+
	possible communication before they can spread facility;  (ii) When and to whe communicable discreported;  (iii) Standard and to to be followed to precident; including:  (iv) When and how resident; including:  (A) The type and depending upon the involved, and:  (B) A requirement to least restrictive postic circumstances.  (v) The circumstant must prohibit employed contact with resident contact will transmit (vi) The hand hygie by staff involved in the facility's I actions taken by the centre of the precion of th	duration of the isolation, ne infectious agent or organism that the isolation should be the ssible for the resident under the nees under which the facility loyees with a communicable diskin lesions from direct ents or their food, if direct it the disease; and ene procedures to be followed direct resident contact.  cording incidents identified IPCP and the corrective		2. Any resident has the potential to be affected if Center staff fail to properly dispose of used items. An inspection of Center shower rooms and resident rooms will be conducted to verify used items have disposed of properly in trash receptacles. Any resident has the potential to be affected if nurse fails to adhere to infection control practices during med administration. Random med pass observation will be conducted to ensure nurses are adhering to infection control practices when administering medications.	d	
		•			1	i .

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495038	B. WING	-			С
	PROVIDER OR SUPPLIE SAS HEALTH AND R	2	,	STRE 8575	ET ADDRESS, CITY, STATE, ZIP CODE RIXLEW LANE	04	4/06/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
	£ :	,			DEFICIENCY)		
	annual review of it program, as necess This REQUIREME by: Based on observation document review a was determined the follow infection commedication administication control programmer in the follow infection control programmer in the following including in the following including  The facility will conduct an s IPCP and update their sary. ENT is not met as evidenced ation, staff interview, facility and clinical record review, it at the facility staff failed to ntrol practices during the stration observation for one of ident #17); and failed to follow actices in one of two resident shower room on the Magnolia nurse) #3 touched one of a with her bare hand prior to nedication to the resident.  failed to dispose of used an incontinence brief in a the shower room on the	F 4		<ol> <li>The Nurse Educator or designee will educate Center staff on ensuring that used items are disposed of in trash receptacles and not less on floor. The Nurse Educator will re-educator nurses on infection control practices during medication administration.</li> <li>Random rounds will be conducted weekly x 4 weeks, then monthly x months to ensure all used items are disposed of in proper receptacles. Random med pass observation will be conducted weekly x 4 weeks, then monthly x months to ensure nurse.</li> </ol>	et te g		
	3/7/14. Resident # were not limited to: pressure and arthrifrecent MDS (minimassessment with ar	admitted to the facility on 17's diagnoses included but high cholesterol, high blood is. Resident #17's most um data set), an annual ARD (assessment reference ed the resident as being			are adhering to infection control practices during medication administration. The DC	on g	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER SAS HEALTH AND R	•		STREET ADDRESS, CITY, STATE, ZIP 8575 RIXLEW LANE MANASSAS, VA 20109		700/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	RN #3 preparing FRN #3 popped Resmilligram tablet (pablister card that cobare hand and drocup. RN #3 popped individual package medication cup with After preparing the administered all medications to Resmonducted with RN should touch pills with stated, "No." RN # above observation oxycodone with her demonstration of hemedications utilizing medications that we top of and into the made aware the oxith that contained multiple observed her pop thand and drop the part of the stated, "I don't resmondate the contained multiple of the part of the pa	a.m., this surveyor observed desident #17's medications. Sident #17's oxycodone 5 ain medication (1)) out of a ntained multiple pills into her pped the pill into a medication of all other medications from sover top of and into the hout touching the medications. medications, RN #3 edications (including the ident #17.  a.m., an interview was #3. RN #3 was asked if she with her bare hands. RN #3 was made aware of the of her handling Resident #17's bare hand. RN #3 provided a low she popped the g hand motions of popping the gree individually packaged over medication cup. RN #3 was ycodone was in a blister card iple pills, and this surveyor ne oxycodone into her bare bill into a medication cup. RN	F 44	or designee will refindings and report the QAPI Committee further recommendations.  5. Date of compliance May 10, 2017,	t to ee for	

PRINTED: 04/13/2017 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495038	B. WING		C 04/06/2047
	PROVIDER OR SUPPLIER		STF 857	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109	04/06/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 441	Tablets and Capsul medication with fing	organized and safe manner6. les- b. Never touch any of the	F 441		
	website: https://dailymed.nlm	n was obtained from the n.nih.gov/dailymed/drugInfo.cf 7c02-4f6c-acc5-1f6dcbab92c0			
	gloves and part of a	failed to dispose of used an incontinence brief in a the shower room on the			
	observation of the re Magnolia Unit was of practical nurse) # 1, (other staff member housekeeping. Observation of synthetic material synthetic material in stated, "It's a piece of brief]." LPN # 1 furt glove or the material piece of the incontin have been placed in aides should have the was asked how ofte cleans the resident stated, "They are cleaned they inconting the property of the inconting the property of	roximately 4:15 p.m. an resident shower room on the conducted with LPN (licensed, the unit manager and OSM r) # 8, the director of servation of the resident ed a used glove and a piece al. When asked to identify the in the whirlpool tub LPN # 1 of a brief [adult incontinent ther stated, "I can't tell if the al is used." When asked if the ment brief and the glove should in the tub, LPN # 1 stated, "The hrown them out." OSM # 8 ean the housekeeping staff shower rooms. OSM # 8 eaned in the morning and two he day, after their lunch and we for the day."			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3CQ311

Facility ID: VA0003

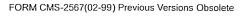
If continuation sheet Page 101 of 114



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) DA	TE SURVEY MPLETED
	495038	B. WING		0/	C 9/ <b>06/2017</b>
NAME OF PROVIDER OR SUPPLIER MANASSAS HEALTH AND RI			STREET ADDRESS, CITY, STATE, ZIP 8575 RIXLEW LANE MANASSAS, VA 20109		100/2017
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
Magnolia Unit was unit manager, OSM maintenance, OSM housekeeping, and member) # 1, the athe resident showelying on the floor between agreed the place in the trash because of it.  On 4/5/17 at 5:15 pector of nursing, above findings.  No further informate 483.50(a)(2)(i) LAB SS=D ORDERED BY PHY  (a) Laboratory Server (2) The facility muse or clinical accordance with Stappactice laws. This REQUIREMENT by:  Based on staff intereview it was determinated to obtain a physical process.	resident shower room on the conducted with LPN # 1, the M # 3, the director of M # 8, the director of M # 8, the director of M # 8, the director of M # 8, the director of M # 8, the director of M # 8, the director of M # 8, the director of M # 8, the director of M # 8, the director of M # 8, the diministrator. Observation of M # 1, the were should have been parrel and not on the floor. The picked up the glove and M # 2, the were made aware of the M # 2, the were made aware of the M # 1, the were made aware of the M # 2, the were made aware of the M # 3, the were made aware of the M # 3, the were made aware of the M # 3, the were made aware of the M # 3, the were made aware of the M # 3, the were made aware of the M # 3, the were made aware of the M # 3, the were made aware of the M # 3, the were made aware of the M # 3, the were made aware of the W # 3, the were made aware of the M # 3, the were made aware of the W # 3, the were made aware of the W # 3, the were made aware of the W # 3, the were made aware of the W # 3, the were made aware of the W # 3, the were made aware of the W # 3, the were made aware of the W # 3, the were made aware of the W # 3, the were made aware of	F 44	F504  1. Resident #8's phy was notified that had been obtaine 5/2/16 without a physician's order a order was obtaine	a BMP d and an ed to BMP t past past pleted s r or ate e	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION IG		TE SURVEY MPLETED
			A. BUILDIN			С
		495038	B. WING _		04	/06/2017
	PROVIDER OR SUPPLIER SAS HEALTH AND RI			STREET ADDRESS, CITY, STATE, ZIP COI 8575 RIXLEW LANE MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 504	Continued From page	age 102	F 50			
	order for a BMP (Elaboratory test for all aboratory test for all all all all all all all all all al	admitted to the facility on moses that included but were fibrillation (1), reflux disease (2), diabetes s, anxiety (4), depression, 5), dysphagia (6), hypokalemia of urine.  At recent MDS (minimum data dessment with an ARD ence date) of 03/20/17, coded foring a 15 on the brief I status (BIMS) of a score of 0 ditively intact for making daily int #8 was coded as requiring the of one staff member for ing.  I cal record for Resident #8 so of a BMP laboratory test Further review of the clinical dence a physician's order for a.m. at approximately 3:00 p. as conducted with ASM finember) #2, director of ed about the physician's order is MP laboratory test ASM #2		<ol> <li>The UM or designee waudit lab results weekly 4 weeks, then monthly 2 to verify lab results received have a correlating physician's order. The DON or designee will review findings and report to QAPI committee for further recommendations.</li> <li>Date of compliance: N 10, 2017</li> </ol>	ly x y x	





Facility ID: VA0003

If continuation sheet Page 103 of 114



STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495038	B. WING			1	C
	PROVIDER OR SUPPLIER			ST 85	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109	04/	/06/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 514 SS=D	documented, "Procorder for all lab worphysician's order sl On 4/5/17 at 5:15 pmember) # 1, the adirector of nursing, above findings. No further information References:  1. A problem with the heartbeat. This information was obtained from the website: https://www.nlm.nih.  2. Stomach content the esophagus and was obtained from the https://www.nlm.nih.  3. A chronic disease regulate the amount information was obtained from the https://www.nlm.nih.  4. Fear. This inform website: https://www.nlm.nih.  4. Fear. This inform website: https://www.nlm.nih.#summary.  483.70(i)(1)(5) RES	sedure: A. obtain a physician's rk and write the order on the heet."  a.m. ASM (administrative staff dministrator and ASM # 2, the were made aware of the son was provided prior to exit.  The speed or rhythm of the primation was obtained from agov/medlineplus/atrialfibrillatics to leak back, or reflux, into irritate it. This information	F 51				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		495038	B. WING			0.4	C <b>/06/2017</b>
	PROVIDER OR SUPPLIER	HAB CENTER	1	85	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE IANASSAS, VA 20109	1 04.	700/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	standards and prac		F 5	514 -	F514		
:	<ul><li>(i) Complete;</li><li>(ii) Accurately docu</li></ul>	mented;			<ol> <li>The physician visit note for Resident #1 was obtained from the</li> </ol>		
•	(iii) Readily accessi	ble; and			physician and scanned into the electronic		
	(iv) Systematically of	organized			medical record.		The state of the s
	(5) The medical rec	ord must contain-			Resident #6 will be assessed by the UM or		
1	(i) Sufficient informa	ation to identify the resident;			designee to determine		
	(ii) A record of the r	esident's assessments;			what non- pharmacological		P. C. C. C. C. C. C. C. C. C. C. C. C. C.
	(iii) The comprehen provided;	sive plan of care and services			interventions may be appropriate to offer her		
	(iv) The results of a and resident review determinations cond				when she experiencing an increase in anxiety and nurses will be educated		
	professional's progr				on utilization and documentation of non-		
	services reports as This REQUIREMEN by:	plogy and other diagnostic required under §483.50.  IT is not met as evidenced view and clinical record			pharmacological interventions as an adjunct to medications in the management of		
	review, it was deterr failed to maintain a	nined that the facility staff complete and accurate clinical 5 residents in the survey			anxiety.		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		495038	B. WING		0.4	C
	PROVIDER OR SUPPLIEI		S1 85	TREET ADDRESS, CITY, STATE, ZIP COD 575 RIXLEW LANE ANASSAS, VA 20109		/06/2017
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 514	Continued From p	age 105	F 514		***************************************	
	The facility staft physician visit note #1's clinical record	ff failed to obtain a copy of the e dated 10/31/16 for Resident I.		Resident #12's pain will be assessed to determine what non-	e `	
,	<ol> <li>The facility staff failed to document non-pharmacological interventions prior to administering an anti-anxiety medication to Resident #6.</li> <li>Facility staff failed to document non-pharmacological interventions in the clinical record for Resident #12.</li> </ol>	·	pharmacological interventions may be effective in offering her prior to administration of	r		
	non-pharmacologic	cal interventions in the clinical		PRN medications and nurses will be educated on the utilization and		
	The findings included the findings included the facility staff physician visit notes #1's clinical record	f failed to obtain a copy of the added 10/31/16 for Resident		documentation of non- pharmacological interventions as an adjunct to PRN		
	with diagnoses tha	dmitted to the facility on 8/8/14 t included, but were not limited eimer's, depression and		medications in the management of pain.  2. An audit will be completed to ensure		
	(minimum data set an ARD (assessme revealed, in part, th the BIMS (brief inte one out of a possib	nt #1's most recent MDS ), a quarterly assessment with ent reference date) of 2/8/17 nat Resident #1 was coded on erview of mental status) as a le score of 15, indicating gnificantly cognitively impaired aking.		residents have a current physicians visit note documented/scanned into the electronic medical record per Center policy.		
	reveal any docume Resident #1 had be	nt #1's clinical record did not ntation that evidenced that een seen by a physician nd 12/5/16, a period of 87		Any resident experiencing pain or anxiety has the potential to be affected if nurses fail to offer non-	Terry department in the control of t	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA 'IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER			STF <b>857</b>	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109		l/06/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	conducted with OSI director of medical to describe his proof physician visits were notes were placed i record. OSM #4 state each month he wou which residents were and he would notify OSM #4 further state problems but it is be made of OSM #4 to Resident #1 had be between 9/19/16 and On 4/5/17 at 12:00 rephysician note dated where the physician stated that it had just called the physician of A/5/17 at 5:10 p. was conducted with member) #1, the addirector of nursing, A and ASM #4 the core administrative staff of findings and a policy accurate record was that she did not have maintaining a complex.	a.m. an interview was M (other staff member) #4, the records. OSM #4 was asked less for ensuring that the etimely and that the physician into the resident's clinical ated that at the beginning of ld run a report to determine re "due" for a physician visit the physician accordingly. Led, "We have had some etter this year. A request was provide evidence that en seen by a physician d 12/5/16.  Indoon OSM #4 provided a d 10/31/16. When asked note was located, OSM #4 at been faxed to him after he is office.  In an end of the day meeting ASM (administrative staff ministrator, ASM #2, the ASM #3, the corporate nurse porate MDS coordinator. The was made aware of the above of regarding a complete and a requested. ASM #3 stated a policy regarding ete and accurate record.	F	514	pharmacological interventions as an adjunct to PRN medications to manage their pain and or anxiety. A review of progress notes for the past 72 hours will be completed to verify nurses are offering non-pharmacological interventions as an adjunct to PRN medications to manage pain and anxiety.  3. The Nurse Educator or designee will review the Center's process on verifying residents have been seen by a physician and visit note is documented/scanned into EMR per Center policy.  The Nurse Educator or designee will educate licensed nurses on the		
	2. The facility staff f	ailed to document					

		T TOTAL OLIVIOLO	7		OIVID IVC	<u>7. 0938-039</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
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NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04	100/2017
MANAS	SAS HEALTH AND RE	HAB CENTER		8575 RIXLEW LANE MANASSAS, VA 20109		×
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 514	Continued From pa	ge 107	F 51	4		
	non-pharmacologic	al interventions prior to				
	administering an an Resident #6.	ti-anxiety medication to		utilization and		Of Child Children
		documentation of non- dent #6 was admitted to the facility on /15 with a readmission on 2/18/17 with noses of arthritis, anxiety, bipolar depression, entia and high blood pressure.  documentation of non- pharmacological interventions as an adjunct to PRN				
	Resident #6 was ad	mitted to the facility on		pharmacological		
	6/17/15 with a readr	mission on 2/18/17 with		interventions as an		
	dementia and high t	s, arixiety, bipolar depression,				
		3		medications in the		
	Resident #6's most	recent MDS (minimum data		management of pain and		
	set) was a significar	nt change assessment with an		anxiety.		
	Resident #6 was co	eference date) of 2/25/17. ded on the MDS as having a		•		
	BIMS (brief interview	v for mental status) score of		a bott of designee will		
	six out of a possible	score of 15, indicating that		complete weekly audit x		
	Resident #6 was sev	verely cognitively impaired		12 weeks to ensure		
	with daily decision if	laking.		timely physician visits are		
	A review of Resident	#6's MAR (medication		documented in the		
	administration record	d) revealed, in part, that		electronic medical record.		
	Resident #6 received	d Xanax (an antianxiety e following dates and times;		The UM or designee will		
	3/4/17 7:15 a.m., 3/5	6/17 0030 (12:30 a.m.), 3/6/17		review 5 charts weekly x		
	9:24 a.m., 3/7/17 15 <sup>-</sup>	18 (3:18 p.m.), 3/20/17 1630		4 week, then monthly x 2		
		1700 (5:00 p.m.), 3/22/17		to verify nurses are		
	3/30/17 1533 (3:33 p	28/17 1738 (5:38 p.m.) and		offering and documenting		
	0.00 (0.00 p			the utilization of non –		
		#6's clinical record did not		pharmacological	i i	
		ation that Resident #6		interventions prior to		
	to receiving Xanax o	acological interventions prior the stated dates		PRN medications as an	and the second	
	-					
	A review of Resident	#6's comprehensive care		adjunct for the		
		evealed, in part, the following		management of pain and	į	
		us; (Name of Resident #6) is on(s) r/t (related to) taking		or anxiety. The DON or		
;	antianxiety and antips	sychotic medications. Date Interventions/Tasks: Utilize		designee will review the		

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		495038	B. WING			С
NAME OF	PROVIDER OR SUPPLIER	433030	D. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE	04	/06/2017
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 514	on 4/5/17 at approximas conducted with nurse) #4, a floor nurse (as needed) antianx LPN #4 stated, "If the abnormal behavior of medication as ordershe would attempt interventions prior to medication. LPN #4 you can to take their making them anxious if it (the distraction) the medication as or she would document interventions attempt document the non-pin the nursing notes.  On 4/5/17 at 10:30 a conducted with LPN was asked to describe administering a prior a resident. LPN #5 stanxious / agitated we coloring, dance and resident is incontiner work then we adminimedication." LPN #5 stanxious / the would document interventions that she "Whatever I do I write notes." LPN #5 was documentation for 3/	al interventions whenever symptoms/behaviors."  cimately 9:30 a.m. an interview LPN (licensed practical arse. LPN #4 was asked to sprior to administering a protect medication to a resident. The person is anxious or having the wealth we would administer the ed." LPN #4 was asked if the incompartment of	F 514	findings and report to the QAPI committee for any further recommendations.  5. Date of compliance: May 10, 2017		

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	T OF DEFICIENCIES OF CORRECTION	[No] D		DATE SURVEY COMPLETED		
		495038	B. WING			C
	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP O 8575 RIXLEW LANE MANASSAS, VA 20109		04/06/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	documentation reginterventions for 3.  On 4/5/17 at 3:20 conducted with LP describe her processanti-anxiety medic (the resident) are adistract the resident doesn't work and to very anxious then medication." LPN documented the nointerventions in the #8 stated, "Someti sometimes I don't. know we are supposed and the resident's to review the afore was administered to asked if she had donon-pharmacologic dates. LPN #8 states what she had done on 4/5/17 at approwas conducted with member) #2, the distributions when antianxiety medical nursing staff "should symptoms of anxies staff prior to administrate of day mee.	s unable to find any garding non-pharmacological (4/17.)  o.m. an interview was N #8. LPN #8 was asked to ess prior to administering an ation. LPN #8 stated, "If they anxious / agitated I try to at and provide activities. IF that he resident continues to be give the anti-anxiety #8 was asked if she on-pharmacological resident's clinical record. LPN mes I document but Sometimes I just get busy. I psed to document what we do response." LPN #8 was asked mentioned dates when Xanax or Resident #6. LPN #8 was occumented at interventions for any of the red she had not documented	F 51	4:		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED . C 04/06/2017	
	495038 B. WING		0.				
	PROVIDER OR SUPPLIER SAS HEALTH AND R			STREET ADDRESS, CITY, STATE, ZI 8575 RIXLEW LANE MANASSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	■ 1.25 m x x	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 514	nurse, and ASM # The administrative above findings. A paccurate record withat she did not ha maintaining a com No further informated of the survey packed of	nursing, ASM #3, the corporate 4, the regional MDS consultant. e staff was made aware of the policy regarding a complete and as requested. ASM #3 stated ave a policy regarding plete and accurate record.  Ition was provided prior to the process ghoxygen passes from your od. This information was website:  In gov/medlineplus/respiratoryfa  Forder. This information was website:  In gov/medlineplus/swallowingdi  I we'll is a condition in which the am in the blood is lower than mation was obtained from the according place of blood information about your body's information was obtained from according pov/ency/article/003462.htm. failed to document cal interventions in the clinical	F 5	514			
	3/2/17 and readmit	ted on 3/17/17 with diagnoses ere not limited to: diabetes,				Community of the Commun	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495038	B. WING		C	
	PROVIDER OR SUPPLIER	3	S 8:	STREET ADDRESS, CITY, STATE, ZIP CODE S575 RIXLEW LANE MANASSAS, VA 20109	04/06/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION	
	anemia, high blood and depression.  The most recent M day assessment, w reference date) of having an 11 out of interview for menta was moderately im The resident was of from staff for all active mental for all active mental for pain as noted up the positioning and other lieve pain, "  Review of the physical documented, "Traw (milligrams) Give 1 as needed for Pain.  Review of the Marc administration record HCL Tablet 50 MG (mouth every 8 hour documented that the on 3/20/17, 3/21/17  Review of the April 2 "Tram ADol HCL Tablet by mouth every Pain." It was documented given on 4/4/1	MDS (minimum data set), a 14 with an ARD (assessment 3/31/17 coded the resident as f 15 on the BIMS (brief al status indicating the resident apaired to make daily decisions. coded as requiring assistance stivities of daily living.  I plan created on 3/3/17 us. Patient has pain or potential pon admission assessment. s. Assist with alternate fer diversional activities to sician's orders dated April 2017 MADol HCL (1) Tablet 50 MG tablet by mouth every 8 hours and 3/17/17."  Ch 2017 MAR (medication for and documented, "TraMADol (milligrams) Give 1 tablet by reas a needed for Pain." It was needed for Pain." It was needed for Mark (milligrams) Give 1 tablet 50 MG (milligrams) Give 1 tablet	F 514			
	Review of the nurse 3/24/17 and 4/4/17 (	e's notes on 3/20/17, 3/21/17, did not evidence			:	

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44 20 20**7** 

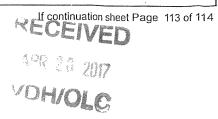
PRINTED: 04/13/2017 FORM APPROVED OMB NO 0938-0391

	OF DEFICIENCIES OF CORRECTION	IENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE		ATE SURVEY OMPLETED			
		495038	B. WING			0	C <b>4/06/201</b> 7
•	PROVIDER OR SUPPLIER	Lama	L	85°	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109		4/00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 514	F 514 Continued From page 112 documentation regarding non-pharmacological interventions attempted prior to the administration of Tramadol.  An interview was conducted on 4/5/17 at 10:40 a.m. with RN (registered nurse) #4, a nurse who gave Resident #12 the Tramadol. When asked what process staff followed when a resident complained of pain, RN #4 stated, "I ask where their pain is. How they rate it on a scale of one to ten with ten being the highest (level of pain). I ask when it started, what makes it get worse, what helps the pain." When asked what the staff did next, RN #4 stated, "Non-pharmacological interventions I can do them as a nurse. I first do that to alleviate the pain." When asked if this was documented, RN #4 stated, "It should have been in the notes." RN #4 reviewed the nurse's notes and stated she had not documented the non-pharmacological interventions. When asked why staff documented the interventions, RN #4 stated, "For other nurses to have a better idea of what's going on with the patient. When asked if she had tried non pharmacological interventions on Resident #12 prior to administering the Tramadol, RN #4 stated, "I don't remember if I did, I usually do."		F				
,	An interview was co p.m. with RN #7, a r Tramadol. When as when a resident con stated, "Ask them w make it feel better a resident) and if that the pain rating." Who documented, RN #7 notes." When asked	nducted on 4/5/17 at 1:00 nurse who gave Resident #12 ked the process staff followed applained of pain, RN #7 here the pain is, what can I to nd try to reposition (the doesn't help then ask them en asked if this would be stated, "In my progress to review the nurse's notes histered the Tramadol, RN #7					

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Event ID: 3CQ311

Facility ID: VA0003



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495038 B. WING		C 04/06/2017				
	PROVIDER OR SUPPLIER  SAS HEALTH AND RE	HAB CENTER		8575 F	ET ADDRESS, CITY, STATE, ZIP CODE RIXLEW LANE ASSAS, VA 20109	1 04/	06/201/
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	p.m. with ASM (admithe director of nursi expected to try non-prior to administerin stated yes. When a would be document expect to see it insignade aware of the made aware of	e a note."  Inducted on 4/5/17 at 4:15 Ininistrative staff member) #2, Ing. When asked if staff were Inpharmacological interventions Ing pain medication, ASM #2 Isked if those interventions Inducted on 4/5/17 at 4:15 Inducted on asked if staff were Inducted interventions Inducted interventions Inducted interventions Inducted interventions Inducted interventions Inducted interventions Inducted interventions Inducted interventions Inducted interventions Inducted intervention Induct	F 5	14			