STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/26/16 through 04/28/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 106 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents # 1 through # 19, # 25 and # 26) and five closed record reviews (Residents # 20 through # 24).	F 000		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to maintain a clean environment in four of 15 resident rooms on the secured unit, (Resident rooms # 302, # 303, # 304 and # 315); and failed to maintain the privacy shower curtains in a clean manner in one of two facility resident shower rooms, (Magnolia Unit shower room). 1. The facility staff failed to maintain clean privacy curtains on the secured unit in resident	F 252	F252 1. The privacy curtains in rooms 302, 303, 304 and 315 were removed and replaced with clean privacy curtains on 4/28/2016. The shower curtain in the Magnolia Unit Shower room was removed and replaced with a clean shower curtain on 4/28/2016. 2. Any resident has the potential to be affected if the staff fails to maintain a clean environment. An audit was completed of resident's rooms with attention to privacy curtains on 5/13/2016. An audit of privacy curtains in the shower rooms within the center was conducted on 05/13/2016. Corrective action was taken as appropriate related to the findings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	5/16/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 1	F 252		

rooms # 302, # 303, # 304 and # 315.

2. The facility staff failed to maintain the privacy shower curtains in a clean manner in the resident shower room on the Magnolia Unit.

The findings include:

1. Observations during the days of the survey revealed dirty and stained privacy curtains on the secured unit in resident rooms # 302, # 303, # 304 and # 315.

On 4/28/16 observations of the privacy curtains on the secured unit in resident rooms # 302, # 303, # 304 and # 315 was conducted with OSM (other staff member) # 9, director of environmental services. After observing the privacy curtains in resident rooms # 302, # 303, # 304 and # 315, OSM # 9 acknowledged that the curtains were dirty and needed to be cleaned. OSM # 9 further stated, "We'll take them down and clean them."

On 4/28/16 at approximately 1:00 p.m. an interview was conducted with OSM # 9. When asked about the procedure for cleaning the resident's privacy curtains, OSM # 9 stated, "The housekeepers check them every day when they are cleaning the rooms. If they are dirty they are taken down and cleaned."

The facility's policy "Environmental Services Schedule List / Check Sheet" documented, "Nine Step Cleaning Procedures 1 (one). 10. Check Privacy Curtains (cleanliness)."

On 4/28/16 at approximately 2:00 p.m. ASM (administrative staff member) # 1, the

3. The Environmental Services Director was re-educated on schedule for cleaning privacy curtains. Environmental Services staff were re-educated on the daily cleaning checklist to include privacy curtains. Administrative, department heads, and licensed staff responsible for daily room rounds were re-educated on the process to ensure care areas are maintained in a clean manner.
4. The environmental services director or designee will complete a random audit of 10 privacy curtains and shower room curtains for cleanliness daily 5x/week times 4 weeks and then monthly x 2 months. The results will be communicated at quarterly QA for review.
5. Allegation of compliance: 5/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 2	F 252		

Administrator, was made aware of the findings.

No further information was provided prior to exit.

2. Observations during the days of the survey revealed the privacy shower curtains in one of two resident's shower rooms on the Magnolia Unit were dirty.

On 4/28/16 observations of the resident's shower room on the Magnolia Unit were conducted with OSM (other staff member) # 9, director of environmental services. The shower curtains had a brown to black discoloration and were dirty in appearance. After observing the shower and privacy curtain in resident's shower room OSM # 9 acknowledged that the curtains were dirty and needed to be cleaned. OSM # 9 further stated, "We'll take them down and clean them."

On 4/28/16 at approximately 1:00 p.m. an interview was conducted with OSM # 9. When asked about the procedure for cleaning the shower and privacy curtains in the resident's shower room OSM # 9 stated, "The housekeepers check them every day when they are cleaning. If they are dirty they are taken down and cleaned."

The facility's policy "Environmental Services Schedule List / Check Sheet" documented, "Nine Step Cleaning Procedures 1 (one). 10. Check Privacy Curtains (cleanliness)."

On 4/28/16 at approximately 2:00 p.m. ASM (administrative staff member) # 1, the Administrator was made aware of the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 3 No further information was provided prior to exit.	F 252		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to maintain resident rooms in good repair in six of 15 resident rooms on the secured unit, (Resident rooms # 302, # 303, # 308, # 309, # 313 and # 314). The facility staff failed to maintain resident rooms in good repair on the secured unit in resident rooms # 302, # 303, # 303, # 308, # 309, # 313 and # 314. The findings include: Observations during the days of the survey revealed the wall mounted toilet paper holder in resident rooms # 302 and 314 were broken; broken window blinds in resident rooms # 303 and # 308; broken wall mounted towel racks in resident rooms #303 and # 309 and damaged and unrepaired walls behind the head of the beds on the D (door)-side of resident rooms # 303, # 308 and # 313. On 4/28/16 an observation of resident rooms # 302, # 303, # 308, # 309, # 313 and # 314 on the secured unit at approximately 1:20 p.m. was conducted with OSM (other staff member) # 5,	F 253	F253 1. The wall mounted toilet paper holder in rooms 302 and 314 were repaired on 4/28/2016. The broken window blinds in rooms 303 and 308 were replaced on 05/13/2016. The broken wall mounted towel racks in rooms 303 and 309 were repaired on 05/13/2016. The wall damage behind the beds in rooms 303, 308 and 313 were repaired on 04/28/2016. 2. Any resident has the potential to be affected by the facility not maintaining rooms in good repair. An audit of resident rooms was completed to identify items in need of repair on 05/13/2016. Areas identified are being corrected, replaced or repaired.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 4 director of maintenance. After observing the wall mounted toilet paper holder in resident rooms # 302 and 314; the broken window blinds in resident rooms # 303 and # 308; the broken wall mounted towel racks in resident rooms #303 and # 309 and the damaged and unrepaired walls behind the head of the beds on the D-side of resident rooms # 303, # 308 and # 313, OSM # 5 stated that the resident's rooms were in need of repair. On 4/28/16 at approximately 1:30 p.m. an interview was conducted with OSM # 5. When asked about the procedure for being notified of repairs, OSM # 5 stated, "Information for a repair is put into a computer application. The application is reviewed constantly throughout the day and the work is prioritized based on safety and quality of life." OSM # 5 further stated that he was not aware of the needed repairs in the resident rooms on the secured unit. The facility's policy "Maintenance Service" documented, "The maintenance department is responsible for maintaining the buildings and grounds in a safe, clean, comfortable and home-like environment." On 4/28/16 at approximately 2:00 p.m. ASM (administrative staff member) # 1, the Administrator, was made aware of the findings. No further information was provided prior to exit.	F 253	3. Department heads responsible for conducting room rounds including maintenance and housekeeping, along with licensed staff were re-educated on the process of inspecting resident areas for items needing repair and the process for using software to report their findings. The Maintenance Director was educated on monitoring software program for any work orders and conducting regularly scheduled rounds to observe for other issues. 4. The Administrator/designee will complete a random audit of 10 resident rooms to inspect for repair and replacement opportunities daily 5x/week times 4 weeks and then monthly x 2 months. The results will be communicated at quarterly QA for review. 5. Allegation of compliance: 5/31/16	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 5	F 278		

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to complete an accurate MDS (Minimum Data Set) assessment for four of 26 residents in the survey sample; Residents #11, #12, #6, and #7.
1. The facility Staff failed to properly code section O0300 (Pneumococcal Vaccine) of Resident #11's quarterly MDS (Minimum Data Set) assessment, with an ARD (Assessment

F278 Accuracy of Assessment

1. Resident #11, #12, #6, and #7's MDS inaccurate entries related to pneumococcal vaccine administration (O0300) were modified per the instruction of the RAI manual on 4/28/2016.

2. Any resident has the potential to be affected if the facility fails to complete an accurate MDS assessment. A review of the current resident's will be conducted to ensure accurate coding of Section O0300 (pneumococcal vaccine) with corrective actions taken as indicated by the findings.

3. The interdisciplinary team responsible for coding Section O0300 (pneumococcal vaccine) will be educated regarding accurate coding of the MDS per the RAI manual.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 6	F 278		

Reference Date) of 3/9/16.
2. The facility Staff failed to properly code section O0300 (Pneumococcal Vaccine) of Resident #12's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/7/16; and Resident #12's annual MDS with an ARD of 4/8/2015.
3. The facility staff failed to accurately code Resident #6's quarterly MDS (minimum data set) assessments with the assessment reference dates of 2/12/16, 11/12/15, and 8/13/15 for the pneumococcal vaccine administration.

4. The facility staff failed to accurately code Resident #7's 9/14/15, 10/19/15, 1/12/16 and 3/8/16 MDS (minimum data set) assessments for the pneumococcal vaccine administration.

The findings include:
1. The facility Staff failed to properly code section O0300 (Pneumococcal Vaccine) of Resident #11's quarterly MDS (Minimum Data Set) assessment, with an ARD (Assessment Reference Date) of 3/9/16.
Resident #11 was admitted to the facility on 06/18/14 with diagnoses that included but were not limited to: dementia with behavioral disturbance, adjustment disorder with mixed anxiety, osteoarthritis, anemia, high blood pressure and hypothyroidism.

Resident #11's most recent MDS (minimum data set) was a quarterly review assessment with an ARD (assessment reference date) of 3/9/16. The resident was coded as being cognitively impaired in the ability to make daily life decisions scoring four out of 15 on the BIMS (Brief Interview for Mental Status). Further review of Resident #11's quarterly MDS assessment with an ARD of 3/9/16

4. Administrator/designee will conduct an audit of 10 completed MDS assessments weekly x 4 weeks then monthly for 2 months for coding of Section O0300.

   Results will be reported to the Quality Assurance Committee for further discussion and recommendations

5. Date of alleged compliance: 5/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 7	F 278		

documented the following under Section O0300 (Pneumococcal Vaccine):
"A. Is the resident's Pneumococcal vaccine up to date?
0. No --> (arrow) Continue to O03008, If pneumococcal vaccine not received, state reason
1. Yes --> (arrow) Skip to O0400. Therapies.
B. If Pneumococcal vaccine not received, state reason:
1. Not eligible-medical condition.
2. Offered and declined.
3. Not offered."
Part A. was coded a "0"(zero), indicating that Resident #11's pneumococcal vaccination was not up to date. Part B was coded with a "-"(dash), indicating that this question was not completed.
Review of Resident #11's admission packet that was signed by the RP (responsible party) revealed that Resident #11's pneumococcal vaccination was last received in the year 2014. Resident #11's pneumococcal vaccination was up to date (received within the last five years*).
On 4/27/16 at 3:25 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #5, the MDS coordinator. When asked what dashes meant on the MDS assessment, she stated that dashes meant that the question was not assessed or the information was not found in the clinical record. When asked how LPN #5 completes section O0300, she stated that she will look back into the resident's clinical record to find information. When asked why Part A of section O0300 was coded as a "zero" when Resident #11's pneumococcal vaccination was up to date, she stated, "I did not complete this MDS. [Name of other MDS nurse] completed this. I will go get her."
On 4/27/16 at 3:52 p.m., an interview was conducted with RN (Registered Nurse) #4, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 8	F 278		

second MDS coordinator. She stated that dashes on the MDS meant that she could not find the information in the clinical record to determine if Resident #11 had received the pneumococcal vaccination. When asked why Part A of section O0300 was coded as a zero when Resident #11's vaccination was up to date, she stated, "I missed that. I could not find that her vaccination was up to date." RN #4 stated that she uses the RAI (Resident Assessment Instrument) manual as a reference when completing section O0300.
On 4/27/16 at approximately 5:00 p.m., administration was made aware of the above findings. No further information was presented prior to exit.
The MDS 3.0 RAI (Resident Assessment Instrument) manual documents the following coding instructions for section O0300:
"Coding Instructions O0300A
Is the Resident's Pneumococcal Vaccination Up to Date?
·Code 0, no: if the resident's pneumococcal vaccination status is not up to date or cannot be determined. Proceed to item O0300B, If Pneumococcal vaccine not received, state reason.
·Code 1, yes: if the resident's pneumococcal vaccination status is up to date. Skip to O0400, Therapies.

Coding Instructions O0300B,
If Pneumococcal Vaccine Not Received, State Reason If the resident has not received a pneumococcal vaccine, code the reason from the following list:
·Code 1, Not eligible: if the resident is not eligible due to medical contraindications, including a life-threatening allergic reaction to the pneumococcal vaccine or any vaccine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 9	F 278		

component(s) or a physician order not to immunize.
· Code 2, Offered and declined: resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the pneumococcal vaccine.
·Code 3, Not offered: resident or responsible party/legal guardian not offered the pneumococcal vaccine."
Pneumococcal Polysaccharide Vaccine
How many doses of PPSV are needed, and when?
Usually one dose of PPSV is all that is needed. However, under some circumstances a second dose may be given. A second dose is recommended for people 65 years and older who got their first dose when they were younger than 65 and it has been 5 or more years since the first dose. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/druginfo/meds/a607022.html#app4

2. The facility Staff failed to properly code section O0300 (Pneumococcal Vaccine) of Resident #12's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/7/16; and Resident #12's annual MDS with an ARD of 4/8/2015.
Resident #12 was admitted to the facility on 01/10/15 with diagnoses that included but were not limited to Alzheimer's disease, dementia, high blood pressure, colon cancer, anxiety disorder, and hypothyroidism. Resident #12's most recent MDS (minimum data set) was a quarterly review assessment with an ARD (assessment reference date) of 1/7/16. The resident was coded as being cognitively impaired in the ability to make daily life

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 10	F 278		

decisions, scoring 99 out of 15 on the BIMS (Brief Interview for Mental Status).
Review of Resident #12's quarterly MDS assessment with an ARD of 1/7/16 and annual assessment with an ARD of 4/8/2015 documented the following under Section O0300. (Pneumococcal Vaccine):
"A. Is the resident's Pneumococcal vaccine up to date?
0. No --> (arrow) Continue to O03008, If pneumococcal vaccine not received, state reason
1. Yes --> (arrow) Skip to O0400. Therapies.
B. If Pneumococcal vaccine not received, state reason:
1. Not eligible-medical condition.
2. Offered and declined.
3. Not offered."
Part A. was coded a "0"(zero), indicating that Resident #12's pneumococcal vaccination was not up to date. Part B. was coded a "3" indicating the pneumococcal vaccination was not offered.
Review of Resident #12's admission assessment dated 07/29/13 revealed that Resident #12 had received the vaccination while in the hospital. Resident #12's pneumococcal vaccination was up to date.
On 4/27/16 at 12:42 p.m., an interview was conducted with LPN (licensed practical nurse) #5, the MDS coordinator. When asked what "Not offered" meant for Part B of section O0300, she stated, "If I cannot see in the clinical record that the pneumnovac was offered or if I cannot find any information in the clinical record, I will document that the vaccination was not offered." She stated that she was not the nurse who completed Resident #12's MDS. She stated that she uses the RAI (Resident Assessment Instrument) manual as a reference when completing the MDS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 11	F 278		

On 4/27/16 at 3:10 p.m., an interview was conducted with ASM (Administrative Staff Member) #2, the Senior Clinical Services Specialist. She stated that if a resident is brought into the facility from the hospital, the nurse should ask the hospital immunization status of the Resident. She stated the admission agreement will ask each resident or family member if the resident received the influenza or pneumococcal vaccination. She stated that if a Resident's immunizations are not up to date, the facility must offer the vaccinations. She stated that MDS could have missed the immunization status of Resident #12 because her admission agreement was in her thinned record.
On 4/27/16 at 3:52 p.m., an interview was conducted with RN (Registered Nurse) #4, the MDS coordinator. She stated that after looking at Resident #12's pneumococcal consent form she realized that Resident #12 had declined the vaccination upon admission. RN #4 stated that Resident #12's vaccination was up to date and she would do a modification to Resident #12's MDS assessment.
On 4/27/16 at approximately 5:00 p.m., administration was made aware of the above findings. No further information was presented prior to exit.

3. The facility staff failed to accurately code Resident #6's quarterly MDS (minimum data set) assessments with the assessment reference dates of 2/12/16, 11/12/15, and 8/13/15 for the pneumococcal vaccine administration.

Resident #6 was admitted to the facility on 8/17/12 with diagnoses that included but were not limited to: high blood pressure, diabetes, depression, chronic fibromyalgia (a disorder that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 12	F 278		

causes muscle pain and fatigue) (1), insomnia and anxiety.
The most recent MDS assessment with an assessment reference date (ARD) of 2/12/16 coded the resident as being cognitively intact to make daily decisions.
Further review of the quarterly MDS assessment, with an ARD of 2/12/16 coded the resident in Section O - Special Treatments, Procedures and Programs as having not been offered the pneumococcal vaccine.
Review of the quarterly MDS assessment, with an ARD of 11/12/15 coded Resident #6 in Section O - Special Treatments, Procedures and Programs as having not been offered the pneumococcal vaccine.
Review of the quarterly MDS assessment, with an ARD of 8/13/15 coded Resident #6 in Section O - Special Treatments, Procedures and Programs as having not been offered the pneumococcal vaccine.
Review of the electronic clinical record did not reveal any documentation of the administration of pneumococcal vaccine or documentation of the offering or declining the pneumococcal vaccine.
An interview was conducted with LPN (licensed practical nurse) #5, the MDS coordinator, on 4/27/16 at 12:42 p.m. When asked to explain why the MDS assessments would be coded "Not offered," LPN #5 stated, "It means I can't find it in the record." When asked should everyone be offered a pneumococcal vaccine, LPN #5 stated, "You'd have to ask the nursing department."
An interview was conducted with administrative staff member (ASM) #2, the Senior Clinical Services Specialist, on 4/27/16 at 3:10 p.m. When asked the facility process for the pneumococcal vaccine, ASM #2 stated, "When the nurse gets report from the hospital on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 13	F 278		

resident, ideally, they would ask the pneumococcal and flu (influenza) vaccine status. On the admission assessment, I believe there is a question about when vaccines were received. If there is no documentation or the family cannot tell you, then we should offer it. It's also in the admission contract, the dates of when the vaccines were given."
Review of the electronic clinical record was conducted for the admission contract for Resident #6. The part of the 30 page admission paperwork, that documented the pneumococcal and influenza vaccine, was blank.
On 4/27/16 at 4:04 p.m. ASM #2 presented a form dated 8/17/12, "Patient Discharge/Transition." The form documented a check mark next to "Pneumococcal: Already Received." When asked where this documentation was located, ASM #2 stated, "It was in the thinned record." When asked if the thinned record was part of the clinical record, ASM #2 stated, "Yes." When asked what the MDS assessments listed above should have been coded as, ASM #2 stated, "They should have been coded that the resident was up to date on her pneumococcal vaccination."
The administrator, ASM #2, and ASM #4, the corporate MDS nurse, were made aware of the above findings on 4/27/16 at 5:24 p.m.
On 4/28/16 at approximately 10:30 a.m. ASM #2 presented a list of residents. The form documented that Resident #6 had received her pneumococcal vaccine in 2010.
The RAI (Resident Assessment Instrument) Manual, October 2015, documented:
Review the resident's medical record and interview resident or responsible party/legal guardian and/or primary care physician to determine pneumococcal vaccination status,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 14	F 278		

using the following steps:
- Review the resident ' s medical record to determine whether a pneumococcal vaccine has been received. If vaccination status is unknown, proceed to the next step.
- Ask the resident if he/she received a pneumococcal vaccine. If vaccination status is still unknown, proceed to the next step.
- If the resident is unable to answer, ask the same question of a responsible party/legal guardian and/or primary care physician. If vaccination status is still unknown, proceed to the next step.
- If vaccination status cannot be determined, administer the appropriate vaccine to the resident, according to the standards of clinical practice.

No further information was provided prior to exit.
(1) This information was obtained from: https://www.nlm.nih.gov/medlineplus/fibromyalgia.html

4. The facility staff failed to accurately code Resident #7's, 9/14/15, 10/19/15, 1/12/16 and 3/8/16 MDS (minimum data set) assessments for the pneumococcal vaccine administration.

Resident #7 was admitted to the facility on 7/15/15 with a readmission on 9/9/15 with diagnoses that included but were not limited to: dementia, heart disease, depression, kidney failure, high blood pressure and anxiety.

Review of the most recent MDS, a quarterly assessment, with an ARD (assessment reference date) of 3/8/16 the resident was coded as having a 6 out of 15 on the BIMS (brief interview of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 15	F 278		

mental status) indicating the resident was severely impaired cognitively. In section O0300 titled, "Pneumococcal Vaccine" of the MDS, Resident #7 was coded "A. Is the resident's Pneumococcal vaccination up to date?" a "0" was documented indicating that the vaccine was not up to date. Under B. "If Pneumococcal vaccine not received, state reason:" a "3" was documented indicating the vaccine was not offered.

Review of the admission agreement dated and signed on 7/15/15 on page seven under the section titled, "FLU AND PNEUMONIA VACCINE" did not evidence documentation of Resident #7's last pneumococcal vaccine.

Review of section O0300, Pneumococcal vaccine on the 9/14/15, 10/19/15 and 1/12/16 MDS assessments documented that the Pneumococcal vaccine had not been offered to the resident.

Review of the physician's orders dated and signed 4/3/16 did not evidence documentation for an order for the pneumococcal vaccine.

An interview was conducted on 4/27/16 at 12:45 p.m. with LPN (licensed practical nurse) #5, the MDS coordinator. When asked who completed the vaccination portion of the MDS, LPN #5 stated that is was the MDS staff's responsibility. When asked what it meant when it was documented in the MDS that the pneumococcal vaccine was not offered, LPN #5 stated, "It means I couldn't find it (the vaccine information) in the record." When asked if all residents should be offered a pneumococcal vaccine, LPN #5 stated, "I would ask nursing." When asked what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 16	F 278		

policy they follow to complete section O0300 of the MDS, LPN #5 stated, "The RAI (resident assessment instrument)."

An interview was conducted on 4/27/16 at 3:11 p.m. with ASM (administrative staff member) #2, the senior clinical services specialist. When asked the process staff followed to obtain information from the resident about the pneumococcal vaccine, ASM #2 stated, "When the resident is brought into the facility the nurse is to ask if they had the pneumococcal vaccine in the hospital or what is their immunization status. If there is no documentation regarding the vaccine and we ask the RP (responsible party) or resident. If they can't tell you we should give it." A request for documentation of Resident #7's pneumococcal vaccination was made.

On 4/27/16 at 4:00 p.m., ASM #2 stated, "In his (the resident's) admission assessment it was documented that it (the pneumococcal vaccine) was done within five years. This (the admission assessment) is part of the closed record." When asked if the MDS coordinators had access to that record ASM #2 stated that they did. When asked if Resident #7's MDS assessments were coded correctly, ASM #2 stated, "No."

Review of the nursing admission assessment dated 7/15/15 at 5:11 p.m. documented, "IMMUNIZATIONS. f. Has resident had a pneumovax (pneumococcal vaccine)?" The answer yes was checked, "f1. If resident had a PNEUMOVAX, give date if known." It was documented that the resident had received the vaccination, "Within 5 years."

On 4/27/16 at 5:15 p.m. ASM #1, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 17 administrator and ASM #2 were made aware of the findings. Review of the facility's policy title, "IMMUNIZATIONS" documented in part, "POLICY: Immunizations are necessary to protect the residents and staff from exposure to disease which are potentially fatal to the elderly and debilitated residents in long term care facilities." No further information was provided prior to exit. Infection with Streptococcus pneumoniae (pneumococcus) is a leading cause of illness in young children and of illness and death in elderly people and people with immune deficiencies and chronic illness. Pneumococcus causes a spectrum of disease: infections of the upper respiratory tract, otitis media, invasive infections such as bacteraemia and meningitis, and infections of the lower respiratory tract such as pneumonia. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1123818/	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 24 residents in the survey sample, Resident #14.	F 281	F281 1. The ordered clonidine for resident # 14 was discontinued on 04/28/2016. 2. Residents receiving medications have the potential to be affected if physician's orders are not clearly written and staff fails to clarify them. Physician's orders for medications written within the past 14 days will be reviewed to ensure directions for use are clear with no clarification needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 18	F 281		

The facility staff failed to clarify a physician order for Clonidine (used to treat high blood pressure (1)) for Resident #14.

The findings include:

Resident #14 was admitted to the facility on 5/23/14 with diagnoses that included but were not limited to: dementia, high blood pressure, hypothyroid disease, osteoporosis, glaucoma, depression, anxiety and dysphagia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/16/16, coded the resident as scoring a nine on the BIMS (brief interview for mental status) score, indicating that she is moderately impaired to make cognitive daily decisions. In Section I - Active Diagnoses, the resident was coded as having high blood pressure. Resident #14 was coded as being on hospice care.

Review of the physician orders dated, 11/14/15, and signed by the physician on 4/15/16, documented, "Clonidine HCL (hydrochloride) Tablet 0.1 MG (milligram); give 1 tablet by mouth every 4 hours as needed for SBP (systolic blood pressure) more than 155."

The MARs (medication administration records) for January 2016 through April 2016 documented, "Clonidine HCL Tablet 0.1 MG; Give 1 tablet by mouth every 4 hours as needed for SBP more than 155." The medication was never administered during these four months.

Review of the nurse's notes from 1/1/16 through

3. Licensed nurses will be re-educated to review orders for the necessary components of a clearly written physician order for medications to include: patient, route, dose, time, medication and any other instructions for use.
4. The DON/designee will audit newly written physician orders daily 5x/week times 4 weeks, then weekly times 8 weeks. Results will be forwarded to QA committee for review.
5. Allegation of compliance: 5/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 19	F 281		

4/28/16 did not reveal any documented blood pressure readings.

Review of the vital signs section of the electronic medical record did not reveal any documented blood pressure readings between 1/1/16 through 4/28/16.

The comprehensive care plan dated, 5/15/14 and revised on 10/20/14, documented, "Focus: (Resident #14) has altered cardiovascular status which has the potential to impact daily activities/activity tolerance r/t (related to) hypertension (high blood pressure)." The "Interventions/Tasks" documented in part, "Vital signs per MD (medical doctor) orders and as indicated by s/s (signs and symptoms). Notify physician of significant deviations/abnormalities."

On 4/28/16 at 11:06 a.m. ASM (administrative staff member) #2, the senior clinical services specialist, informed this surveyor that there were no vital signs in the computer system from 1/1/16 through 4/28/16. ASM #2 stated, "Hospice has been taking the vital signs." ASM #2 presented hospice notes from 1/1/16 through 4/28/16. The hospice notes documented the following blood pressures:
1/11/16 - 130/72
1/20/16 - no blood pressure documented
1/28/16 - 110/70
1/29/16 - 110/70
2/12/16 - 110/68
2/24/16 - 120/60
3/2/16 - 110/70
3/9/16 - 128/70
3/16/16 - 110/68
3/23/16 - 130/72
4/6/16 - 110/70

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 20	F 281		

An interview was conducted with RN (registered nurse) #1 on 4/28/16 at 11:36 a.m. RN #1 was asked to review the above order for Resident #14. When asked what should be done in relationship to that order, RN #1 stated, "We should have an order to check her blood pressure every four hours."

An interview was conducted with administrative staff member (ASM) #3, the interim director of nursing; on 4/28/16 at 11:38 a.m. ASM #3 was asked to review the above order for Clonidine. When asked what a nurse is to do with this order, ASM #3 stated, "We should be getting vital signs every four hours. It doesn't make sense; there is no order to check her vital signs every four hours. That order needs to be clarified."

An interview was conducted with ASM #2, the senior clinical services specialist; on 4/28/16 at 11:45 a.m. ASM #2 was asked to review the above order for Clonidine. When asked what a nurse is to do with this order, ASM #2 stated, "We would need to know what her systolic blood pressure is. She's on hospice care. Don't know why she has that order. And the order was written after she went on hospice care in July 2015."

The facility policy, "General Guidelines for Medication Administration" documented, "11. Obtain and record any vital signs as necessary prior to medication administration."

According to Fundamentals of Nursing, 6th edition Potter and Perry, 2005, page 846, "A medication order is required for any medication to be administered by a nurse...If the medication order is incomplete, the nurse should inform the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 21 prescriber and ensure completeness before carrying out any medication order." The administrator was made aware of the above findings on 4/28/16 at 12:53 p.m. No further information was provided prior to exit. (1) Clonidine tablets (Catapres) are used alone or in combination with other medications to treat high blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682243.html	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to follow physician's orders for two of 26 residents in the survey sample, Residents # 4, and # 2. 1. For Resident # 4, the facility staff failed to monitor blood pressure and heart rate prior to the administration of the medication (1) metoprolol [medication to treat high blood pressure] per the physician ordered parameters.	F 309	F309 1. The physician was notified of the staff's failure to take resident #4's blood pressure and pulse prior to the administration of metoprolol. No new orders were given. The physician was notified of the staff's failure to hold atenolol and lisinopril per physician written parameters for resident # 2. The parameters were revised to remove the word "equal to" for resident #2's atenolol. The parameters for the lisinopril were discontinued.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 22	F 309		

2. For Resident #2, the facility staff failed to hold the medications, Atenolol and Lisinopril (both used to treat high blood pressure), per the physician ordered parameters.

The findings include:

1. For Resident # 4, the facility staff failed to monitor blood pressure and heart rate prior to the administration of the medication metoprolol [medication to treat high blood pressure (1)] per the physician ordered parameters.

Resident #4 was admitted to the facility on 5/2/14 with diagnoses that included but were not limited to: cerebral vascular accident (when blood flow to your brain stops (2)), depression, anxiety (fear (3)), atrial fibrillation (a problem with the speed or rhythm of the heartbeat (4), anemia (low iron (5)) and hypertension (high blood pressure (6)).

Resident # 4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/19/16, coded Resident # 4 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 4 was coded as requiring extensive assistance of one staff member for activities of daily living.

Resident #4's electronic clinical record revealed a physician's order dated 4/1/16. The physician's order documented, "Metoprolol Tablet. Give 0.5 mg (milligram) tablet by mouth at bedtime related to essential hypertension. Hold for SBP (systolic blood pressure (7)) [blood pressure when the

2. Residents receiving medications have the potential to be affected if monitoring and administration of medication are not done in conjunction with ordered parameters. Physician's orders for medications written with parameters within the past 14 days will be reviewed to ensure monitoring and administration is being done according to stated parameters.
3. Licensed nurses will be re-educated regarding following physician ordered parameters including monitoring vital signs prior to administration as applicable and giving/holding medications appropriately per physician order.
4. The DON/designee will audit at least 10 medications administered with parameters included weekly times 12 weeks to ensure monitoring and administration is appropriate per the physician's order. Results will be forwarded to the QA committee for review.
5. Allegation of compliance: 5/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 23	F 309		

heart beats while pumping blood] equal to or less than 100, or heart rate equals or less than 60. Start Date: 03/21/2016."

Resident #4's eMAR (electronic medication administration record) dated March 2016 documented, "Metoprolol Tablet. Give 0.5 mg tablet by mouth at bedtime related to essential hypertension. Hold for SBP (systolic blood pressure) equal to or less than 100, or heart rate equals or less than 60. Start Date: 03/21/2016. 2100 (9:00 p.m.)." The eMAR documented the administration of Metoprolol to Resident # 4 on 3/21/16 through 3/31/16 at 9:00 p.m. Further review of the eMAR failed to evidence documentation of Resident # 4's systolic blood pressure and heartrate.

Resident #4's eMAR dated April 2016 documented, "Metoprolol Tablet. Give 0.5 mg tablet by mouth at bedtime related to essential hypertension. Hold for SBP equal to or less than 100, or heart rate equals or less than 60. Start Date: 03/21/2016. 2100." The eMAR documented the administration of Metoprolol to Resident # 4 on 4/1/16 through 4/26/16 at 9:00 p.m. Further review of the eMAR failed to evidence documentation of Resident # 4's systolic blood pressure and heartrate.

On 4/27/16 at 4:30 p.m., an interview was conducted with LPN (licensed practical nurse) # 11. When asked to describe the procedure for administering a resident's medication with parameters, LPN # 11 stated, "Check the resident's blood pressure and heart rate first. If they are below the parameters, hold the medication, notify the physician and responsible party". When asked where the resident's heart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 24	F 309		

rate and blood pressure should be documented, LPN # 11 stated, "It should be on the MAR."

On 4/27/16 at approximately 4:32 p.m., an interview was conducted with RN (registered nurse) # 1. When asked to describe the procedure for administering a resident's medication with physician ordered parameters, RN # 1 stated, "Check the resident's blood pressure and heart rate first. If they are below the parameters, hold the medication, notify the physician and responsible party". When asked where the resident's heart rate and blood pressure should be documented, RN # 1 stated, "It should be on the MAR."

On 4/27/16 at 4:35 p.m., an interview was conducted with LPN # 12. When asked to describe the procedure for administering a resident's medication with physician ordered parameters, LPN # 12 stated, "Check the resident's blood pressure and heart rate first. If they are below the parameters, hold the medication, notify the physician and responsible party". After reviewing the eMARs dated March and April for Resident # 4's Metoprolol administration LPN # 12 identified and acknowledged he had administered the Metoprolol to Resident # 4 on several occasions at 9:00 p.m. When asked where Resident 4's heart rate and blood pressure were documented, LPN # 12 stated, "I write down on a piece of paper, it should be on the MAR." When asked for the documentation of Resident # 4's heart rate and blood pressure for the 9:00 p.m. medication administration of metoprolol, LPN # 12 could not provide it and stated, "If it's not documented it wasn't done."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 25	F 309		

On 4/27/16 at 4:35 p.m., an interview was conducted with LPN # 10, unit manager. When asked to describe the procedure for administering a resident's medication with physician ordered parameters, LPN # 10 stated, "They should follow the parameters." After reviewing the eMARs dated March and April for Resident # 4's Metoprolol administration, LPN # 10 stated, "I can't say the parameters were followed from the information on the MAR."

On 4/28/16 at approximately 2:00 p.m. ASM (administrative staff member) # 1, the Administrator, was made aware of the findings.

No further information was provided prior to exit.

References:

(1) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682864.html.

(2) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/stroke.html.

(3) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(4) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(5) This information was obtained from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 26	F 309		

website:
https://www.nlm.nih.gov/medlineplus/anemia.html
.

(6) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(7) This information was obtained from the website:
http://www.nhlbi.nih.gov/health/health-topics/topics/hbp.

2. For Resident #2, the facility staff failed to hold the medications, Atenolol and Lisinopril (both used to treat high blood pressure), per the physician ordered parameters.

Resident #2 was admitted to the facility on 3/23/12 with diagnoses that included but were not limited to: Parkinson's disease, diabetes, dementia, anxiety, high blood pressure, glaucoma and gastroesophageal reflux disease.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/29/16, coded the resident as being cognitively intact to make daily decisions, scoring a 15 on the BIMS (brief interview for mental status) scale. The resident was coded as requiring extensive assistance to being totally dependent on one or more staff members for all of her activities of daily living.

The physician orders dated, 3/23/12, and renewed on 12/9/15, documented, "Atenolol Tablet (used to treat high blood pressure (1)) 50

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 27	F 309		

MG (milligrams); give 50 mg by mouth one time a day related to UNSPECIFIED ESSENTIAL HYPERTENSION. Hold for Systolic B/P (blood pressure) less or equal to 100 or apical pulse less or equal to 60." The physician orders also documented, "Lisinopril Tablet (used to treat high blood pressure (2)) 20 MG; give 20 mg by mouth two times a day related to UNSPECIFIED ESSENTIAL HYPERTENSION. Hold for Systolic B/P (blood pressure) less or equal to 100 or apical pulse less or equal to 60."

The Medication Administration Record (MAR) for January 2016 documented the above orders for Atenolol and Lisinopril. The MAR documented the Atenolol was given on the following days with the pulse being documented at 60 beats per minute, 1/5/16, 1/10/16 and 1/18/16. The January 2016 MAR also documented the Lisinopril was administered on the following dates and times when the apical pulse was less or equal to 60:
1/5/16 - 9:00 a.m. Pulse = 60
1/10/16 - 9:00 a.m. Pulse = 60
1/18/16 - 9:00 a.m. Pulse = 60

The February 2016 MAR documented the above orders for Atenolol and Lisinopril. The MAR documented the Atenolol was given on the following days with Resident #2's pulse being documented at 60 beats per minute, 2/6/16, 2/7/16 and 2/21/16. The February 2016 MAR also documented no blood pressure or pulse readings for the administration of Lisinopril for the 9:00 a.m. dose or the 4:00 p.m. dose.

The March 2016 MAR documented the above orders for Atenolol and Lisinopril. The MAR documented the Atenolol was given on 3/5/16 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 28	F 309		

9:00 a.m. with Resident #2's pulse being documented at 60 beats per minute. The March 2016 MAR documented no blood pressure or pulse readings for the administration of Lisinopril at 9:00 a.m., on 3/1/16 through 3/4/16 and 3/7/16 through 3/8/16. The medication was documented as being administered on 3/5/16 at 9:00 a.m. and 3/29/16 at 4:00 p.m. with a pulse documented as 60. The medication was documented as being given with no pulse reading on 3/5/16.

The April 2016 MAR documented the above orders for Atenolol and Lisinopril. The MAR documented the Atenolol medication was given on 4/3/16 at 9:00 a.m. with the pulse being documented at 60 beats per minute. The April 2016 MAR also documented, the Lisinopril was administered on 4/3/16 at 9:00 a.m. and 4/9/16 at 4:00 p.m. with Resident #2's pulse rate documented on both days as 60."

The comprehensive care plan, dated, 4/16/12 and revised on 9/11/15, documented, "Focus: (Resident #2) is at risk for complications related to hypertension." The "Interventions/Tasks" documented in part, "Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate and effectiveness. Staff will obtain blood pressure readings per MD (medical doctor) orders."

An interview was conducted with RN (registered nurse) #1 on 4/27/16 at 3:33 p.m. RN #1 was reviewed the above orders. When asked what a nurse is to do when administering these medications, RN #1 stated, "You have to take the blood pressure and pulse prior to administering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 29	F 309		

the medication. If the vital signs are out of the prescribed parameters, you hold the medication and send a message to the doctor." When asked if the pulse was 60, should the medications be held, RN #1 stated, "Yes, the order says less or equal to 60."

An interview was conducted with LPN (licensed practical nurse) #10, the unit manager; on 4/27/16 at 3:36 p.m. LPN #10 reviewed the above orders. When asked what the nurse is to do when administering these medications, LPN #10 stated, "You need to take the blood pressure and pulse prior to giving the medication. If the blood pressure and pulse are outside the parameters you need to hold the medications and notify the physician." When asked if the pulse was 60, should the medication be held, LPN #10 stated, "Yes, the order says less than or equal to 60."

An interview was conducted with administrative staff member (ASM) #3, the interim director of nursing; on 4/28/16 at 9:40 a.m. ASM #3 reviewed the MARS for Resident #2 and the orders for Atenolol and Lisinopril. ASM #3 was asked if the medications should have been administered," ASM #3 stated, "It says less than or equal to 60, they should have been held."

The facility policy, "General Guidelines for Medication Administration" documented, "11. Obtain and record any vital signs as necessary prior to medication administration."

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc.; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 30 believe the orders are in error or would harm clients." The administrator was made aware of these findings on 4/28/16 at 12:53 p.m. (1) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/druginfo/meds/a684031.html (2) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/druginfo/meds/a692051.html	F 309	F329 1. The physician was notified of the staff's failure to take resident #4's blood pressure and pulse prior to the administration of metoprolol. No new orders were given. The physician was notified of the staff's failure to hold atenolol and lisinopril per physician written parameters for resident # 2. The parameters were revised to remove the word "equal to" for resident #2's atenolol. The parameters for the lisinopril were discontinued. 2. Residents receiving medications have the potential to be affected if monitoring and administration of medication are not done in conjunction with ordered parameters. Physician's orders for medications written with parameters within the past 14 days will be reviewed to ensure monitoring and administration is being done according to stated parameters.	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 31	F 329		

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to ensure for two of 26 residents in the survey sample, (Residents # 4, and # 2) the drug regimen was free from unnecessary drugs.

1. The facility staff failed to monitor blood pressure and heart rate per the physician ordered parameters prior to the administration of the medication (1) metoprolol [medication to treat high blood pressure] to Resident # 4 on multiple occasions during March and April 2016.

2. The facility staff administered Atenolol and Lisinopril (both used to treat high blood pressure), to Resident #2, on multiple occasions during the months of January, February, March and April 2016, when per the physician ordered parameters, the medications should have been held.

The findings include:

1. The facility staff failed to monitor blood pressure and heart rate per the physician ordered parameters prior to the administration of the medication (1) metoprolol [medication to treat high blood pressure] to Resident # 4 on multiple occasions during March and April 2016.

3. Licensed nurses will be re-educated regarding following physician ordered parameters including monitoring vital signs prior to administration as applicable and giving/holding medications appropriately per physician order.
4. The DON/designee will audit at least 10 medications administered with parameters included weekly times 12 weeks to ensure monitoring and administration is appropriate per the physician's order. Results will be forwarded to the QA committee for review.
5. Allegation of compliance: 5/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 32	F 329		

Resident #4 was admitted to the facility on 5/2/14 with diagnoses that included but were not limited to: cerebral vascular accident (when blood flow to your brain stops (2)), depression, anxiety (fear (3)), atrial fibrillation (a problem with the speed or rhythm of the heartbeat (4), anemia (low iron (5)) and hypertension (high blood pressure (6)).

Resident # 4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/19/16, coded Resident # 4 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 4 was coded as requiring extensive assistance of one staff member for activities of daily living.

Resident #4's electronic clinical record revealed a physician's order dated 4/1/16. The physician's order documented, "Metoprolol Tablet. Give 0.5 mg (milligram) tablet by mouth at bedtime related to essential hypertension. Hold for SBP (systolic blood pressure (7)) [blood pressure when the heart beats while pumping blood] equal to or less than 100, or heart rate equals or less than 60. Start Date: 03/21/2016."

Resident #4's eMAR (electronic medication administration record) dated March 2016 documented, "Metoprolol Tablet. Give 0.5 mg tablet by mouth at bedtime related to essential hypertension. Hold for SBP (systolic blood pressure) equal to or less than 100, or heart rate equals or less than 60. Start Date: 03/21/2016. 2100 (9:00 p.m.)." The eMAR documented the administration of Metoprolol to Resident # 4 on 3/21/16 through 3/31/16 at 9:00 p.m. Further review of the eMAR failed to evidence

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 33	F 329		

documentation of Resident # 4's systolic blood pressure and heartrate.

Resident #4's eMAR dated April 2016 documented, "Metoprolol Tablet. Give 0.5 mg tablet by mouth at bedtime related to essential hypertension. Hold for SBP equal to or less than 100, or heart rate equals or less than 60. Start Date: 03/21/2016. 2100." The eMAR documented the administration of Metoprolol to Resident # 4 on 4/1/16 through 4/26/16 at 9:00 p.m. Further review of the eMAR failed to evidence documentation of Resident # 4's systolic blood pressure and heartrate.

On 4/27/16 at 4:30 p.m., an interview was conducted with LPN (licensed practical nurse) # 11. When asked to describe the procedure for administering a resident's medication with parameters, LPN # 11 stated, "Check the resident's blood pressure and heart rate first. If they are below the parameters, hold the medication, notify the physician and responsible party". When asked where the resident's heart rate and blood pressure should be documented, LPN # 11 stated, "It should be on the MAR."

On 4/27/16 at approximately 4:32 p.m., an interview was conducted with RN (registered nurse) # 1. When asked to describe the procedure for administering a resident's medication with physician ordered parameters, RN # 1 stated, "Check the resident's blood pressure and heart rate first. If they are below the parameters, hold the medication, notify the physician and responsible party". When asked where the resident's heart rate and blood pressure should be documented, RN # 1 stated, "It should be on the MAR."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 34	F 329		

On 4/27/16 at 4:35 p.m., an interview was conducted with LPN # 12. When asked to describe the procedure for administering a resident's medication with physician ordered parameters, LPN # 12 stated, "Check the resident's blood pressure and heart rate first. If they are below the parameters, hold the medication, notify the physician and responsible party". After reviewing the eMARs dated March and April for Resident # 4's Metoprolol administration LPN # 12 identified and acknowledged he had administered the Metoprolol to Resident # 4 on several occasions at 9:00 p.m. When asked where Resident 4's heart rate and blood pressure were documented, LPN # 12 stated, "I write down on a piece of paper, it should be on the MAR." When asked for the documentation of Resident # 4's heart rate and blood pressure for the 9:00 p.m. medication administration of metoprolol, LPN # 12 could not provide it and stated, "If it's not documented it wasn't done."

On 4/27/16 at 4:35 p.m., an interview was conducted with LPN # 10, unit manager. When asked to describe the procedure for administering a resident's medication with physician ordered parameters, LPN # 10 stated, "They should follow the parameters." After reviewing the eMARs dated March and April for Resident # 4's Metoprolol administration, LPN # 10 stated, "I can't say the parameters were followed from the information on the MAR."

On 4/28/16 at approximately 2:00 p.m. ASM (administrative staff member) # 1, the Administrator, was made aware of the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 35	F 329		

No further information was provided prior to exit.

References:

(1) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682864.html.

(2) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/stroke.html.

(3) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(4) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(5) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html.

(6) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(7) This information was obtained from the website: http://www.nhlbi.nih.gov/health/health-topics/topics/hbp.

2. The facility staff administered Atenolol and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 36	F 329		

Lisinopril (both used to treat high blood pressure), to Resident #2, on multiple occasions during the months of January, February, March and April 2016, when per the physician ordered parameters, the medications should have been held.

Resident #2 was admitted to the facility on 3/23/12 with diagnoses that included but were not limited to: Parkinson's disease, diabetes, dementia, anxiety, high blood pressure, glaucoma and gastroesophageal reflux disease.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/29/16, coded the resident as being cognitively intact to make daily decisions, scoring a 15 on the BIMS (brief interview for mental status) scale. The resident was coded as requiring extensive assistance to being totally dependent on one or more staff members for all of her activities of daily living.

The physician orders dated, 3/23/12, and renewed on 12/9/15, documented, "Atenolol Tablet (used to treat high blood pressure (1)) 50 MG (milligrams); give 50 mg by mouth one time a day related to UNSPECIFIED ESSENTIAL HYPERTENSION. Hold for Systolic B/P (blood pressure) less or equal to 100 or apical pulse less or equal to 60." The physician orders also documented, "Lisinopril Tablet (used to treat high blood pressure (2)) 20 MG; give 20 mg by mouth two times a day related to UNSPECIFIED ESSENTIAL HYPERTENSION. Hold for Systolic B/P (blood pressure) less or equal to 100 or apical pulse less or equal to 60."

The Medication Administration Record (MAR) for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 37	F 329		

January 2016 documented the above orders for Atenolol and Lisinopril. The MAR documented the Atenolol was given on the following days with the pulse being documented at 60 beats per minute, 1/5/16, 1/10/16 and 1/18/16. The January 2016 MAR also documented the Lisinopril was administered on the following dates and times when the apical pulse was less or equal to 60:
1/5/16 - 9:00 a.m. Pulse = 60
1/10/16 - 9:00 a.m. Pulse = 60
1/18/16 - 9:00 a.m. Pulse = 60

The February 2016 MAR documented the above orders for Atenolol and Lisinopril. The MAR documented the Atenolol was given on the following days with Resident #2's pulse being documented at 60 beats per minute, 2/6/16, 2/7/16 and 2/21/16. The February 2016 MAR also documented no blood pressure or pulse readings for the administration of Lisinopril for the 9:00 a.m. dose or the 4:00 p.m. dose.

The March 2016 MAR documented the above orders for Atenolol and Lisinopril. The MAR documented the Atenolol was given on 3/5/16 at 9:00 a.m. with Resident #2's pulse being documented at 60 beats per minute. The March 2016 MAR documented no blood pressure or pulse readings for the administration of Lisinopril at 9:00 a.m., on 3/1/16 through 3/4/16and 3/7/16 through 3/8/16. The medication was documented as being administered on 3/5/16 at 9:00 a.m. and 3/29/16 at 4:00 p.m. with a pulse documented as 60. The medication was documented as being given with no pulse reading on 3/5/16.

The April 2016 MAR documented the above

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 38	F 329		

orders for Atenolol and Lisinopril. The MAR documented the Atenolol medication was given on 4/3/16 at 9:00 a.m. with the pulse being documented at 60 beats per minute. The April 2016 MAR also documented, the Lisinopril was administered on 4/3/16 at 9:00 a.m. and 4/9/16 at 4:00 p.m. with Resident #2's pulse rate documented on both days as 60."

The comprehensive care plan, dated, 4/16/12 and revised on 9/11/15, documented, "Focus: (Resident #2) is at risk for complications related to hypertension." The "Interventions/Tasks" documented in part, "Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate and effectiveness. Staff will obtain blood pressure readings per MD (medical doctor) orders."

An interview was conducted with RN (registered nurse) #1 on 4/27/16 at 3:33 p.m. RN #1 was reviewed the above orders. When asked what a nurse is to do when administering these medications, RN #1 stated, "You have to take the blood pressure and pulse prior to administering the medication. If the vital signs are out of the prescribed parameters, you hold the medication and send a message to the doctor." When asked if the pulse was 60, should the medications be held, RN #1 stated, "Yes, the order says less or equal to 60."

An interview was conducted with LPN (licensed practical nurse) #10, the unit manager; on 4/27/16 at 3:36 p.m. LPN #10 reviewed the above orders. When asked what the nurse is to do when administering these medications, LPN #10 stated, "You need to take the blood pressure and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 39	F 329		

pulse prior to giving the medication. If the blood pressure and pulse are outside the parameters you need to hold the medications and notify the physician." When asked if the pulse was 60, should the medication be held, LPN #10 stated, "Yes, the order says less than or equal to 60."

An interview was conducted with administrative staff member (ASM) #3, the interim director of nursing; on 4/28/16 at 9:40 a.m. ASM #3 reviewed the MARS for Resident #2 and the orders for Atenolol and Lisinopril. ASM #3 was asked if the medications should have been administered," ASM #3 stated, "It says less than or equal to 60, they should have been held."

The facility policy, "General Guidelines for Medication Administration" documented, "11. Obtain and record any vital signs as necessary prior to medication administration."

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc.; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

The administrator was made aware of these findings on 4/28/16 at 12:53 p.m.

(1) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/druginfo/meds/a684031.html
(2) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/druginfo/me

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 40 ds/a692051.html	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334		

The facility must develop policies and procedures that ensure that --
(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;

F334
1. The pneumococcal vaccine was administered to resident # 5 on 05/14/2016.
2. Residents who are eligible for the pneumococcal vaccine have the potential to be affected if staff fails to offer and administer it. An audit will be done of current residents to identify any resident who may not have been offered the vaccine with corrective action taken as appropriate.
3. Licensed nurses will be re-educated about the process for determining vaccination status, offering (if eligible), administering the vaccine (if requested) and documenting in the electronic medical record.
4. The DON/designee will audit new admission records 5 times per week x 4 weeks for pneumococcal vaccine documentation, then weekly x 8 weeks thereafter. Results will be forwarded to the QA committee for review.
5. Allegation of compliance: 5/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 41	F 334		

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to offer the pneumonia vaccine to one of 26 residents in the survey sample, Resident #5.

The facility staff failed to offer Resident #5 the pneumonia vaccine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 42	F 334		

The findings include:

Resident #5 was admitted to the facility on 11/18/13 with diagnoses that included but were not limited to: urinary incontinence, stroke, depression and high blood pressure.

A review of the most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 3/25/16 coded the resident as having a one out of 15 on the BIMS (brief interview of mental status) indicating the resident was severely cognitively impaired. The resident was coded as requiring extensive assistance from staff for all activities of daily living. In section O300 titled, "Pneumococcal Vaccine" it was documented, "A. Is the resident's Pneumococcal vaccination up to date?" It was documented that the vaccine was not up to date and that the vaccine had not been offered to the resident.

Review of Resident #5's admission agreement dated and signed on 11/19/13 documented on page seven, "FLU AND PNEUMONIA VACCINE. Resident last received the pneumonia vaccine on: N/A (not applicable)."

Review of Resident #5's MDS assessments section O300 for 7/13/15, 10/13/15, 1/12/16 and 1/18/16 documented that the pneumococcal vaccine was not offered to the resident.

Review of the physician's orders dated and signed on 1/18/16 documented, "May have Pneumovaccine per MD (medical doctor). Order status. Active. Order Date. 11/18/2013."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 43	F 334		

An interview was conducted on 4/27/16 at 12:45 p.m. with LPN (licensed practical nurse) #5, the MDS coordinator. When asked who completed the vaccination portion of the MDS, LPN #5 stated that is was the MDS staff's responsibility. When asked what it meant when it was documented in the MDS assessment that the pneumococcal vaccine was not offered, LPN #5 stated, "It means I couldn't find it (the vaccine information) in the record." When asked if all residents should be offered a pneumococcal vaccine, LPN #5 stated, "I would ask nursing."

An interview was conducted on 4/27/16 at 3:11 p.m. with ASM (administrative staff member) #2, the senior clinical services specialist. When asked the process staff followed to obtain information from the resident about the pneumococcal vaccine, ASM #2 stated, "When the resident is brought into the facility the nurse is to ask if they had the pneumococcal vaccine in the hospital or what is their immunization status. If there is no documentation regarding the vaccine we ask the RP (responsible party) or resident. If they can't tell you we should give it." A request was made for documentation of the pneumococcal vaccination for Resident #5.

On 4/27/16 at 4:00 p.m. ASM #2 stated that there was no documentation that the pneumococcal vaccination had been offered to Resident #5. ASM #2 stated that she had talked to the resident's husband that day and he wanted the resident to receive the vaccination and that the staff would administer it.

On 4/27/16 at 5:15 p.m. ASM #1, the administrator and ASM #2 were made aware of the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 44	F 334		

An interview was conducted on 4/28/16 at 12:30 p.m. with RN (registered nurse) #2. When asked how staff gathered information regarding the status of the resident's pneumonia vaccine, RN #2 stated, "We have a form we get from the hospital and at the bottom it documents the vaccination status." When asked what process staff followed if that information was not on the form, RN #2 stated, "If we don't know, we ask the family or the patient when they get admitted." When asked what process staff follows if the family or patient did not know, RN #2 stated, "I would ask my supervisor for guidance."

An interview was conducted on 4/28/16 at 12:32 p.m. with RN #3. When asked how staff gathered information regarding the status of the resident's pneumonia vaccine, RN #3 stated, "When we take the verbal report (from the hospital)." When asked what process staff followed if the pneumonia vaccine information was not provided by the hospital, RN #3 stated, "I would contact the family and ask them who the resident's private physician was and contact the office. If I couldn't find out then I would contact our facility physician and get an order." When asked why the staff obtained information about the residents' immunization status, RN #3 stated, "Because they are so susceptible (to pneumonia), they are at risk because they are not moving around as much."

Review of the facility's policy title, "IMMUNIZATIONS" documented in part, "POLICY: Immunizations are necessary to protect the residents and staff from exposure to disease which are potentially fatal to the elderly and debilitated residents in long term care facilities."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 45 No further information was provided prior to exit. Infection with Streptococcus pneumonia (pneumococcus) is a leading cause of illness in young children and of illness and death in elderly people and people with immune deficiencies and chronic illness. Pneumococcus causes a spectrum of disease: infections of the upper respiratory tract, otitis media, invasive infections such as bacteraemia and meningitis, and infections of the lower respiratory tract such as pneumonia. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1123818/	F 334		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to maintain the dumpster area in a clean and sanitary manner. The findings include: Observation was made of the dumpster area on 4/28/16 at 12:30 p.m. accompanied by other staff member (OSM) #6, the dietary district manager. OSM #5, the director of maintenance, was at the dumpster using a snow shovel removing debris from the ground.	F 372	F372 1. The area behind the dumpster was cleaned at the time of survey on 04/28/2016. 2. Any resident is at risk if the facility staff fails to maintain the dumpster area in a clean and sanitary manner. 3. Facility staff were re-educated regarding the regulation for maintaining the dumpster area. The maintenance director was educated on the process to monitor the dumpster area as part of daily rounding on 05/13/2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 372	Continued From page 46	F 372		

Observation of the area included used gloves, there were too many to obtain an accurate count, a bag of peritoneal dialysis solution, a plastic bag that was ripped and contained both unused briefs and several used briefs. There were other trash items including used gloves. The above was located at the back of the dumpster. Gloves were located at the back of the dumpster but also on each sides of the dumpster. Some of the gloves had landed between the slats of wood pallets that were stored in the back right side. There were used medication bubble packets observed scattered around the dumpster.

When asked when the last time the area was cleaned, OSM #5 stated, "I cleaned it last week." They (the trash service) emptied it yesterday."

When asked if that amount of debris was just from the trash service yesterday, OSM #5 stated, "No Ma'am, I can't tell you that."

When asked whose responsibility it is to maintain the dumpster area, OSM #6 stated, "It's both maintenance and dietary."

On 4/28/16 at 12:33 p.m. the above was shared with the administrator. The administrator stated, "But they just dumped it yesterday and things fall out when they dump it." The administrator was informed the facility staff had knowledge of when the dumpster is emptied and the area was still with debris the next day at noon. The administrator stated, "Maintenance checks the area once a week."

The facility policy, "Disposal of Dietary Garbage & Refuse" documented, "4. Dumpster Area: a. Lid to dumpster is kept closed, when not in use. b.

4. The Maintenance Director or designee will conduct a random monitoring of the dumpster area including behind the dumpster to ensure the area remains clean and free of debris daily 5x/week times 4 weeks then weekly x 8 weeks. Results will be forwarded to the quarterly QA for review.
5. Allegation of compliance: 5/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 372	Continued From page 47 The area around the dumpster is free of debris, including discarded equipment, no foul odors, and is maintained in a sanitary fashion. c. The Maintenance Director is responsible for monitoring the dumpster area and alerting the appropriate offending department when debris is found and required attention." No further information was provided prior to exit.	F 372		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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	F 431	F 431 1. LPN # 7 was counseled regarding leaving the medication cart unlocked and unattended on 05/16/2016 2. Residents have the potential to be negatively affected by medication carts that are left unlocked and unattended. Medication carts were randomly visualized at the time of survey and thereafter to ensure the carts are being locked when unattended. 3. Licensed nurses will be re-educated to ensure medication carts are kept locked when unattended and out of the line of sight of the nurse responsible. 4. The DON/designee will audit 6 of 6 medication carts randomly daily 5 times per week times 12 weeks to ensure compliance with securing medications. Results will be forwarded to the QA committee for review. 5. Allegation of compliance: 5/31/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 48	F 431		

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 and facility document review, it was determined that the facility staff failed to store medications in a safe manner for one of six medication cart.

Facility staff failed to lock the medication cart on the locked unit.

The findings include:

An observation was made on 4/26/16 at 11:35 a.m. of the medication cart on the locked resident unit. LPN (licensed practical nurse) #7 was standing at the medication cart which was located at the side of the nurse's station. LPN #7 left the cart to assist residents in the day room area. LPN #7's back was to the medication cart and the cart was unlocked. LPN #7 was then observed to enter room 305 and was in the room for approximately 45 seconds, LPN #7 could not visualize the cart during that time. LPN #7 then pushed a resident in a wheelchair into the day area. At 11:39 a.m. LPN #7 returned to the medication cart. An observation of the medication cart at 11:40 a.m. was made, the cart was locked.

An interview was conducted on 4/26/16 at 3:00 p.m. with LPN #7. When asked why staff locked the medication carts, LPN #7 stated, "For security

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 49	F 431		

reasons so no one can come to it (the cart) and steal the medicine." When asked what could happen if a resident took medications from the cart, LPN #7 stated, "They could swallow it and it might not be their medicine."

An interview was conducted on 4/26/16 at 4:10 p.m. with ASM (administrative staff member) #3, the interim director of nursing. When asked what process staff followed to ensure medication safety and security, ASM #3 stated, "Definitely the computer screen should be locked so resident information isn't visible. The cart should be locked obviously, no personal items, drinks or scissors that could cause resident injury." When asked why staff needed to lock the cart, ASM #3 stated, "Safety, it contains residents' medications and someone could come and take it and the nurse is accountable for those meds (medications)." ASM #3 was made aware of the findings at that time.

Review of the facility's policy titled, "GENERAL GUIDELINES FOR MEDICATION ADMINISTRATION", documented in part, "PROCEDURE. 1. Bring medication cart in the vicinity of resident's room. Cart must always be visible to the nurse administering medications. 2. Unlock the medication cart. Cart may remain unlocked only when in direct line of sight." NOTES. 4. The medication cart is to be kept locked at all times unless in use and within nurse's sight."

On 4/27/16 at 5:15 p.m. ASM #1, the administrator and ASM #2, the senior clinical services specialist, were made aware of the findings.

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 50 "Make sure all medications are in locked containers in a room (eg., a medication room) or are under constant surveillance." Potter and Perry, Fundamentals of Nursing, seventh edition, 2009, p. 703.	F 431	F441 1. LPN #6 was counseled regarding the failure to wash hands after patient contact during medication pass on 05/16/2016. The gloves found on the shower room floor were immediately removed and appropriately disposed of by staff on 4/28/16. 2. Residents receiving care within the facility have the potential to be affected by staff's failure to wash hands after patient contact and trash not disposed of properly. Observations of the shower rooms were made during survey and thereafter for the presence of gloves and/or other trash on the floor with corrections made as needed. A medication pass review will be performed with LPN #6 to ensure compliance with hand washing on 05/16/2016. 3. Licensed nurses will be re-educated regarding hand washing requirement during medication pass procedure. Licensed staff will be re-educated regarding proper disposal of gloves and other trash within the shower room and other common care areas.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 51	F 441		

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that facility staff failed to follow infection control practices for two of 12 residents in the medication pass observation, (Resident #12 and #26); and failed to follow infection control practices in one of two resident shower rooms.

1. The facility staff failed to sanitize their hands after administering medications to Resident #12 and Resident #26.

2. Four pairs of used gloves were found lying on the floor in the resident's shower room on the Magnolia Unit.
The findings include:

1. Resident #12 was admitted to the facility on 01/10/15 with diagnoses that included but were not limited to Alzheimer's disease, dementia, high blood pressure, colon cancer, anxiety disorder, and hypothyroidism. Resident #12's most recent MDS (minimum data set) was a quarterly review assessment with an ARD (assessment reference date) of 1/7/16. The resident was coded as being cognitively impaired in the ability to make daily life decisions, scoring 99 out of 15 on the BIMS (Brief Interview for Mental Status). The resident was coded as requiring extensive assistance from

4. The DON/designee will perform at least 2 medication pass reviews per week times 12 weeks to ensure appropriate hand washing. The DON/designee will observe shower rooms randomly throughout the day 5 times per week times 12 weeks to ensure no trash is found on the floor including gloves. Results will be forwarded to the QA committee for review.
5. Allegation of compliance: 5/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 52	F 441		

staff with most ADLS (activities of daily living).

Resident #26 was admitted to the facility on 6/15/15 and readmitted on 2/19/16 with diagnoses that included but were not limited to: heart failure, chronic pain syndrome, diabetes, stroke and high blood pressure. The most recent MDS, a significant change assessment, with an ARD of 3/3/16 coded the resident as having 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact.

An observation was conducted on 4/26/16 at 4:05 p.m. of the medication administration pass with LPN (licensed practical nurse) #6. LPN #6 had just returned from administering medication to a resident and sanitized his hands. LPN #6 poured the medications for Resident #12 and took them into the resident's room to administer the medications. LPN #6 handed the medication cup and water cup to Resident #12. After the resident took the medication and drank the water, LPN #6 retrieved the medication and water cups from Resident #12 with his bare hands and placed them into the trash. LPN #6 returned to the medication cart and without sanitizing his hands poured the medications for Resident #26. LPN #6 went into the resident's room to administer the medications. LPN #6 handed the medication cup and water cup to Resident #26. After the resident took the medication and drank the water, LPN #6 retrieved the medication and water cups from Resident #26 with his bare hands and placed them into the trash. LPN #6 sanitized his hands when he returned to the medication cart.

An interview was conducted on 4/27/16 at 3:30 p.m. with RN (registered nurse) #1. When asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 53	F 441		

what infection control practices staff followed when administering medications, RN #1 stated, "Wash hands before start to prepare meds (medications), wear gloves if have a liquid. Wear gloves if spoon feed them (the resident). Wash hands or hand sanitize as appropriate after."

An interview was conducted on 4/27/16 at 3:40 p.m. with LPN #6. When asked what infection control practices staff followed when administering medications, LPN #6 stated, "Hand washing." When asked when that was done, LPN #6 stated, "Before and after." When asked why it was important to wash your hands, LPN #6 stated, "Because I might have come in contact (with something) that could cause an infection. It is to avoid passing infections even to myself." When the observations from 4/26/16 were shared, LPN #6 stated, "I washed my hands some of the time." When asked if he should have washed his hands each time, LPN #6 stated, "Yes."

An interview was conducted on 4/27/16 at 4:35 p.m. with ASM (administrative staff member) #3, the interim director of nursing. When asked what infection control practices staff followed when administering medications, ASM #3 stated, "Sanitize their hands before they start the med (medication) pass, sanitize after administering the meds." When asked why it was important for staff to sanitize their hands, ASM #3 stated, "It's infection control, you're going from patient to patient to patient. We're the number one carrier (of infection), it's their (the staffs) protection as well."

Review of the facility's policy titled, "HAND WASHING" documented in part, "When caring for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 54	F 441		

people, the hands are always touching the resident, or articles and equipment used in the care of the residents. As a result, germs from these are transferred to your hands. In turn, you transport them to other persons and places, including your own face and mouth. All residents are possible sources of infections. Also, so-called "well" persons, including facility personnel, may be carriers of disease-producing organisms. Anyone can become the victim of an infection. TIMES WHEN HAND WASHING IS VERY IMPORTANT: C. Before and after resident contact."

On 4/27/16 at 5:15 p.m. ASM #1, the administrator and ASM #2, the senior clinical services specialist were made aware of the findings.

No further information was provided prior to exit.

In Fundamentals of Nursing, Lippincott Williams and Wilkins page 140-143 concerning hand washing and the use of hand sanitizer: "The hands are conduits for almost every transfer of potential pathogens from one patient to another, from a contaminated object to the patient, or from a staff member to the patient. Hand hygiene is the single most important procedure in preventing infection....typically hands are washed with soap before coming on duty; before and after direct or indirect patient contact;...before preparing or administering medications...always wash your hands with soap after removing gloves...when using hand sanitizer, apply a small amount of the alcohol-based hand rub to all surfaces of the hands. Rub hands together until all of the product has dried (usually about 30 seconds)."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 55	F 441		

2. During the General Observation Task conducted on 4/28/16 with OSM (Other Staff Member) # 9, director of environmental services. At approximately 12:45 p.m., observation of the resident shower room located on the Magnolia Unit, revealed four pair of used plastic gloves lying on the floor in the shower room. OSM # 9 stated, "They should be thrown out."

On 4/28/16 at approximately 12:45 p.m., ASM (administrative staff member) # 3, interim director of nursing was asked to observe the resident shower room on the Magnolia Unit. When asked if the gloves found in the shower rooms were disposed of properly, ASM # 3 stated, "No. They should have been put in the trash."

On 4/28/16 at approximately 2:00 p.m. ASM (administrative staff member) # 1, the Administrator, was made aware of the findings.

No further information was provided prior to exit.

F 502 SS=D 483.75(j)(1) ADMINISTRATION

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to obtain physician ordered laboratory tests for two of 26

F 502

F502
1. Resident #6's physician was notified of the HgA1c not obtained on 04/27/2016 no new orders given. Resident #4's physician was notified of the HgA1c not obtained on 04/27/2016 no new orders given.
2. Residents with physician's orders for laboratory testing have the potential to be affected if the lab is not obtained as ordered. An audit of physician ordered laboratory testing within the past 30 days will be completed to ensure lab was obtained, corrective action will be taken as indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 56	F 502		

residents in the survey sample, (Resident #6 and Resident #4).

1. The facility failed to obtain a physician ordered laboratory test, Hgb A1C (hemoglobin A1C (1)) for Resident #6.

2. The facility staff failed to obtain a physician ordered laboratory test, HgbA1c (hemoglobin A1C -average level of blood sugar [glucose] over the previous 3 months (1)), for Resident #4.

The findings include:

1. Resident #6 was admitted to the facility on 8/17/12 with diagnoses that included but were not limited to: high blood pressure, diabetes, depression, chronic fibromyalgia (a disorder that causes muscle pain and fatigue (1)), insomnia and anxiety.
The most recent MDS assessment with an assessment reference date (ARD) of 2/12/16 coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she was independent after set up assistance was provided.
The physician order dated, 7/27/15, and signed by physician on 4/15/16, documented, "Hgb A1C Q (every) 3 months (Aug, Nov, Feb, May) on the 1st every 3 months starting on the 1st for 1 day for labs (laboratory tests)."

The comprehensive care plan dated, 5/15/15, documented, "Focus: Diabetes Mellitus with potential for fluctuating blood sugar levels that may impact health status and day to day

3. Licensed nurses will be re-educated on the process for entering, scheduling and obtaining physician ordered labs.
4. The DON/designee will audit lab orders weekly times 12 weeks to ensure labs were obtained as ordered. Results will be forwarded to the QA committee for review.
5. Allegation of compliance: 5/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 57	F 502		

function." The "Interventions" documented in part, "Labs (laboratory tests) ordered by doctor."

Review of the clinical record failed to reveal an Hgb A1C level in November 2015.

The "Laboratory Administration Report" for the month of November 2015 documented, "Hgb A1C Q 3 months (Aug, Nov, Feb, May) on the 1st every 3 months." There was no documentation that the test was completed.

At the end of the day meeting on 4/27/16 at 5:24 p.m., a copy of the missing laboratory test was requested.

On 4/28/16 at 9:20 a.m. administrative staff member (ASM) #2, the Senior Clinical Services Specialist, informed this surveyor that the facility could not find evidence that the laboratory test was completed.

An interview was conducted with ASM #3, the interim director of nursing, on 4/28/16 at 9:45 a.m. When asked the process for obtaining laboratory tests, ASM #3 stated, "There is a physician order. We make a lab slip. It is drawn in the morning. Around 12:00 p.m. to 1:00 p.m. the lab faxes the results to three printers. We take them off the printer and give them to the nurses to send them to the doctors." When asked how they ensure all laboratory tests are done per the physician orders, ASM #3 stated, "We check the laboratory administration record."

The facility policy, "Laboratory Test Results, Reporting" did not address the need for a physician order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 58	F 502		

According to Fundamentals of Nursing, 5th Edition, Lippincott Williams & Wilkins, 2007. Page 165, Laboratory tests are always interpreted in relation to the client's underlying health problems and treatment modalities. These results can also identify actual or potential health problems....Sometimes, laboratory tests and diagnostic procedures are used to judge the effectiveness of nursing interventions or medical treatment."

The administrator was made aware of the above finding on 4/28/16 at 12:53 p.m.

(1) HbA1c is a lab test that shows the average level of blood sugar (glucose) over the previous 3 months. It shows how well you are controlling your diabetes. Alternative Names include: Hemoglobin - glycosylated; A1C. (5) This information was obtained from the website: <http://www.nlm.nih.gov/medlineplus/ency/article/003640.htm>

2. The facility staff failed to obtain a physician ordered laboratory test, HgbA1c (hemoglobin A1C -average level of blood sugar [glucose] over the previous 3 months (1)), for Resident #4.

Resident #4 was admitted to the facility on 5/2/14 with diagnoses that included but were not limited to: cerebral vascular accident (when blood flow to your brain stops (2)), depression, anxiety (fear (3)), atrial fibrillation (a problem with the speed or rhythm of the heartbeat (4)), anemia (low iron (5)) and hypertension (high blood pressure (6)).

Resident # 4's most recent MDS (minimum data

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 59	F 502		

set), a quarterly assessment with an ARD (assessment reference date) of 2/19/16, coded Resident # 4 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 4 was coded as requiring extensive assistance of one staff member for activities of daily living.

Resident #4's electronic clinical record revealed a physician's order dated 12/2/15. The physician's order documented, "HgbA1c tomorrow."

Review of Resident # 4's electronic clinical record failed to evidence laboratory results for Resident # 4's HgbA1c laboratory test.

On 4/28/16 at 9:30 a.m., an interview was conducted with ASM (administrative staff member) # 2, senior clinical services specialist. When asked about the laboratory test results for Resident # 4's HgA1c, ASM # 3 stated, "We're unable to locate the lab. We called the lab and they didn't have it. The order should have been transcribed and the lab drawn."

On 4/28/16 at approximately 2:00 p.m. ASM (administrative staff member) # 1, the Administrator, was made aware of the findings.

No further information was provided prior to exit.

References:

(1) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/ency/article/003640.htm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 60 (2) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/stroke.html. (3) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.	F 502		
F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review it was determined that facility staff failed to file laboratory test reports in the clinical record for two of 26 residents in the survey sample; Resident #10 and #17. 1. The facility staff failed to file a Pro-BNP test result, ordered by the physician on 2/18/16 in the clinical record for Resident #10. Pro-BNP (Brain natriuretic peptide) is a test used to detect heart failure. Increased levels in the blood can indicate increased tension in the walls of the heart.(1) 2. The facility staff failed to file the results of a TSH (thyroid stimulating hormone) and a Vitamin B 12 level in the clinical record for Resident #17.	F 507	F507 1. Resident # 10's ProBNP was scanned into the medical record on 04/28/2016. Resident # 17's TSH and Vitamin B12 results were scanned into the medical record on 5/16/2016. 2. Residents having orders for laboratory testing have the potential to be affected if lab results are not placed into the medical record. An audit of physician ordered laboratory testing within the past 30 days will be completed to ensure lab is present in the medical record, corrective action will be taken as necessary. 3. Licensed nurses and the medical records clerk will be re-educated on the process for ensuring laboratory results are obtained and placed into the medical record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 61	F 507		

The findings include:

1. Resident #10 was admitted to the facility on 3/25/12 and readmitted on 10/3/13 with diagnoses that included but were not limited to: anoxic brain damage, difficulty swallowing, depressive symptoms, and stroke. Resident #10's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/8/16. Resident #10 was coded as being severely cognitively impaired in the ability to make daily life decisions on the staff assessment for mental status exam.

Review of Resident #10's physician telephone orders revealed the following order dated and signed by the physician on 2/18/16: "(2) Pro-BNP test tomorrow..."

Review of Resident #10's order summary report revealed that this order was completed on 2/19/16.

The ordered Pro-BNP results could not be found in Resident #10's clinical record.

On 4/27/16 at 2 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #10. When asked the process of filing a laboratory test she stated that once a laboratory test is received, it is placed in the MD (Medical Doctor) box until he signs it. She stated that medical records will then scan the labs into the medical record. She stated that she could not find Resident #10's Pro-BNP laboratory test dated 2/18/16.

On 4/27/16 LPN #10 provided a copy of the

4. The DON/designee will audit lab orders weekly x 12 weeks to ensure results are scanned into the electronic medical record. Results will be forwarded to the QA committee for review.
5. Allegation of compliance: 5/31/16 2567.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 62	F 507		

Pro-BNP that was faxed over from the laboratory company. The date and time the laboratory result was faxed to the facility was on 4/27/16 at 11:13 a.m. The results were within normal limits.

On 4/28/16 at approximately 9:00 a.m., an interview was conducted with OSM (other staff member) #3, the unit coordinator. When asked the process of filing laboratory results in the clinical record she stated, "First nurses will call for the laboratory test, fill out a laboratory slip and call lab to come to the facility to draw the ordered test. Results are faxed to our fax machine and the nurses will review the test. If the laboratory test is abnormal they will notify the doctor right away. If the lab is normal the lab goes into the MD box. When the physician comes into the facility he will review all labs in his box and signs them." OSM #3 stated she will help medical records scan singed laboratory tests into the computer system. She stated that if the physician does not sign the labs they will leave the results the MD box. She stated that a lab from February should have been in the clinical record.

The facility policy titled, "Medical Records-General information and Audit" documents in part, the following: "A complete, current and properly authenticated medical record shall be maintained for each patient/resident in accordance with accepted professional standards and state and federal rules, regulations and laws to provide complete and accurate patient information systems for continuity of care."

On 4/28/16 at 5:00 p.m., ASM (administrative staff member) # 1, the administrator, and ASM # 2, the senior clinical services specialist, were made aware of the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 63	F 507		

No further information was presented prior to exit.

References:

(1) This information was obtained from the National Institutes of Health http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1767525/.
(4) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(5) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html

(6) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

2. The facility staff failed to file the results of a TSH (thyroid stimulating hormone (1)) and a Vitamin B 12 (2) level in the clinical record for Resident #17.

Resident #17 was admitted to the facility on 3/7/16 with diagnoses that included but were not limited to: stroke, high blood pressure, dysphagia, diabetes, mood disorder, scoliosis, and gastroesophageal reflux disease.

The most recent MDS (minimum data set) assessment a quarterly assessment with an assessment reference date of 3/23/16, coded the resident scoring an 11 on the BIMS (brief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 64	F 507		

interview for mental status) score indicating that she was moderately impaired to make daily cognitive decisions.

Review of the clinical record revealed a physician order dated, 3/7/16, that documented, "CBC (complete blood count (3)), Chem 14 (Comprehensive Metabolic Panel (CMP) (4)), Lipid panel (5), TSH, Vitamin B 12."

Review of the clinical record revealed a laboratory test results dated, 3/8/16, which documented the results of the lipid panel, Chem 14 and the CBC. There were no results for the TSH or Vitamin B12 level.

An interview was conducted with ASM (administrative staff member) #3, the interim director of nursing, on 4/28/16 at 9:45 a.m. When asked the process for obtaining laboratory tests, ASM #3 stated, "There is a physician order. We make a lab (laboratory) slip. It is drawn in the morning. Around 12:00 p.m. to 1:00 p.m. the lab faxes the results to three printers. We take them off the printer and give them to the nurses to send them to the doctors." When asked how they ensure all laboratory tests are done per the physician orders, ASM #3 stated, "We check the laboratory administration record."

On 4/28/16 at approximately 10:00 a.m. a copy of the TSH and Vitamin B 12 level for Resident #17 were requested from ASM #2.

On 4/28/16 at 11:56 a.m. ASM #2, the senior clinical services specialist, presented a copy of the TSH and Vitamin B12 levels that had been faxed to the facility on 4/28/16 at 10:22 a.m. When asked if they were in the clinical record,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 65	F 507		

ASM #2 stated, "Those tests take longer to run. It's not to say they weren't here. But we had lab fax them over. There were done, just not in the clinical record."

The facility policy, "Laboratory Test Results, Reporting" documented, "Purpose: To ensure lab results are received and acted upon in a timely manner. Procedure: 1. Upon completing of the ordered lab tests, the lab will send written results to the facility. 2. The lab will identify any critical values notify the facility as soon as possible; and the Nurse will notify the physician as soon as possible. 3. The Nurse will call or fax the abnormal results to the physician. All written reports will be sent to the physician or left in the physician's mailbox in the facility to be initialed to verify physician review. 4. When the nurse has called or faxed the results to the physician, the Nurse will write on the lab slip: Results faxed to Dr. Smith at 800-555-1212 on Sept 12, 1997 at 3:00 p.m."

The administrator was made aware of the above findings on 4/28/16 at 12:53 p.m.
(1) A TSH test measures the amount of thyroid stimulating hormone (TSH) in your blood. TSH is produced by the pituitary gland. It tells the thyroid gland to make and release thyroid hormones into the blood. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/ency/article/003684.htm
(2) These vitamins help the process your body uses to get or make energy from the food you eat. They also help form red blood cells. This information was obtained from the website:
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 66	F 507		

medlineplus-bundle&query=Vitamin+B+12.
(3) A CBC measures the number of red blood cells (RBC count) The number of white blood cells (WBC count) ... . This information was obtained from the website: http://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&query=CBC&x=24&y=17
(4) Chem 14 or Comprehensive Metabolic Panel (CMP) is used as a broad screening tool to evaluate organ function and check for conditions such as diabetes, liver disease, and kidney disease. The CMP may also be ordered to monitor known conditions, such as hypertension, and to monitor people taking specific medications for any kidney- or liver-related side effects. If a doctor is interested in following two or more individual CMP components, she may order the entire CMP because it offers more information. This information was obtained from the website: <http://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&query=CMP&x=9&y=21>
(5) A blood test called a lipid panel measures triglycerides and cholesterol. This information was obtained from the website: http://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3afile=viv_9ra3Vt&server=pvlbsrch00.nlm.nih.gov&v:state=root%7Croot-10-10%7C0