PRINTED: 03/04/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495217	B. WING	·····			C 04/2016
NAME OF PI	ROVIDER OR SUPPLIER	L	STREET ADDRESS, CITY, STATE, ZIP CODE				
MANORCA	ARE HEALTH SERVICES	-FAIR OAKS			2475 LEE JACKSON MEMORIAL HIGHWAY REVIS	SED COP	<i>(</i>
				FAIRFAX, VA 22033			7
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Mestandard survey was 2/4/16. Complaints was urvey. Corrections a with 42 CFR Part 483 requirements. The census in this 15 135 at the time of the consisted of three cur (Residents # 5 through record reviews (Residents # 5 through record reviews (Residents Was 10(b)(11) NOTIF (INJURY/DECLINE/R) A facility must immedicantly with the resident involving the injury and has the pot intervention; a significantly van deterioration in health status in either life threclinical complications) significantly (i.e., a new existing form of treatment); or a decisithe resident from the figure of the facility must also the facility must also.	dicare/Medicaid abbreviated conducted 2/2/16 through the investigated during the are required for compliance. Federal Long Term Care 5 certified bed facility was survey. The survey sample rent Resident reviews the #7) and four closed lents #1 through #4). Y OF CHANGES OOM, ETC) Tately inform the resident; and if dent's legal representative of member when there is an resident which results in ential for requiring physician and change in the resident's sychosocial status (i.e., a mental, or psychosocial eatening conditions or a need to alter treatment ed to discontinue an ment due to adverse commence a new form of on to transfer or discharge facility as specified in	F	157		plan of on to ement hereing the tiance cies rrected. ty to blood was sugar The any tside of the cies any	
		ident's legal representative ember when there is a			II.		
THE STATE FOR		ember when there is a ommate assignment as		i	Residents having physician of	orders	to
ABORATORY/	RECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURE	1	-	/ TITLE		(X6) DATE

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 A. BUILDING			SURVEY LETED
		495217	B. WING			02/) 04/2016
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY REVISED COPY FAIRFAX, VA 22033			
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F 157	resident rights under regulations as specif this section. The facility must reco	ie 1 Federal or State law or fied in paragraph (b)(1) of ord and periodically update or number of the resident's or interested family member.	F	157	be notified when blood sugareadings are outside of order parameters have the potential affected. An audit of resider insulin was performed. Identification of the sum	red Il to be ats on tified nsure	
	This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to notify the physician, per the physician order of an elevated blood sugar for one of seven residents in the survey sample, Resident #5. The physician order was to notify the physician if Resident #5's blood sugar went over 400. It went over 400 and the physician was not notified. Blood glucose values for adults is 60-100 mg/dl (1) The findings include: Resident #5 was admitted to the facility on 10/14/12 with a recent readmission on 12/30/15 with diagnoses that included but were not limited to: congestive heart failure, gastroesophageal reflux disease, glaucoma, anemia, high blood pressure, peripheral vascular disease, and diabetes. The most recent MDS (minimum data set)			The state of the s	III. Nursing staff was educated of following physician orders a notifying the physician when order indicates. An audit of on insulin was performed. It residents were reviewed to eappropriate parameters were place.	1	
					IV. Residents on insulin will be to ensure the physician is no when a blood sugar reading outside of the parameters as indicated on the physician of This audit will occur 5 times for 2 weeks, 2 times a week following 2 weeks and then week for the following 4 we Results of the audit will be results.	tified is rder. a wee for the once pe	k er

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F 157	with an assessment coded the resident a (brief interview for m the resident was cog decisions. The reside extensive assistance of his activities of da Medications, the reside of the look back period	care 14 day assessment, reference date of 1/11/16, is scoring a 13 on the BIMS ental status) score, indicating nitively intact to make daily ent was coded as requiring of one or two people for all illy living. In Section N - dent was coded as having tions fur the past seven days od. I dated, 12/31/15, documented insulin with Novolog L (units per milliliter)if BS (plus) = (equals) give 10 or than) 400, give insulin and eously before meals and at etes mellitus)." Inistration Record (MAR) for lented in part: "Sliding scale solution 100 units/ML (units blood sugar) 401 + = give 10 or than) 400, give insulin and eously before meals and at letes mellitus)." On 1/19/16, sugar was documented as ulin was documented as	F	157	by the Administrator and subto the QAPI committee for reand action as appropriate. The committee will determine the for further audits and or action V. 3/4/16	eview le QAP e need	·I

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Endod Diabe "Admi Repor thirst/s (nause An interpraction regard document the blot the nut. LPN # know." physic the process of	tes." The "Inte nister medicat t symptoms of urination, hung ea/vomiting) a erview was concal nurse) #3 of the state of th	elated to; Insulin Dependent rventions" documented, ions per physician orders. Fyperglycemia: excessive ger, weakness, N/V cetone breath." Inducted with LPN (licensed on 2/3/16 at 4:06 p.m. ale insulin orders with eters to call the physician if ever 400. When asked what of the blood sugar was 401, isall the doctor and let him where the call to the mented, LPN #3 stated, "In	F	157			

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F 157	(Finger Stick Blood S "Suggested Documer observations and/or of interventions includin physician." In Basic Nursing, Est edition (Potter and Pe was a reference sour notification. Failure to condition appropriate information to the phy provider are causes of way to avoid being lia follow standards of ca care, and to commun providers. The physic is responsible for dire of a patient. ASM #1, (administrat nursing) and ASM #3	ugar)" documented, ntation: Unusual complaints and subsequent g communications with sential for Practice, 6th erry, 2007, pages 56-59), ce for physician's orders and o monitor the patient's ly and communicate that risician or health care of negligent acts. The best ble for negligence is to are, to give competent health icate with other health care ian or health care provider cting the medical treatment or), ASM #2, (director of , (the quality assurance	F .	157					
F 204 SS=D	concern on 2/3/16 at No further information (1) Nurse's Manual of Tests; Bonita Cavana 107. COMPLAINT DEFICE 483.12(a)(7) PREPAR SAFE/ORDERLY TRANSAFE/ORDERLY TRANSAFE/ORDERL	ENCY RATION FOR ANSFER/DISCHRG e sufficient preparation and	Ľ.	204	F204 It is the practice of this facility provide sufficient preparation ensure a safe discharge. I. Resident #3 was discharged facility on 8/22/15.	n to	he		

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	ARE HEALTH SERVICES	-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHWAY REVISED OF FAIRFAX, VA 22033			•
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F 204	written notification pri to the State Survey A ombudsman, residen legal representatives responsible parties, a transfer and adequate as required at §483.7 This REQUIREMENT by: Based on staff interviacility document reviacility document reviacomplaint investigation the facility staff failed preparation to ensure seven residents in the #3. The facility staff failed need for a mechanical Also, the facility staff quality for needed me	ne facility must provide or to the impending closure gency the State LTC ts of the facility, and the of the residents or other s well as the plan for the e relocation of the residents, 5(r). T is not met as evidenced liew, clinical record review, ew and in the course of a on, it was determined that	F	204	II. Residents discharging from facility who require medica equipment have the potential affected. III. Education was provided to the social services department relating to preparation for social discharge. Residents discharge from the facility will be resulted to ensure sufficient preparation related to medical equipment is provided to esafe discharge. This review documented in the clinical a progress note. The Admin will audit discharge progres to ensure compliance. This occur 2 times a week for the once weekly for 4	staff in ent safe arging viewed t cal nsure a vill b record nistrate as audit wo week	by e as or es will
	Resident #3 was adm 9/24/14 with diagnose limited to: *multiple so disease that affects y edema (swelling), urin blood pressure. Resi (minimum data set) (p quarterly assessment reference date) of 7/4 being cognitively intac	es that included but were not clerosis (a nervous system our brain and spinal cord), nary tract infection and high dent #3's most recent MDS orior to discharge), a with an ARD (assessment /15, coded the resident as	Appendix and a second a second and a second		IV. Results of the audits will be reviewed by the Administ submitted to the QAPI confor review and action as a The QAPI committee will the need for further audits action plans	rator ar mmitte ppropri detern	e ate. nine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 204	personal hygiene. Se as requiring extensive staff with transfers, to dependent of one state documented Residen wheelchair. Residen the facility on 8/22/15. A physical therapy dis 5/13/15 documented, "Interventions Provide s/p (status post) refer intervention focused independence with bethera acts, thera exer (neurological) re-edu progress with therapy (minimum to moderal the bar and min A to remove the transfer. However, prenough for safe transvaries depending on (secondary to) to prosclerosis). Pt is curred the transfer of the same transfer of the same transfer of the same transfer. A social services note "SW (Social Worker) the resident stating his she stated her house complete until Octobe be discharging from the transfer of the sak for a copy of her did provide the invoice Administrator about the not leaving the facility as a supplementation of the same transfer.	ability, locomotion, eating and ection G coded the resident erasistance of two or more obliet use and being totally ff with bathing. G0600 tr #3 normally used a tr #3 was discharged from eta #3 was discharged from eta #4 was discharged from eta #4 was discharged from eta #4 was discharged from eta from the nursing. PT on increasing pts eta mobility and transfers with ecise and neuro cation. Pt has made slow eta erasist) with sit to stand in mod A with squat pivot to progress is not functional fers. Pts performance the muscle fatigue 2/2 (sic) gressing MS (multiple ently discharging from reached maximum	F 20	V. 3/4/16			

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F 204	October 1st. SW app discuss other housing them was to have resident will receive hotel. Resident did soption. SW did pull u area. Later in the after the SW and the Admi a house. This house and in a basement lethospital bed in the beowner. SW confirmed (durable medical equivalence) reaching the company). Per the receiving. The followin 1 commode, reaching wheelchair, and a shoorder in with (name o company). Per the receiving the presentative from the person conducted an resident. This prografinancial assistance to SW notified the resided discharge of 8/22/15, coming to pick her up continue to follow up the discharge planning the stage of the stage	not be accessibly (sic) until proached the resident to g options with her. One of sident stay at an extended at few weeks. SW stated that home health therapy at the eem to be open to the hotel up hotel rates in the local ernoon, the resident notified mistrator that she did locate is handicapped accessible well home. She has a edroom from the previous d with the resident her DME inpment) she will be ing pieces will be ordered: 3 er, transfer board, ower bench. SW put the f medical equipment esident's request, SW called in agency) for custodial care SW faxed the request of erapy), OT (occupational red nurse) to the head nurse alth agency). A he Money Follows the assessment with the m can possibly provide the home renovations. Ent that on the day of medical transport will be a around 12:30 p.m. SW will as needed and assist with g."	F	204			
***************************************	"SW received a mess company to provide d	e dated 8/20/15 documented, age from (name of lurable medical equipment) chair and bedside commode	***************************************				

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until 2016 to get new resident about the up provided her a copy of showed her past order she will find a way to home. SW also provider with moving her between the with moving her between the home. SW made arrangements with (not company) for the day continue to follow up a staff with transfers, us method. OSM #9 state to use a sliding board Resident #3 a lot after	In 2009, the resident int and will not qualified (sic) equipment. SW notified the date on equipment. SW of the documents that er in 2009. Resident stated locate her equipment at her ided her a resource to assist pelongings from the facility to a transportation ame of transportation of discharge. SW will as needed." The ehensive care plan initiated ed/cancelled on 4/2/15 to does not show potential for munity due to physical care: Reassess care needs and er as needed. Support representative as needed" The man interview was (certified nursing assistant) her wasn't sure but she used a standing lift. The wasn't sure was (other staff member) #9, the to who worked with Resident with #9 stated in May 2015, the stimum assistance of one sing the stand and pivot ted the resident did not want wities" and maintained her wittes" and maintained her	F	204				

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		495217	B. WING			02/	04/2016
NAME OF PR	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORCA	RE HEALTH SERVICES	LEAID OAKS		12475 LEE JACKSON MEMORIAL HIGHWAY		SED COP	<i>(</i>
MARONOA	IVE HENETH SERVICES	PIAIN DANG		FAIRFAX, VA 22033			
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	#4 stated Resident #5 financial issues and v #4 stated the resident and the home health enter within 24 or at r stated Resident #3 re bed side commode. received those items qualify for those items qualify for those items stated on the day of F (OSM #4) spoke to a resident borrowed a v OSM #4 stated Resid at stated Resident required toileting and dressing thought Resident #3 is asked if the lift was or discharge, OSM #4 st ordering the lift. Whe assessed by the thera discharge, OSM #4 st green light from the th further stated someor Resident #3. OSM #4 agency was responsi up care. OSM #4 sta mechanical lift was no or the facility staff. On 2/3/16 at 2:02 p.m conducted with CNA is CNA #2 stated Reside staff was using a star On 2/3/16 at 2:18 p.m	m., an interview was #4, the social worker. OSM 3 was discharged due to vasn't paying her bill. OSM t was discharged on 8/22/15 agency was scheduled to most 48 hours. OSM #4 quested a wheelchair and OSM #4 stated the resident in 2009 and would not again until 2016. OSM #4 Resident #3's discharge, she nurse who stated the vheelchair from the facility. Itent #3 only needed selchair. When asked how assistance with showering, OSM #4 stated she used a Hoyer lift. When refered for the resident's tated she didn't remember an asked if Resident #3 was apy department prior to her tated she always got the herapy department. OSM #4 he from the county assessed 4 stated the home health ble for Resident #3's follow ted she remembered a bit requested by Resident 3 h., an interview was #2 regarding Resident #3. ent #3 required a lift and ad lift to get the resident up.	F	204			

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F 204	Continued From page	e 10	F 2	204		,	
	business office mana					}	
		charged because she didn't					
		stated she should have a					
		e notice on file. (Note-					
	1	ge letter revealed Resident		j			
		23/15 that she would be	11.100.000 a d.c.				
		5 due to failure to maintain	İ				
	_	ing had a balance of \$6,263).					
	On 2/3/16 at 2:25 p.n	n an interview was		an annotation of the state of t			
	conducted with RN (r						
		3. RN #3 stated the resident					
		d times three and had					
		gs so she transferred with a					
	stand lift.	•					
	On 2/3/16 at 2:48 p.n						
		#3. CNA #3 stated Resident	Week.	7000.4			
		dent of one staff with bed					
		a sit and stand lift with	İ				
		g. CNA #3 was asked if					
		regarding Resident #3's					
		rge and stated no one had just knew the resident was		ment about			
	leaving.	just knew the resident was		A Linear Annual			
	On 2/3/16 at 4:40 p.n	n. an interview was		į.		l l	
		#10, the physical therapist					
		sident #3 in May 2015. OSM		1			
		#3 required a maximum					
		yer lift with two or three					
	people for transfers.					***************************************	
		home alone so staff					
		s of what was required for				Į.	
1		DSM #10 stated she wasn't					
		nt #3's discharge in August					
	but she had attended			\$			
		stated Resident #3 insisted		İ			
	on going home. OSN	// #10 stated she thought the					

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an independent level for wheelchair. OSM #4 stated ischarged with a wheel commode. OSM #4 stated wheelchair from the faci to. OSM #4 stated she coordinate Resident #3's the resident was dischart therapy department didr #3 to have a lift and stated board and home health she remembered the resident with a sliding board. On 2/3/16 at 5:00 p.m., conducted with ASM (ac member) #2, the director stated during discharge about what residents ne wasn't really involved in	d with a commode and OSM #10 stated anyone with her (at another interview was (the social worker). In the social worker) and have a discussion a mechanical lift prior to a OSM #4 stated she ses and CNAs about bught the resident was at roperating her ated Resident #3 was not lichair or bed side ated the resident took a lity but wasn't supposed called a company to see medical equipment after arged. OSM #4 stated the n't recommend Resident and the sident saying she was fine an interview was diministrative staff or of nursing. ASM #2 plan meetings, staff talks ared. ASM #2 stated she Resident #3's discharge. ASM #1, the administrator aware of the above	F	204			

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	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	3-FAIR OAKS		12	FREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY REVI AIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 250 SS=D	between all department smoothly transitioning setting in their communication. The compliant patient cert the patients and their care plan, therapy er No further information was https://www.nlm.nih.gosis.html COMPLAINT DEFICE 483.15(g)(1) PROVIS RELATED SOCIAL STATE The facility must proviservices to attain or reservices.	is a collaborative effort ents to assist the patient in g to the next desired care funity or to a long term his is achieved through need care that focuses on r goals with every admission, ncounter and discharge" In was presented prior to exit. Is obtained from the website: gov/medlineplus/multiplescler IENCY SION OF MEDICALLY SERVICE vide medically-related social maintain the highest mental, and psychosocial		250	F250 It is the practice of this faciliprovide medically related so services. I. Resident #3 was discharged	ocial	he
	by: Based on staff intervent facility document, and complaint investigation that the facility staff for related social services in the survey sample. The facility staff failed need for a mechanical	on review, it was determined ailed to provide medically as for one of seven residents			facility on 8/22/15. II. Residents discharging from the facility who require medical equipment have the potential affected. III. Education was provided to state the social services department relating to preparation for sail	taff in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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**************************************		495217	B. WING			02/	04/2016	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
RANDEC	ARE HEALTH SERVICES	EAID OAKS		1	2475 LEE JACKSON MEMORIAL HIGHWAY REVI	SED COPY	1	
WANGICO	ANG HEALTH SERVICES	-rair dans	FAIRFAX, VA 22033					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 250	quality for needed me wheelchair and a bed discharge. The findings include: Resident #3 was adm 9/24/14 with diagnose limited to: *multiple sed disease that affects yedema (swelling), urishlood pressure. Resident guarterly assessment reference date) of 7/4 being cognitively intareference date) of 7/4 being cognitively intareference date) as requiring extensive staff with bed mo personal hygiene. Seas requiring extensive staff with transfers, to dependent of one staff occumented Resident wheelchair. Resident wheelchair. Resident the facility on 8/22/15 A physical therapy dis 5/13/15 documented, (Patient) is evaluated from the nursing. PT increasing pts indeper and transfers with the neuro re-education. I with therapy. Pt is mi moderate assist) with min A to mod A with showever, pt progress safe transfers. Pts personal process.	adical equipment such as a slide commode prior to stitled to the facility on as that included but were not clerosis (a nervous system our brain and spinal cord), nary tract infection and high dent #3's most recent MDS prior to discharge), a swith an ARD (assessment last section G coded ding extensive assistance of assistance of two or more dilet use and being totally flewith bathing. G0600 at #3 normally used a standard was discharged from as the same size of the sylvation of t	F	250	discharge. Residents discharfrom the facility will be reviby the IDT to ensure sufficience preparation related to medice equipment is provided to ensafe discharge. This review documented in the clinical ras a progress note. The Administrator will audit disprogress notes to ensure compliance. This audit will times a week for two weeks once weekly for 4 weeks. IV. Results of the audits will be reviewed by the Administrate submitted to the QAPI common for review and action as app. The QAPI committee will defend the need for further audits at action plans. V. 3/4/16	iewed ent cal sure a will be ecord charge occur then tor and mittee propriate	2 Ie.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	СОМР	(X3) DATE SURVEY COMPLETED C	
		495217	B. WING_		02/04/2016		
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY REVISED COF FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 250	reached maximum fur A social services note "SW (Social Worker) the resident stating he She stated her house complete until Octobe be discharging from the ask for a copy of her did provide the invoic Administrator about the not leaving the facility receive voicemail from stating the house will October 1st. SW approximates of the stating the house will October 1st. SW approximates of the stating the house will october 1st. SW approximates of the stating the house will october 1st. SW approximates of the stating the house will receive hotel. Resident did supplied. SW did pull undereal that swall house. This house and in a basement lethospital bed in the becowner. SW confirmed (durable medical equireceiving. The follow in 1 commode, reachwheelchair, and a shoorder in with (name ocompany). Per the recompany). Per the recompany.	iple sclerosis). Pt is from therapy 2/2 to pt has inctional potential" didated 8/19/15 documented, received a voicemail from er housing did not work. It renovations will not be er 1st and that she will not the facility until then. She did payment to the facility. SW et to her. SW notified the the resident's statement of the until October 1st. SW did the the resident's landlord the resident's landlord the resident's landlord to options with her. One of dident stay at an extended the few weeks. SW stated that the tome health therapy at the elem to be open to the hotel p hotel rates in the local ernoon, the resident notified inistrator that she did locate is handicapped accessible wel home. She has a droom from the previous did with the resident her DME ipment) she will be ing pieces will be ordered: 3 er, transfer board, ower bench. SW put the	F 2	50			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		COMP	(X3) DATE SURVEY COMPLETED	
		495217	B. WING			1	C 04/2016
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS				1247	ET ADDRESS, CITY, STATE, ZIP CODE 5 LEE JACKSON MEMORIAL HIGHWAY REV RFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 250	Person conducted ar resident. This prografinancial assistance to SW notified the resid discharge of 8/22/15, coming to pick her up continue to follow up the discharge planning. A social services note "SW received a mess company to provide ovia fax that her whee will not be delivered. Ordered the equipme until 2016 to get new resident about the upprovided her a copy of showed her past ordered she will find a way to home. SW also provided her with moving her ther home. SW made arrangements with (roompany) for the day continue to follow up. Resident #3's compron 2/15/15 and revisit documented, "Patien discharge to the composition of t	alth agency). A he Money Follows the he assessment with the an can possibly provide to the home renovations. ent that on the day of medical transport will be a around 12:30 p.m. SW will as needed and assist with hg." e dated 8/20/15 documented, sage from (name of durable medical equipment) lichair and bedside commode. In 2009, the resident int and will not qualified (sic) equipment. SW notified the idate on equipment. SW of the documents that er in 2009. Resident stated locate her equipment at her ided her a resource to assist belongings from the facility to e transportation of discharge. SW will as needed." ehensive care plan initiated ed/cancelled on 4/2/15 t does not show potential for munity due to physical care : Reassess care needs and e as needed. Support representative as needed"	F	250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF D	שאו ממבט מת פונימט ובט	430211	5. WING			02	/04/2016	
IAVIAIT OI. E	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
MANORC	ARE HEALTH SERVICES	-FAIR OAKS		ı	12475 LEE JACKSON MEMORIAL HIGHWAY REV FAIRFAX, VA 22033	ISED COP	Y	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 250	thought Resident #3 On 2/3/16 at 10:50 a. conducted with OSM occupational therapis #3 in May 2015. OSI resident required may staff with transfers, us method. OSM #9 sta to use a sliding board Resident #3 a lot afte	me wasn't sure but she used a standing lift. m., an interview was (other staff member) #9, the t who worked with Resident M #9 stated in May 2015, the kimum assistance of one sing the stand and pivot ted the resident did not want . OSM #9 stated she saw r May and the resident ities" and maintained her	F	250				
	On 2/3/16 at 1:45 p.m conducted with OSM #4 stated Resident #3 financial issues and w #4 stated the resident and the home health enter within 24 or at m stated Resident #3 rebed side commode. Or received those items qualify for those items stated on the day of F (OSM #4) spoke to a resident borrowed a w OSM #4 stated Resid assistance into a whee the resident required toileting and dressing thought Resident #3 wasked if the lift was or discharge, OSM #4 stordering the lift. Whe assessed by the there	a., an interview was #4, the social worker. OSM B was discharged due to vasn't paying her bill. OSM t was discharged on 8/22/15 agency was scheduled to nost 48 hours. OSM #4 quested a wheelchair and OSM #4 stated the resident in 2009 and would not again until 2016. OSM #4 Resident #3's discharge, she nurse who stated the vheelchair from the facility. ent #3 only needed elchair. When asked how assistance with showering,						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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MANORCA	ARE HEALTH SERVICES	FAIR OAKS		FAIRFAX, VA 22033		OLD GOT	•
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F 250	Continued From page	e 17	F:	250			000
	further stated someo Resident #3. OSM # agency was responsi up care. OSM #4 sta	herapy department. OSM #4 ne from the county assessed 4 stated the home health ble for Resident #3's follow ited she remembered a ot requested by Resident 3	TO A DATE OF THE PARTY.				
	CNA #2 stated Resid	n., an interview was #2 regarding Resident #3. ent #3 required a lift and nd lift to get the resident up.					
	On 2/3/16 at 2:18 p.m., an interview was conducted with OSM (other staff member) #1, the business office manager. OSM #1 stated Resident #3 was discharged because she didn't pay her bill. OSM #1 stated she should have a copy of the discharge notice on file. (Note-review of the discharge letter revealed Resident #3 was notified on 7/23/15 that she would be discharged on 8/22/15 due to failure to maintain her account and having had a balance of \$6,263).					,	
	was alert and oriente	egistered nurse) #3, 3. RN #3 stated the resident	and the second s				
	#3 was totally depend mobility and required transfers and toileting anyone talked to her needs prior to discha	n., an interview was #3. CNA #3 stated Resident dent of one staff with bed a sit and stand lift with J. CNA #3 was asked if regarding Resident #3's rge and stated no one had just knew the resident was					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
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MANORC	ARE HEALTH SERVICES	FAIR OAKS		P	FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 250	leaving. On 2/3/16 at 4:40 p.n conducted with OSM who worked with Res #10 stated Resident assistance of the Hoy people for transfers. resident wanted to go explained the proces the resident's care.	n. an interview was #10, the physical therapist ident #3 in May 2015. OSM #3 required a maximum yer lift with two or three OSM #10 stated the to home alone so staff s of what was required for DSM #10 stated she wasn't other was required in August	F	250			
	meetings. OSM #10 on going home. OSM resident was discharg wheelchair but not a	stated Resident #3 insisted ##10 stated she thought the ged with a commode and	THE STATE OF THE S				
	conducted with OSM OSM #4 stated she dwith anyone regardin Resident #3's dischaltalked to therapists, resident #3 and she an independent level wheelchair. OSM #4 discharged with a whocommode. OSM #4 wheelchair from the four osm #4 stated sloordinate Resident at the resident was discontant of the stated sloordinate Resident was discontant was discontant of the stated sloordinate Resident was discontant was di	stated Resident #3 was not eelchair or bed side stated the resident took a acility but wasn't supposed ne called a company to #3's medical equipment after harged. OSM #4 stated the lidn't recommend Resident stated she needed a sliding	AND THE PROPERTY OF THE PROPER		The state of the s		
		Ith therapist. OSM #4 stated resident saying she was fine	Walter				

	OT OR MILDIO/MIL G	VILLOID III OLIVIOLO				01410140	7. 0000 000 t
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		1 499211	5. VIIIVG			j 02/	04/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANORC	ARE HEALTH SERVICES	-FAIR OAKS		1	2475 LEE JACKSON MEMORIAL HIGHWAY REVI FAIRFAX, VA 22033	SED COPY	!
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	i	PROVIDER'S PLAN OF CORRECTION		(X5)
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F 250	Continued From page	e 19	F	250			
	with a sliding board.						
	On 2/3/16 at 5:00 p.m						
	conducted with ASM	-					
	f	ctor of nursing. ASM #2 ge plan meetings, staff talks			OVO A		
		need. ASM #2 stated she					
		in Resident #3's discharge.					
	On 2/3/16 at 5:30 n m	n., ASM #1, the administrator					
	-	ide aware of the above			* 3		
	concern.	are arrane or the above					
		titled "Clinical Services:					
	Discharge Planning"	· · · · · · · · · · · · · · · · · · ·					
		s a collaborative effort ents to assist the patient in	İ		Parent Company		
		to the next desired care					
	setting in their commi						
	_	is is achieved through					
		tered care that focuses on					
		goals with every admission,					
	care plan, therapy en	counter and discharge"	***				
	The facility social wor				***************************************		
		Worker Responsibilities:					
	Facilitates communic						
	members aimed at pr	ly and interdisciplinary team					
		t informed decision-making.	j				1000
		ferrals to other consultants,					
		or Center departments in					
	order to facilitate the	resident's/patient's	And a state of the				
		urces, and to promote the					
		creased level of social					
	functioning"				ALCONOMINA DE LA CONTRACTOR DE LA CONTRA		
:	No further information	was presented prior to exit.			1	i	:
			Ì				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495217	B. WING _			02/0	04/2016
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY RE FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
F 250	https://www.nlm.nih.g osis.html	s obtained from the website: lov/medlineplus/multiplescler	F2	250			
	provide the necessar or maintain the highe mental, and psychose	RE/SERVICES FOR NG eceive and the facility must y care and services to attain st practicable physical,	F3	309	F309 It is the practice of this facing provide the necessary care a services to maintain resider highest practicable level of wellbeing.	and nts'	
	by: Based on staff intervifacility document revifacility document revifacility document revifacility staff failed to maintain residents	is not met as evidenced iew, clinical record review, ew and in the course of a on, it was determined that to provide care and services highest practicable level of f seven residents in the lents #4, #1 and #5.	e e de la companya de		I. Resident #1 and #4 have be discharged from the facility physician for resident #5 w notified regarding the blood reading of 401. The physic be notified of blood sugar routside of the parameters for resident #5.	/. The as disugar will be ading	1
	*Novolog insulin (use to Resident #4 on 5/2 order to hold the insu than 110 and the resi mg/dl (milligrams/dec 2. Facility staff failed for resident #1.	ministered four units of d to treat high blood sugar) 1/15 although there was an lin for a blood sugar less dent's blood sugar was 84 iliter). to monitor fluid restrictions iled to follow the physician	TO A STATE OF THE		II. Residents receiving insulin physician orders that indica hold and/or call MD if bloo reading is outside of the sta parameter and residents whe fluid restrictions have the p to be affected. An audit of residents on insulin was	ite to d suga ted o have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495217	B. WING			02/0	4/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
REALION C	ARE HEALTH SERVICES	EVID OVE		12	475 LEE JACKSON MEMORIAL HIGHWAY REVI	SED COPY	
MANORCA	AKE HEALIH SERVICES	FFAIR DANG	FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	order to notify the physugar went over 400. physician was not not a physician was not not a physician was not not a physician was not not a physician was not not a physician was not not a physician was not not a physician was not not a physician was not not a physician was not not not a physician was not not not not not not not not not not	ysician if Resident #5's blood It went over 400 and the tified. admitted to the facility on so that included but were not nia (lung infection), ***bipolar set and ****diabetes (high ent #4 was discharged on so most recent MDS prior to discharge), a 14 day at with an ARD (assessment 23/15, coded the resident as ct. Section N documented I insulin injections seven out	F	309	performed. Identified reside were reviewed to ensure appropriate parameters were place. An audit of residents fluid restrictions was perfor identify those residents. III. Licensed nursing staff were educated on following phys orders to hold medication as notifying the physician whe order indicates. Licensed nu staff were educated on documenting the amount of provided to residents having restrictions to ensure proper monitoring.	e in s on med to cician nd/or en the ursing fluids g fluid	
	administration record Novolog insulin was with breakfast on 5/2 nurse's initials and a resident's blood suga Resident #4's comprinitiation date of 4/9/ Endocrine System re diabetesIntervention per physician orders.	check mark) although the ar was recorded as 84. ehensive care plan with an 15 documented, "Focus: lated to insulin dependent ons: Administer medication			IV. The Director of Nursing or designee will audit docume for residents having orders fluid restriction to ensure appropriate documentation place. Residents on insuling be audited to ensure the physis notified when blood sugar readings are outside of the	ntation for is in n will ysician	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495217	B. WING			02/	04/2016
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY REVISED COPY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	On 2/3/16 at 2:30 p.n conducted with RN (r was asked what show a physician's order to Novolog and to hold is less than 110. RN residents' blood sugar RN #1 stated if a resithan 110 then she wow When asked what sholood sugar was 84,	ident #4 on 5/2/15 was no ne facility.	F	309	parameters as indicated on physician order. These aud occur 5 times a week for 2 2 times a week for the followeeks and then once per w the following 4 weeks. Rest the audits will be reviewed Administrator and submitted QAPI committee for review action as appropriate. The committee will determine the for further audits and or act plans	lits will weeks, owing 2 eek for oults of by the ed to the QAPI the meed	
	was asked what a ch on the MAR. ASM # initials on the MAR m asked to clarify what confirmed it meant th administered. On 2/3/16 at 5:30 p.r	(administrative staff ector of nursing). ASM #2 eck mark with initials meant 2 stated the check mark with heant, "It's done." When "it's done" meant, ASM #2 e medication was		To the second se	V. 3/4/16		
	the above findings. The facility policy title Administration: Inject "Procedure: 1. Open administration record review physician med medication label"	ed "Medication cions" documented in part,		mino/Ad and			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495217	B. WING_	·	C 02/04/2016	
	NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY R FAIRFAX, VA 22033		
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F 309	Continued From page	23	F3	09		
	http://dailymed.nlm.ni	s obtained from the website: ih.gov/dailymed/drugInfo.cfm i09-40D0-876C-B4CB2BE56				
		s obtained from the website: ov/medlineplus/pneumonia.				
	meta?v%3Aproject=r	as obtained from the ih.gov/vivisimo/cgi-bin/query- nedlineplus&v%3Asources= query=bipolar+disorder	A a a a a a a a a a a a a a a a a a a a			
		ih.gov/vivisimo/cgi-bin/query- nedlineplus&v%3Asources=				
	COMPLAINT DEFICI	ENCY				
	2/10/15 with diagnose limited to: atrial fibrilla congestive heart failure heart can't pump eno body's needs) anxiety pressure), hyponatre cerebral vascular accuratery disease* (comi	admitted to the facility on es that included but were not ation* (irregular heart beat), ire* (a condition in which the ugh blood to meet the y, hypertension* (high blood mia* (too much sodium), ident* (stroke), coronary mon type of heart disease),				
	glucose, or blood sug	disease in which your blood par, levels are too high), emaker, prostatectomy*				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495217	B. WING		C 02/04/2016		
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY REVISED COPY FAIRFAX, VA 22033				
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F 309	painful form of arthriti and stiff joints), inson * This information wa https://www.nlm.nih.g 003462.htm The most recent MDS admission assessme (assessment referent the resident as scorir interview for mental size - 15, 15 being cogniti was coded as requirit one to two staff mem daily living. The POS (physician - 2/28/15 for Residen "Controlled Lo (low) Size Regular texture. LIM 1.5 (one and a half) I Order Date: 02/10/20 The physician's telep by the physician on 2 documented, "Control Fluid restriction 1.5 in The POS (physician (March) 5, 2015 for Fi "Controlled Diet. Regular Reg	ate), gout* (a common, is. It causes swollen, red, hot main and general weakness, is obtained from the website: gov/medlineplus/ency/article/ S (minimum data set) an int, with an ARD ce date) of 2/17/15 coded ing an 11 on the brief status (BIMS) of a score of 0 vely intact. The resident ing extensive assistance of bers for all of his activities of corder sheet) dated 2/1/2015 it # 1 documented, sodium Cardiac Diet. IIT DAILY FLUID INTAKE TO LITERS OR 48 OUNCES. IS Start Date: 02/10/2015." Inhone order dated and signed it/14/15 for Resident # 1 olled diet. Regular texture. Iters." In order sheet) dated Mar Resident # 1 documented, gular texture. Fluid Order Date: 02/14/2015.	F 309				
	Resident # 1 dated F documented, "Limit E	administration record) for eb (February) 2015 Daily Fluid Intake to 1.5 Liters hift. D/C (discontinue)." The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495217	B. WING			C)2/04/2016
	ROVIDER OR SUPPLIER	ES-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY REVISED CO FAIRFAX, VA 22033			DPY
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	TAR revealed check the "Night" shift on 2/11/15, 2/12/15 are (evening) shifts on Further review of 1 2/28/15 revealed is Resident # 1's fluid monitored. Review of Resider 2015 revealed that Resident # 1's fluid monitored. The nurse's "Programment of the shift of	ck marks and nurse's initials on 2/10/15, the "Days" shift on ad 2/13/15, on the "Eveni" 2/11/15, 2/12/15 and 2/13/15." FAR dated 2/14/15 through staff failed to document that direstriction was being at # 1's TAR dated Mar (March) that failed to document that direstriction was being at # 1's TAR dated Mar (March) that failed to document that direstriction was being at # 1's TAR dated Mar (March) that direstriction was being at # 1's TAR dated Mar (March) that direstriction was being at # 1's TAR dated Mar (March) that direstriction was being at # 1's TAR dated Mar (March) that direstriction was being at # 1's TAR dated Mar (March) that direstriction was being at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction but at # 1's TAR dated Mar (March) that direstriction that direstriction that direstriction that direstriction that direstriction that direstriction that direstriction that direstriction that direstriction that direstriction that direstriction that direstriction that direstriction that direstriction that direstriction that direstriction that direstriction	F 309			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495217	B. WING			02/04/2016	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY REVISED FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)			
F 309	2/11/15 for Resident a restriction ordered 1.1 physicians orders. N centimeters), Dietary [7:00 a.m. to 3:00 p.m. to 11:00 p.m.] 300 cc a.m.] 180 cc." Resident # 1's compression order. Date of the second order. Date of the second order. Date of the second order. Date of the second order ordered, "Dietary physician order. Date of the second order ordered ordered ordered ordered ordered ordered. The second ordered ordered. When asked expressed any concestated, "Nothing was on 2/3/16 at 9:50 a.m. conducted with OSM the dietician. When a Resident # 1 and the ordered ordered." When a second ordered orde	ge Plan Worksheet" dated # 1 documented, "Fluid 5 liter / (per) day per ursing 780 cc (cubic 720 CC. Nursing shift (7-3) n.] 300 cc; (3-11) [3:00 p.m. ; (11-7) [11:00 p.m. to 7:00 ehensive care plan dated "Focus: Cardiac disease on." Under "Interventions" it y and/or fluid restrictions per e initiated: 2/11/15." n. an interview was registered nurse) # 1, unit re procedure for residents RN # 1 stated, "Dietary owing how much fluid a d how much is included in sing) would offer the fluids the resident's room to king more that the doctor red if the family had rns regarding care RN # 1 reported to me." n. an interview was (other staff member) # 6, asked if she was familiar with family OSM # 1 stated, wife the day after admission restriction sheet. There were	F3	09			
	conducted with RN #	When asked about	1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495217	B. WING				02/	04/2016
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		<u></u>	
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MANORCA	ARE HEALTH SERVICE	S-FAIR OAKS		FAIF	RFAX, VA 22033			
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F 309	the resident." On 2/4/16 at 8:20 a. conducted with RN # the documentation or restrictions. After re Resident # 1 dated I RN # 1 stated that if documented on Resident # 1 dated I restrictions asked to review Notes" dated 2/10/1 asked if Resident # documented in the rable to identify documented in the rable to identify documented in the rable to identify documented in the rable to identify documented in the rable to identify documented in the rable to identify documented that the much fluid the reside documented on the was done and the air gets each shift. Whe purpose of fluid restriction are resident does supposed to get. The monitor how much fluirse's notes." Whe described was follow stated, "Not really." missing documentating restriction, RN # 1 st documented I can't so the 2/4/16 at approx.	m. an interview was #1, unit manager regarding of Resident #1's fluid eviewing the TARs for February and March 2015, the fluid restriction was not ident #1's TAR it could be nurse's notes. RN #1 was withe nurse's "Progress through 3/7/15. When 1 fluid restriction was nurse's notes, RN #1 was mentation on 2/16/2015 at /16/2015 at 18:42 (6:42 p.m.), /16:03 p.m.), 2/22/2015 at /123/2015 at 03:23 (3:23 a.m.) /18:26 (6:26 p.m.). RN #1 e nurses supervise how ent gets and it should be TAR that the fluid restriction mount of fluid the resident en asked what would be the rictions RN #1 stated, "It is in't get more than they are ne nurse is supposed to fluid the resident took in the en asked if the process she eved for Resident #1, RN #1 When asked about the ion of Resident #1's fluid	F	309				
	procedure of a resident on fluid restrictions. RN#							

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBERS		A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495217	B. WING_		C 02/04/2016
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY RI FAIRFAX, VA 22033	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 309	4 stated that the dieti and it's put with the 2 tell the CNAs (certified much the resident gedocumented RN # 4 and in the 24 hour renursing monitors the takes, RN # 4 stated, fluids." When asked fluid a resident took in stated, "The manage on 2/4/16 at approximate approximate conducted with procedure of a resided 2 stated, "Every shift Document if the resident total of the day is on intake is documented when asked who mointake RN # 2 stated of nursing were made of nursing were made."	cian develops a worksheet 4 hour report and nursing d nursing assistants) how ts. When asked where it is stated in the nurse's notes port. When asked how amount of fluids the resident "We monitor the trays with who monitors the amount of a 24 hors period, RN # 4 r and the dietician." mately 8:32 a.m. an interview RN # 2 regarding the ent on fluid restrictions. RN # we put fluids in the room. lent drinks that shift. The the 24 hour report. The l in the progress notes." nitors the resident's fluid the nursing manager. n. ASM (administrative staff strator and ASM # 2, director e aware of the findings. n was provided prior to exit.	F	309	
	10/14/12 with a recer with diagnoses that it to: congestive heart f reflux disease, glauce	admitted to the facility on nt readmission on 12/30/15 ncluded but were not limited failure, gastroesophageal oma, anemia, high blood vascular disease, and	The second secon		

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY REVISED COPY FAIRFAX, VA 22033				
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F 309	with an assessment recoded the resident as (brief interview for me the resident was cognidecisions. The reside extensive assistance of his activities of dail Medications, the reside received insulin inject of the look back period the look back period in part: "Sliding scale Solution 100 units/MI (blood sugar) 401 + (units; If BS > (greater call doctor, subcutant bedtime for dm (diaboth January 2016 docum insulin with Novolog sper milliliter)if BS (units; If BS > (greater call doctor, subcutant bedtime for dm (diabothe 11:00 a.m. blood 401. Ten units of instadministered. Review of the Progre not reveal any docum notified of Resident # (milligram/deciliter) bloodered.	are 14 day assessment, eference date of 1/11/16, a scoring a 13 on the BIMS ental status) score, indicating nitively intact to make daily nt was coded as requiring of one or two people for all y living. In Section N - dent was coded as having tions fur the past seven days and. Idated, 12/31/15, documented insulin with Novolog (units per milliliter)if BS plus) = (equals) give 10 of than) 400, give insulin and eously before meals and at letes mellitus)." Inistration Record (MAR) for ented in part: "Sliding scale solution 100 units/ML (units polood sugar) 401 + = give 10 of than) 400, give insulin and eously before meals and at letes mellitus)." Inistration Record (MAR) for ented in part: "Sliding scale solution 100 units/ML (units polood sugar) 401 + = give 10 of than) 400, give insulin and eously before meals and at letes mellitus)." On 1/19/16, sugar was documented as allin was documented as	F	309				

PRINTED: 03/04/2016 FORM APPROVED OMB NO. 0938-0391

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING_ С B. WING 495217 02/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY REVISED COPY MANORCARE HEALTH SERVICES-FAIR OAKS FAIRFAX, VA 22033 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 309 Continued From page 30 F 309 with a revision on 12/27/15, documented, "Focus: Endocrine System related to; Insulin Dependent Diabetes." The "Interventions" documented, "Administer medications per physician orders. Report symptoms of hyperglycemia: excessive thirst/urination, hunger, weakness, N/V (nausea/vomiting) acetone breath." An interview was conducted with LPN (licensed practical nurse) #3 on 2/3/16 at 4:06 p.m. regarding sliding scale insulin orders with documented parameters to call the physician if the blood sugar is over 400. When asked what the nurse would do if the blood sugar was 401, LPN #3 stated, "I'd call the doctor and let him know." When asked where the call to the physician was documented, LPN #3 stated, "In the progress notes." An interview was conducted with RN (registered nurse) #6 on 2/3/16 at 4:15 p.m., regarding sliding scale insulin orders with documented parameters to call the physician if the blood sugar is over 400. When asked what the nurse would do if the blood sugar was 401. RN #6 stated, "I have to call the doctor and follow what orders he may give me." When asked where the call to the physician is documented, RN #6 stated, "I have to write a note in the progress notes." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 2/3/16 at 4:28 p.m. When asked if the physician wrote an order to be notified if the resident's blood sugar is less than 70 or over 400, what is expected of the nurse if the blood sugar is

doctor."

401, ASM #2 stated, "They should have called the

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY PLETED	
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notification. Failure to m condition appropriately a information to the physic provider are causes of n way to avoid being liable	ary" documented, ion: Unusual plaints and subsequent communications with tital for Practice, 6th (2007, pages 56-59), for physician's orders and conitor the patient's and communicate that ian or health care egligent acts. The best of or negligence is to to give competent health the with other health care or health care providering the medical treatment. ASM #2, (director of the quality assurance aware of the above 0 p.m. as provided prior to exit. Aboratory and Diagnostic in Fourth Edition page. CY SVCS TO SURE SORES Insive assessment of a trensure that a resident thout pressure sores	AND THE PROPERTY AND TH	assess and mor	ee of this facility to nitor pressure ulcers as been discharged ty.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMPI	
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F 314	Continued From pag individual's clinical c they were unavoidal pressure sores recei services to promote prevent new sores fr	F	314	II. Residents admitted to the factorial with open areas have the potto be affected. III. Licensed nursing staff were	- 1		
	This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to assess and monitor a pressure ulcer for one of seven residents in the survey sample, Resident #2. Resident #2 was identified as having an open area on his sacrum; treatment was applied but no further assessment or orders related to the pressure ulcer were documented. The findings include: Resident #2 was admitted to the facility on 5/19/15 with a readmission on 6/8/15 with diagnoses that included but were not limited to: heart failure, high blood pressure, lung cancer with metastasis to the bone and brain, chronic venous insufficiency, stasis dermatitis and shortness of breath.		The state of the s	- OOMS WAS A SOUTH A POST	educated on the facility's sk practice guidelines which in documentation of noted ope areas, second skin assessmen notification to the wound tea	cludes n nt and	
					IV. The admission assessment a skin note will be audited by Director of Nursing or her designee to ensure proper documentation and interven for residents admitted with a skin areas. This audit will on times per week for 2 weeks times per week for 2 weeks then weekly for 4 weeks to compliance. Results of the a	tions open ocur 5 then 2 and ensure	
	assessment, a Medi with an assessment coded the resident a (brief interview for m the resident was coo decisions. The resident	OS (minimum data set) care five day assessment, reference date of 6/15/15, is scoring a 15 on the BIMS iental status) score, indicating gnitively intact to make daily dent was coded as requiring e of one to two staff members			will be reviewed by the Administrator and submitted QAPI committee for review action as appropriate. The Committee will determine the for further audits and or actional committee will action to the committee will determine the committee audits and or actional committee.	and API se need	

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495217	B. WING			C 02/04/2016	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	F-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW FAIRFAX, VA 22033		COPY	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 314	moving in the bed an Skin Conditions, the at risk for developing have any pressure ul. The hospital dischard documented, "Dischaskin tear: continue with centimeter and super. The "Patient Admissi dated, 6/8/15, documented, 6	of daily living including d transfers. In Section M - resident was coded as being pressure ulcers but did not cers. ge summary dated 6/8/15, arge Instructions: 10) Sacral pound care, this is less than a	F 31	v. 3/4/16			
	"low risk for skin breat * A Braden Score is a resident for the risk of ulcers. The total sco- lower total score indi- pressure ulcer develo- highly reliable when a greatest risk for pres **NON-BLANCHABL tissue that do not turn firmly with a finger or ulcer. (3) ***A stage II pressure thickness loss of deri open ulcer with a red slough (non viable ye brown tissue; usually	a valid tool used to assess a if developing pressure re ranges from 6 to 23; a cates a higher risk for opment. The Braden Scale is used to identify clients at					

CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495217	B. WING_			l	04/2016	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	F-FAIR OAKS	1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY REVISED COF FAIRFAX, VA 22033				
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F 314	Continued From page intact or open/rupture		F;	314				
	range of wounds like ulcers, or diabetic ulc	sing suitable for a wide venous leg ulcers, pressure ers. Mepilex® minimizes tin damage at dressing						
	p.m.) documented, "E nonblanchable redne open area observed,	ated, 6/8/15 at 21:54 (9:54 Blanchable and ss noted to sacrum, small no draig=nage (sic) borders served, Mepilex applied."	The state of the s					
	Review of the physician orders did not reveal an order for the Mepilex or any treatment for the pressure ulcer on the Resident #2's sacrum.							
	ŧ.	progress notes did not ation of the open area on the 2.	Accounts on the second of					
	documented, "Focus: integrity related to im "Interventions" documeri area/buttocks as reposition as needed needed. Observe sk (activities of daily living integrity in	nented, "Barrier cream to needed. Encourage to , use assistive devices as in condition with ADL ng) care daily; report de preventative skin care						
	A "Skin Worksheet" d "Shower given, no sk	lated 6/11/15, documented, in issues."						
	member) #2, the dire	n. ASM (administrative staff ctor of nursing, was asked if ound documentation on the	WALLACE OF THE PROPERTY OF THE					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	ľ	(X3) DATE COMP	SURVEY LETED
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F 314	Continued From pag	e 35	F3	314	,			
	area documented in the progress notes and on the skin assessment on 6/8/15. ASM #2 stated, "No, we don't have any."							
	practical nurse) #4 o asked the process for treatment of pressure new patients get a slip by the admitting nurse or the wound in second assessment, second assessment stated, "The nurse with progress note." LPN assessment is normal Wednesdays. The Cassistants) do a skin resident a shower to A telephone interview.	#4 further stated, "A skin ally done every week on CNAs (certified nursing sheet when they give the o."						
	#1, the nurse who co assessment and nur 2/2/16 at 1:37 p.m. L skin assessment we phone. When asked nonblanchable mear "Nonblanchable is a When asked what or stated, "If the area is pressure ulcer." Whe she has assessed the the Mepilex, LPN #1 hour report sheet the see resident for apprent	ompleted the skin ses' note on 6/8/15, on .PN #1's nursing note and re read to her over the lawhat the word at, LPN #1 stated, stage 1 pressure ulcer." on area means, LPN #1 open, then it's a stage 2 on asked what happens after the resident's skin and applied stated, "I put it on the 24 at the wound nurse needs to ropriate treatment orders."						
		dent as a readmission. nentation of the need for						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 314	nurse practitioner, #4 was asked to re 6/9/15. Once revie looked at Resident stated, "I don't belie concern then I wou not aware of any si normally tells me o morning meeting. look at the skin." Waskin assessments, nurse assesses the skin assessment. The wound nurse a and do a second si everything." ASM progress note of 6/have been notified	onducted with ASM #4, the on 2/3/16 at 1:51 p.m. ASM view her progress notes of wed, ASM #4 was asked if she #2's sacral area. ASM #4 eve I did. If there was a Id have looked at it but I was kin concerns. The staff f any skin issues in the I then go with the nurse and then asked the process for ASM #4 stated, "The admitting a resident and completes a The second day of admission and manager (unit manager) go kin assessment. They tell me #4 was asked to read the 8/15. ASM #4 stated, "I would of any wound. Since my note ything I would believe I was	F	314			
	nurse) #5, the wou p.m., when asked the assessments at the admitting nurse does at the time of admit another nurse does If there are any skin we call the doctor for where the second second documented, RN # second assessment note." When asked or 6/9/15, RN #5 st	e facility, RN #5 stated, "The es a head to toe assessment ssion. The next day, I or a second skin assessment. In assessment abnormalities, or orders." When asked					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED		
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS						REET ADDRESS, CITY, STATE, ZIP CODE 175 LEE JACKSON MEMORIAL HIGHWAY REVISED COPY				
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	F 314	director of nursing, or #2 was asked for any a second assessmen wounds were comple stated, "The unit man time is no longer here assessment but didn' shower sheet on 6/11 seen by the CNA. All cream after each inco was ambulatory and there have been an a of the area noted on and documentation or	ducted with ASM #2, the n 2/3/16 at 4:35 p.m. ASM documentation evidencing t of Resident #2 's sacral ted on 6/9/15. ASM #2 ager who was here at that a. I am sure she did the t document it. On the /15 there was no skin issues CNAs apply a protective ontinence care. This resident continent." When asked if ssessment and monitoring 6/8/15 by a licensed nurse	F3	314					
		done but she's no lon documentation issue. The ASM #1, the adn	ger here and it's a " ninistrator, ASM #2 and ASM e Coordinator, were made	. Control of the cont						
		The facility policy, "SI documented, "Phase Admission Evaluation body audit to identify ulcers or other skin a findings on the Nursin The Nursing Admission the initial Braden Scalntegrity: If alteration admission, a designateam evaluates the si within 24 hours of adwith the licensed nursing the side of th	xin Practice Guide" 1: Complete the Nursing 1: including a head-to-toe full the presence of pressure Iterations. Document ng Admission Evaluation. Iterations also contains							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		495217	B. WING			C 02/04/2016			
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE					
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MANORCARE HEALTH SERVICES-FAIR OAKS				FAIRFAX, VA 22033					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVI CROSS-REFERENCEI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 314	and initiated as order alteration in skin integ identified, a PUSH to the wound team, for a comprehensive evalu documented in the pa may include, but not	orders are obtained, noted ed with the identification of grityIf a pressure ulcer is ol is initiated by a member of each site identified. A nation is also completed and attent's clinical record and limited to: depth, unding skin, presence and	F3	314					
	evidence of infection of the wound evaluat physician/family/resp the initial plan of care meet he patient's ind may include, but are surfaces/specialty may positioning, incontine	or painUpon completion ion, the onsible party are notified and is developed and initiated to ividual needs. Interventions not limited to: support attress, turning and nce management, referral to gement, referral to therapy and							
	of Health and Humar Number 15, documer assessment of an incision is the basis for plann treatment effects, and caregivers. Initially, the determine the location pressure ulcer. Accurate of pressure sores is a development and imperfective treatment prongoing monitoring of devices that totally remost commonly by ram"And also,"indiv	lividual with a pressure ulcer ing treatment, evaluating d communicating with other he clinician should n, stage, and size of the rate staging and description			į				

PRINTED: 03/04/2016 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS				124	REET ADDRESS, CITY, STATE, ZIP CODE 175 LEE JACKSON MEMORIAL HIGHWAY REVI IRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SHOULD BE COMPLETION		
F 314	According to Lippin Practice, Eighth Edspecial health prob 187, "nursing and prevention and heathe pressure by: respecial devices to the heels." (1) http://www.molnlycroducts/foam-dress (2) Perry and Potte 6th edition page 14 (3) Centers for Med Long-Term Care Fainstrument User's Ipages M-15, M-18, COMPLAINT DEFI 483.25(I) DRUG RIUNNECESSARY Each resident's druunnecessary drugs drug when used in duplicate therapy); without adequate nindications for its uadverse consequent	cott Manual of Nursing ition, part 2, unit 1, section 9, lems of the older adult, page patient care considerations in sling of pressure ulcers; relieve position every two hours, using cushion specific areas such as the cus/advanced-wound-care-paings/mepilex/#confirm r; Fundamentals of Nursing, 95. dicare & Medicaid Services; acility Resident Assessment Manual; Version 3.0 July 2010, M-2. CIENCY		314	F329 It is the practice of this facility ensure the drug regimen is from unnecessary drugs. I. Resident # 4 has been dischafrom the facility. II.	ree		
	combinations of the			Volumente Veterania de Veterani	Residents prescribed insulin parameters used to determine administration of the medical	•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY		
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	TO TIDE! OF OUR TEMES				· · · ·	SEU CUB	,		
MANORC	ARE HEALTH SERVICES	-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHWAY REVISED COPY FAIRFAX, VA 22033					
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F 329	who have not used an given these drugs unl therapy is necessary as diagnosed and do record; and residents drugs receive gradua behavioral interventio	nust ensure that residents ntipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic I dose reductions, and	F	329	have the potential to be afferd An audit of residents received insulin was conducted to enappropriate physician order parameters were included worder on the medication administration record (MAI). III. Education was provided to Licensed Nurses regarding following physician orders	ring asure ed with the			
	by: Based on staff intervand facility document a complaint investigathe free from unnecessar seven residents in the #4. The facility staff admi *Novolog insulin (use to Resident #4 on 5/2 order to hold the insuthan 110 and the resident #4 was admi with diagnoses that in	d to treat high blood sugar) 1/15 although there was an lin for a blood sugar less dent's blood sugar was 84. nitted to the facility on 4/8/15 actuded but were not limited			ensuring parameters are fol when administering insulin Director of Nursing or her designee will audit the MA patients receiving insulin 5 weekly for 2 weeks and we thereafter for an addition 2 to ensure parameters are fol as ordered and documented IV. Results of the audits will be reviewed by the Administra submitted to the facility's Committee for review and a appropriate. The QAPI con will determine the need for	The R of times ekly month llowed . etor and API ction a nmitted	S		
	to: **pneumonia (lung infection), ***bipolar disorder (mental illness) and ****diabetes (high blood sugar). Resident #4 was discharged on 6/8/15. Resident #4's most recent MDS				audits or action plans.				

AND PLAN OF CORRECTION A95217 A95217 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY REVISED COPY FAIRFAX, VA 22033 (X4) ID PREFIX TAG F 329 Continued From page 41 (minimum data set) (prior to discharge), a 14 day Medicare assessment with an ARD (assessment reference date) of 5/23/15, coded the resident as being cognitively intact. Section N documented Resident #4's clinical record revealed a physician's order dated 4/16/15 to decrease the Novolog with breakfast to four units of Novolog insulin was administered to Resident #4 with breakfast to for units of Novolog insulin was administered to Resident #4 with breakfast to 5/2/15 (as indicated by a nurse's initials and a check mark) although the resident's blood sugar was recorded as 84. Resident #4's comprehensive care plan with an initiation date of 4/9/15 documented, "Focus: Endocrine System related to insulin dependent diabetesInterventions: Administer medication A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY REVISED COPY FAIRFAX, VA 22033 F PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 329 V. 3/4/16 F 329 V. 3/4/16	~	o, on mediorate a	T CERTIFICATION OF THE PROPERTY OF THE PROPERT				<u> </u>	,, 0000 000 i			
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The nurse responsible for administering Novolog with breakfast to Resident #4 on 5/2/15 was no longer employed at the facility. On 2/3/16 at 2:30 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked what should be done if a resident has a physician's order to administer four units of Novolog and to hold if the blood sugar is less than 110. RN #1 stated nurses check residents' blood sugars 30 minutes before meals. RN #1 stated if a resident's blood sugar was less than 110 then she wouldn't give the insulin. When asked what she would do if the resident's blood	F 329	(minimum data set) (Medicare assessmenterence date) of 5/2 being cognitively intal Resident #4 received of the last seven day. Review of Resident #4 physician's order datal Novolog with breakfast the medication for a last Resident #4's May 20 administration record Novolog insulin was with breakfast on 5/2 nurse's initials and a resident's blood sugar Resident #4's comprimitation date of 4/9/Endocrine System rediabetes Intervention per physician orders. The nurse responsib with breakfast to Residenter with breakfast to Residenter employed at the conducted with RN (in was asked what should a physician's order to Novolog and to hold than 110. RN #1 statistical for a resident's 110 then she wouldnistiated if a resid	prior to discharge), a 14 day nt with an ARD (assessment 23/15, coded the resident as act. Section N documented d insulin injections seven out s. #4's clinical record revealed a act 4/16/15 to decrease the ast to four units and to hold blood sugar less than 110. 015 MAR (medication d) revealed four units of administered to Resident #4 bl/15 (as indicated by a check mark) although the ar was recorded as 84. ehensive care plan with an 15 documented, "Focus: elated to insulin dependent ons: Administer medication" ble for administering Novolog sident #4 on 5/2/15 was no the facility. m., an interview was registered nurse) #1. RN #1 uld be done if a resident has to administer four units of if the blood sugar is less ted nurses check residents' utes before meals. RN #1 blood sugar was less than i't give the insulin. When	F	329						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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F 329	insulin and give the eat. On 2/3/16 at 5:00 p.conducted with ASM member) #2, (the dir was asked what a cl on the MAR. ASM # initials on the MAR rasked to clarify what confirmed it meant the administered. On 2/3/16 at 5:30 p.cadministrator) and A the above findings. On 2/4/16 at 8:15 a.cunecessary medica 2/4/16 at 8:35 a.m., not have the requesting. No further information was http://dailymed.nlm.r?setid=3A1E73A2-3FC5 **This information was https://www.nlm.nih.html	1 stated she would hold the resident something to drink or m., an interview was I (administrative staff rector of nursing). ASM #2 heck mark with initials meant #2 stated the check mark with meant, "It's done." When t "it's done" meant, ASM #2 he medication was m., ASM #1 (the SM #2 were made aware of m. a policy regarding ations was requested. On ASM #2 stated the facility did	F	329				
	meta?v%3Aproject=	nn.gov/vivisimo/cgi-bin/query- medlineplus&v%3Asources= &query=bipolar+disorder						

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
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F 329	Continued From pag ****This information website: https://vsearch.nlm.n	e 43 was obtained from the sih.gov/vivisimo/cgi-bin/query- medlineplus&v%3Asources= squery=diabetes	F	329	DEF(CIENCY)					