PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA ANO PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILOING			(X3) OATE SURVEY COMPLETEO		
		495217	B. WING	_		l	C
NAME OF P	ROVIOER OR SUPPLIER	400217	12.71	ет	REET AOORESS, CITY, STATE, ZIP COOE	<u>  05/</u>	1 <b>7/2</b> 01 <b>8</b>
NAME OF FI	NOVIOLIN DIN GUPF LILIN				475 LEE JACKSON MEMORIAL HIGHWAY		
MANORC	ARE HEALTH SERVICES	-FAIR OAKS		FA			
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRI OEFICIENCY)	_	(X5) COMPLETION OATE
E 000	Initial Comments		E	000			
F 000	survey was conducte	_	F	000			
	survey was conducted Four complaints were survey. Corrections a						
F 580 SS=D	124 at the time of sur consisted of 41 currel 426, 62, 113, 110, 419 427, 48, 103, 101, 59 57, 2, 94, 85, 53, 51, 40, 111, 97, and 50) a reviews (199, 469, 37 resident #119 and 319 Notify of Changes (Inj CFR(s): 483.10(g)(14	ury/Decline/Room, etc.) )(i)-(iv)(15)	F	580	The statement made on this pla correction are not an admission not constitute an agreement wit alleged deficiencies herein. To compliance with all Federal and regulations, the center has take take the actions set forth in the	to and h the remain State n or will following	in
ABORATOR∙M	§483.10(g)(14) Notification of Changes.  (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-  (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;  (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a		E		plan of correction. The following constitutes the center's allegation compliance such that all alleged ficiencies cited have been or will corrected by the date indicated.	n of I de- I be	(XS) OATE

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG		(X3) DATE COMF	SURVEY PLETED
		495217	B. WING_				C 1 <b>7/2018</b>
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	FAIR OAKS	•	STREET ADDRESS, CITY, STATE, ZIP (12475 LEE JACKSON MEMORIAL H		1 50,	1172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		TION SHOULD B THE APPROPRI		(X5) COMPLETION OATE
F 580	deterioration in health status in either life-thic clinical complications (C) A need to alter treament due to advecommence a new form (D) A decision to transvesident from the facilish state (C) (1) (ii). (ii) When making noting the facilish with the facilish available and proving physician. (iii) The facility must a resident and the resident an	n, mental, or psychosocial reatening conditions or ); attment significantly (that is, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the lent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph ecord and periodically mailing and email) and	F	580			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		495217	B. WING_			l	C 17/2018
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		12	TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033	1 00/	1172010
(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 B CROSS-REFERENCED TD THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 580	facility document revireview, it was determ to notify the physician treatment for two of 4 sample, Resident #69  1. The facility staff fail that Resident #69 had Aubagio (1) medication  2. The facility staff fail physician when a medion administration on the findings include:  1. Resident #69 was 7/8/17 and readmitted that included but were disease, multiple scledisorder. Resident #60 (minimum data set) as assessment with an Adate) of 4/12/18. Resident intact in cognitive possible 15 on the BII Mental Status) exam.  Review of Resident #60 (Physician Order Sumfollowing medication:  (1) "Aubagio 14 MG (mouth one time a day)	terview, staff interview, ew, and clinical record ined that facility staff failed of a possible need to alter 8 residents in the survey of and #5.  Ided to notify the physician of missed three doses of her on.  Ided to notify Resident #5's dicated gel was not available 5/9/18.  Ided to notify Resident #5's dicated gel was not available 5/9/18.  Ided to notify Resident #5's dicated gel was not available 5/9/18.  Ided to notify Resident #5's dicated gel was not available 5/9/18.  Ided to notify Resident #5's dicated gel was not available 5/9/18.  Ided to notify Resident #5's dicated gel was not available 5/9/18.  Ided to notify Resident #5's dicated gel was not available 5/9/18.  Ided to notify Resident #5's dicated gel was not available 5/9/18.  Ided to notify Resident #5's dicated gel was not available 5/9/18.  Ided to notify Resident #5's dicated gel was not available 5/9/18.	F	580	It is the practice of the facility to physician of a possible need to a treatments.  1. Resident #69, doctor was notice doses of medication. No new orders ob 2. All residents have the poter 3. Licensed nurses will be resolutification of doctor regarding and/or treatments.  4. DON and/or designee will could audit of resident EMAR/ETAR medications are administered and audits will be done weekly x for monthly x two (2). The results of these audits will warded to the Quality Assurance Assessment Committee for revaction as appropriate. The committee for actions.  5. Date of compliance will be a service of the compliance will be a service of the service of the compliance will be a service of the service of the compliance will be a service of the servic	otified of orders of of mistained. It is a make to mak	e affected. d on proper medications for 5 random e sure red. These and then

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Eveni ID: OJ2611

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		(X3) OATE COMP	SURVEY LETEO				
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		495217	B. WING			05/	17/2018
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	S-FAIR OAKS		1:	TREET AOORESS, CITY, STATE, ZIP COOE  2475 LEE JACKSON MEMORIAL HIGHWAY  AIRFAX, VA 22033		
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		IXSI COMPLETION OATE
F 580	that Resident #69 did of Aubagio on 5/2/18 dose of Aubagio was 5/5/18. A nursing note dated	d) for May 2018 revealed in not receive her daily dose , 5/3/18 and 5/4/18. The first not administered until	F	580			
	following: "Daughter did visit today, I did speak to daughter regarding medication Abagio (sic). The medication is sent directly to the daughters house. She is made aware that we have no medication to give at this time. Per the daughter she did verbalize that she "will call" for the medication."						
	evidence any prior at Aubagio. There was medication was atten pharmacy. There wa	Further review of the nursing notes failed to evidence any prior attempts to receive the Aubagio. There was no evidence that this medication was attempted to be obtained by charmacy. There was no evidence in the nursing notes that the physician was made aware of the three missed doses.					
	Resident #69's nurse the process staff follo due to be administere medication cart. LPN	(licensed practical nurse) #3, . LPN #3 was asked about lows if a medication that was led was missing from the I #3 stated that she would					
	the ordered medicatic were not in the STAT physician and family. would also notify pha medication as soon a why Resident #69's A	e STAT (immediate) box for on, and if the medication box, she would notify the LPN #3 stated that she					

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stated that Resident #69's daughter orders the

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Facility IO: VA0153

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STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) OATE SURVEY COMPLETEO	
		495217	B. WING				7/2018
	ROVIOER OR SUPPLIER	-FAIR OAKS		12	REET AOORESS, CITY, STATE, ZIP COOE 475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033	<u>  03/</u>	1772016
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IDENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION OATE
F 580	stated that the medic daughter rather the far now the medication is facility. LPN #3 state facility pharmacy doe When asked if LPN # they did not have the #3 stated that she was the physician was not doses of the Aubagio bad habit of calling the time." LPN #3 state note saying that the M#3 could not provide a notified the MD or NP the three missed dose stated that it should he When asked who LPI Resident #69's Aubag could not remember.	alty pharmacy. LPN #3 ation was delivered to the acility. LPN #3 stated that a delivered right to the d that she was told that the s not supply this medication. 3 notified the daughter that medication on 5/2/18, LPN as not sure. When asked if tified of the three missed , LPN #3 stated, "I have a we MD (medical doctor) all ted that she usually writes a MD was made aware. LPN any evidence that she of (nurse practitioner) about ses of Aubagio. LPN #3 have been documented. N #3 contacted regarding gio, LPN #3 stated that she LPN #3 stated that Aubagio in the emergency STAT	F	580			
		ency STAT box list did not a medication supplied in the					
	stated that she knew supply Resident #69's stated that she would nurses if the resident' available to be admin she or the physician whold the medication u	(administrative staff se Practitioner. ASM #6 the daughter was the one to s medication. ASM #6 expect to be notified by the					

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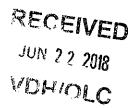
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) OATE SURVEY COMPLETEO	
					·	(	
		495217	B. WING			05/	17/2018
NAME OF P	ROVIOER OR SUPPLIER			S	TREET AOORESS, CITY, STATE, ZIP COOE		
MANORCA	ARE HEALTH SERVICES	-FAIR OAKS		1	2475 LEE JACKSON MEMORIAL HIGHWAY		
MANONO	THE HEAD IN CENTION			F	AIRFAX, VA 22033		
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)	_	(X5) COMPLETION DATE
F 580	Continued From page	e 5	F	580			
	#69's missed doses of	of Aubagio. ASM #6 stated cian was notified, but that he					
		act Resident #69's physician e survey. He could not be ew.					
	staff member) #1, the	m., ASM (administrative administrator and ASM #2, Nursing) were made aware s.					
	No further information	was presented prior to exit.					
	in part, the following: administered according orders are reported to practitioner and documents	tion Guidelines" documents "Medications not ng to medical practitioner's the attending medical mented in the clinical record nd dose of the medication					
	immunomodulatory as multiple sclerosis. The from The National Ins	nlm.nih.gov/compound/Terifl					
	disease that affects you damages the myelin surrounds and protect damage slows down to between your brain ar	(MS) is a nervous system our brain and spinal cord. It sheath, the material that its your nerve cells. This or blocks messages and your body, leading to the is information was obtained					

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Eveni IO: OJ2611

Facility IO: VAD153

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION NG		) DATE SURVEY COMPLETED
·		495217	B. WING_			C <b>05/17/2018</b>
	PROVIDER OR SUPPLIER	3-FAIR OAKS		STREET ADDRESS, CITY, STATI 12475 LEE JACKSON MEMOR FAIRFAX, VA 22033	,	00/11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECT) CROSS-REFERENCE	PLAN OF CORRECTION IVE ACTION SHOULD BE SED TO THE APPROPRIATE FICIENCY)	1X5) COMPLETION OATE
	from The National Ins https://medlineplus.go 2. The facility staff fail physician when a med for administration on the Resident #5 was adm 7/16/16. Resident #5 were not limited to dia and osteoarthritis. Resident #6 with an ARD (assess 5/10/18, coded the resident #5 reported days.  Review of Resident #6 physician's order date (Capsaicin) (1) 0.025 resident's bilateral kne Resident #5's May 20 medication administra "Capsagel Gel 0.025% (bilateral) knees topical On 5/9/18, the eMAR initials and the code "Nurse Notes." The Madministration report of topically applied to be every day in May 2011 nurse's note dated 5/9 "Capsagel Gel 0.025% topically one time a day order placed." There evidence Resident #5's aware the Capsagel was administration report of the code of the	stitutes of Health at ov/multiplesclerosis.html. iled to notify Resident #5's edicated gel was not available 5/9/18.  Initted to the facility on 5's diagnoses included but abetes, muscle weakness esident #5's most recent set), a quarterly assessment ment reference date) of esident's cognition as Section J documented no pain during the last five 15's clinical record revealed a ed 4/12/18 for Capsagel Gel 16%- to be applied to the ees one time a day for pain. 16 (Capsaicin) Apply to bilat eally one time a day for pain. 17 (Capsaicin) Apply to bilat eally one time a day for pain. 18 eMAR (electronic ation record) documented, 18 (Capsaicin) Apply to bilat eally one time a day for pain. 19 (Capsaicin) Apply to bilat eally one time a day for pain. 19 (Capsaicin) Apply to bilat eally 2018 eMAR location of documented Capsagel was 18 except for 5/9/18. A 19/18 documented, 26 Apply to bilat knees ay for pain Pharmacy aware was no documentation to 18's physician was made	F	80		

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STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING		1	(X3) OATE SURVEY COMPLETED	
		495217	B. WING_			1	C 1 <b>7/2018</b>
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS	<b>1</b> .		, CITY, STATE, ZIP CODE SON MEMORIAL HIGHWAY 2033	1 03/	17/2010
(X <b>4</b> ) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IOENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B -REFERENCEO TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION OATE
F 580	7/16/16 documented, painAdminister pain orders"  On 5/15/18 at 12:10 pconducted with Resid she has knee pain bu every day and that he The nurse responsible 5/9/18 nurse's note with facility.  On 5/17/18 at 8:36 a.i. conducted with LPN (LPN #1 was asked with LPN #1 was sheen asked if the cowas not given. LPN #1 was asked if the cowas not given. LPN #1 was asked to read 5/9/18. LPN #1 stated and it says it's on order pharmacy and they say next run then notify th LPN #1 was asked hot they notified the physician should be not medication is not avail LPN #4 stated, "Yes." stated, "Because they	"Generalized medication per physician  i.m., an interview was ent #5. The resident stated it she gets a pill and cream ilps her pain.  e for signing the above as no longer employed at  m., an interview was licensed practical nurse) #1. hat the code "5" on the 1 stated, "Hold. See nurses hown the code "5" for the it 5's eMAR for 5/9/18. LPN bode meant the medication it stated, "It could be." LPN bode meant the medication it stated, "It could be." LPN bode meant the medication it stated, "It could be." LPN bode meant the medication it stated, "It could be." LPN bode meant the medication it stated, "It could be." LPN bode meant the medication it stated, "It could be." LPN bode meant the medication it stated, "It stated be will bring it on the le MD (medical doctor)." by nurses should evidence ician. LPN #1 stated, "By is."  m., an interview was it. LPN #4 was asked if the otified when a resident's lable for administration.  When asked why, LPN #4	F	80			

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Eveni ID: 0J2611

Facility ID: VA0153

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
		495217	B. WING_			ł	C 1 <b>7/2018</b>
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS	,	1247	EET ADDRESS, CITY, STATE, ZIP CODE 15 LEE JACKSON MEMORIAL HIGHWAY RFAX, VA 22033	1 00	11/2010
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	staff member) #1 (the (the director of nursin above findings.  (1) Capsagel is used condition in which joir This information was https://ahrq-ehc-applimedia/pdf/osteoarthri Transfer and Discharg CFR(s): 483.15(c)(1)(s) \$483.15(c)(1) Facility (i) The facility must peremain in the facility, discharge the resident (A) The transfer or disresident's welfare and cannot be met in the f(B) The transfer or dispersive to the resident's ufficiently so the resident's sufficiently so the resiservices provided by f(C) The safety of indivendangered due to the status of the resident; (D) The health of indivotherwise be endange (E) The resident has fappropriate notice, to under Medicare or Medicare	m., ASM (administrative administrator) and ASM #2 g) were made aware of the sto treat osteoarthritis, a ats become swollen and stiff. obtained from the website: cation.s3.amazonaws.com/tis-pain_consumer.pdf ge Requirements i)(ii)(2)(i)-(iii) and discharge-requirements-emit each resident to and not transfer or the from the facility unless-scharge is necessary for the lithe resident's needs facility; scharge is appropriate is health has improved dent no longer needs the the facility; viduals in the facility would ered; failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility.	F		The statement made on this plead correction are not an admission not constitute an agreement walleged deficiencies herein. To in compliance with all Federal regulations, the center has take take the actions set forth in the ing plan of correction. The foll POC constitutes the center's a of compliance such that all alled deficiencies cited have been of corrected by the date indicated.	n to and ith the o remail and Sta en or w e follow- owing illegatio eged r will be	n ate ill
	submit the necessary payment or after the ti Medicare or Medicaid	f the resident does not paperwork for third party hird party, including , denies the claim and the y for his or her stay. For a					

PRINTED: 05/30/2018 FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ANO PLAN OF CORRECTION IOENTIFICATION NUMBER: COMPLETEO A. BUILOING \_ С 495217 B. WING 05/17/2018 NAME OF PROVIOER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 12475 LEE JACKSON MEMORIAL HIGHWAY MANORCARE HEALTH SERVICES-FAIR OAKS FAIRFAX, VA 22033 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID 01 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH OEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCEO TO THE APPROPRIATE DATE TAG OEFICIENCY) Continued From page 9 F 622 resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid: (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1) (i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this

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facility to meet the need(s).

section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving

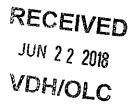
(ii) The documentation required by paragraph (c)

(2)(i) of this section must be made by-(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)

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Facility ID: VAD153

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
						С		
		495217	B. WING_			05/17/2018		
	ROVIDER OR SUPPLIER ARE HEALTH SERVIC	ES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP 12475 LEE JACKSON MEMORIAL H FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 622	necessary under p this section. (iii) Information pro must include a min (A) Contact informa responsible for the (B) Resident repres contact information (C) Advance Direct (D) All special instrict ongoing care, as a (E) Comprehensive (F) All other neces copy of the resident consistent with §48 any other documer a safe and effective This REQUIREMED by: Based on staff inte and clinical record facility staff failed to documentation to to to ensure all require clinical record upor residents in the sur 110, 85, 113, 65, 69  1. The facility staff Resident #433's ca the receiving provict transfer on 4/27/18  2. The facility staff Resident #110's ca	entransfer or discharge is aragraph (c)(1)(i)(C) or (D) of vided to the receiving provider imum of the following: ation of the practitioner care of the resident. sentative information including a tive information uctions or precautions for propriate. Secare plan goals; seary information, including a tive discharge summary, 33.21(c)(2) as applicable, and atation, as applicable, to ensure extransition of care.  NT is not met as evidenced  Proview, facility document review review, it was determined the provide all required the receiving hospital and failed the documentation in the intransfer for nine of 48 to evidence that the plan goals were provided to der for a facility initiated  failed to evidence that the plan goals were provided to der for a facility initiated	F	It is the practice of the vide all required documental required documental record is sent upon the s	tumentation and to ensure tion in the citransfer.  110, #85, #1 and #97 no little potential comprehensing the speech met in facility.	to the all linical 13, longer I to be acated sive on will be ecific ity		

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE S COMPL  AND PLAN OF CORRECTION   IOENTIFICATION NUMBER:   A, BUILDING							
		495217	B. WING			l	0 1 <b>7/2</b> 01 <b>8</b>
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		1:	TREET AOORESS, CITY, STATE, ZIP COOE 2475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033		11/2010
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI: TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION DATE
F 622	3. The facility staff far Resident #85's care in the receiving provider transfer on 5/6/18.  4a. The facility staff far facility a copy of Resifor a facility initiated to the specific needs the face efforts to meet the thouse the receiving fact the needs of Resident transfer.  5. The facility staff fair #65's comprehensive staff when the resider on 4/23/18.  6. The facility staff fair required information were eiving provider for facility-initiated transfer and 4/27/18.  7. The facility staff fair required information were eiving provider for facility-initiated transfer.  8. The facility staff fair required information were eiving provider for facility-initiated transfer.	illed to evidence that plan goals were provided to a for a facility initiated alled to provide the receiving dent # 113's care plan goals ransfer.  ailed to provide the physician evidencing the physician evidencing the sility could not meet, facility's pose needs and the specific acility could provide to meet to the 113 for a facility initiated alled to provide Resident care plan goals to hospital that transferred to the hospital and transferred to the hospital and the specific that all was provided to the Resident #69's for the hospital on 3/28/18 are to the hospital on 2/1/18.  The ded to evidence that all was provided to the Resident #44's for the hospital on 2/1/18.  The ded to evidence the care with Resident #105, for a	F	322	4. DON and/or designee will do audits of five (5) discharges to the to ensure that care plan goals has sent with the resident and that do documented the need that could met in the facility and said inform was communicated to the receiving facility. These audits will be done on the communicated to the receiving facility. These audits will be done of the communicated to the Quality Assurance was appropriate. The communication as appropriate. The communication and/or action.  5. Date of Compliance is June 10.	e hospit ve beer petor not be ation ng e weekly (2). e for- and w and nittee	al n

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE S	
		495217	B. WING _			05/1	7/2018
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZII  12475 LEE JACKSON MEMORIAL  FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD B O THE APPROPRIA		(X5) COMPLETION DATE
F 622	Continued From page	e 12	Fé	522			
	9. The facility staff fail	led to evidence the care with Resident #97, for a					
	The findings include:						
	4/2/18 and readmitted that included but were failure, anemia, obesi The most recent MDS day assessment, with reference date) of 5/1 having scored a 14 or interview for mental si was cognitively intact Review of the nurse's p.m. documented, "Re	6 (minimum data set), a five an ARD (assessment 0/18 coded the resident as at of 15 on the BIMS (brief tatus indicating the resident to make daily decisions.					
	therapy was 115/59 (the 18 (respirations) 97.5 saturation at 86% (not 31/min (liters per minur) prongs that fit in the note (medical doctor) was party) at bedside and doctor) assessed pating resident out to ER (endiagnosis of hypoxia (for the form).	olood pressure) 75 (pulse) (temperature) oxygen rmal 90 - 100) on Oxygen te) via nasal cannula (soft ose to deliver oxygen). md notified RP (responsible made aware. MD (medical ent and ordered to transfer nergency room) for (1)."					
	sent to emergency roo	ion that the care plan was om with the resident. ducted on 5/17/18 at 9:33 and practical nurse) #4.					

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION		IOENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETEO	
		495217	B. WNG				C <b>17/2018</b>	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET AODRESS, CITY, 12475 LEE JACKSON M FAIRFAX, VA 22033	•	<u>,                                     </u>		
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFI TAG	X (EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 622	When asked about the a resident is transferm LPN #4 stated, "I call the diagnosis or what the vital signs, level of oxygen level and what asked what paperwork LPN #4 stated, "The Ithe medication list, results), x-ray if they if sheet." When asked if the resident, LPN #4 this patient is a fall rist care plan was sent, Lover the phone."  On 5/17/18 at 5:45 p.1 member) #1, the admidirector of nursing and assurance consultant findings.  Review of the facility's "INTERDISCIPLINAR CHECKLISTS" documents including a from (name of softwark Seal envelope. Remo patient's clinical recorform titled, "POST ACDOCUMENT CHECK documentation that the the resident.	the process staff follows when the dot the emergency room, the hospital and tell them the problem is. I give them of consciousness, pain, at the family wants." When k was sent with the resident, DNR (do not resuscitate), cent labs (laboratory had a result fall and the face of the care plan is sent with stated, "You can tell them sk." When asked if the actual PN #4 stated, "Sometimes  The dash #3 the quality were made aware of the spolicy titled, as policy titled, as policy titled, and the face of the care plan is sent with stated. "Sometimes the dash #3 the quality were made aware of the spolicy titled, as policy titled, as policy titled, and the face of the care plan is sent with stated." TRANSITIONS mented, "TRANSITIONS mented, "TRANSITION"	F	622				

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		IDENTIFICATION NUMBER		) MULTIPLE CONSTRUCTION BUILOING			(X3) OATE SURVEY COMPLETEO	
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	ROVIOER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS	,	STREET AOORESS, CITY, STATE, ZII 12475 LEE JACKSON MEMORIAL FAIRFAX, VA 22033		, ,		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL .SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCEO TI OEFICIE	CTION SHOULO B O THE APPROPRIA	_	(X5) COMPLETION DATE	
F 622	oxygen in organs, tiss information was obtain https://www.ncbi.nlm. 17626/  2. The facility staff fail Resident #110's care the receiving provider transfer on 4/12/18.  Resident #110 was at 4/4/18 and readmitted that included but were failure, anemia, heart.  The most recent MDS with an ARD of 5/3/18 having scored 12 out the resident was mod The resident was mod The resident was cod from staff for all activitient was set up.  Review of the physician tray was set up.  Further review of the formation was obtained by the formation of the formation of the formation was obtained by the formation of the format	as the reduction or lack of sues, or cells. This ned from: nih.gov/pmc/articles/PMC32  led to evidence that plan goals were provided to for a facility initiated  dmitted to the facility on don 4/20/18 with diagnoses e not limited to: chronic heart attack and high cholesterol.  So, a 14-day assessment, a coded the resident as of 15 on the BIMS indicating erately impaired cognitively, ed as requiring assistance ties of daily living except for dent could perform after the lan's notes dated 4/12/18 at ted, "Notified by nursing that very high BP (blood spite NRM (non-rebreather coffast heart rate). Ordered ER (emergency room) via	F	522				

STATEMENT OF AND PLAN OF C		IDENTIFICATION NUMBER		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		<del>4952</del> 17	B. WING			C 0 <b>5/17/2</b> 01 <b>8</b>	
	VIDER OR SUPPLIER	-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033				
(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 IEACH CORRECTIVE ACTI CROSS-REFERENCED TD T DEFICIENC	ION SHOULD B HE APPROPRIA		
A a V a L the three states of the condition of the condit	a.m. with LPN (license When asked about the resident is transferre PN #4 stated, "I call the diagnosis or what the vital signs, level or exygen level and what paperword PN #4 stated, "The Interpretation list, released the resident, LPN #4 sheet." When asked if the resident, LPN #4 shis patient is a fall rister plan was sent, Liever the phone."  On 5/17/18 at 5:45 p.i thember) #1, the admitirector of nursing and inscurance consultant andings.  It facility staff faire receiving provider ransfer on 5/6/18.  Resident #85 was admitted at included but were the phone but were the phone and included but were the phone discount was a safe and readmitted that included but were the phone is the safe and readmitted that included but were the phone is the safe and readmitted that included but were the phone is the safe and readmitted that included but were the phone is the safe and readmitted that included but were the phone is the safe and readmitted that included but were the phone is the safe and readmitted that included but were the phone is the safe and readmitted that included but were the phone is the safe and readmitted that included but were the phone is the safe and the sa	ducted on 5/17/18 at 9:33 ed practical nurse) #4. e process staff follows when ed to the emergency room, the hospital and tell them the problem is. I give them if consciousness, pain, t the family wants." When k was sent with the resident, DNR (do not resuscitate), cent labs (laboratory had a result fall and the face if the care plan is sent with stated, "You can tell them k." When asked if the actual PN #4 stated, "Sometimes  m. ASM (administrative staff inistrator, ASM #2 the d ASM #3 the quality were made aware of the  was provided prior to exit.  led to evidence that lan goals were provided to	F	522			

PRINTED: 05/30/2018 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			I	C 17/2018	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	;-FAIR OAKS		1	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	1 00/		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 622	The most recent MDS end of therapy asses (assessment reference the resident as having the BIMS indicating the coded as requiring as activities of daily living.  Review of the nurse's a.m., documented, "A writer was alert (sic) the is unresponsive(National assessed patient and to (name of hospital) further evaluation."  Further review of the evidence documentate been sent to the emeresident.  An interview was con a.m. with LPN (licens When asked about the a resident is transferr LPN #4 stated, "I call the diagnosis or what the vital signs, level on oxygen level and what asked what paperwor LPN #4 stated, "The I the medication list, reresults), x-ray if they is sheet." When asked if the resident, LPN #4 this patient is a fall rise.	S (minimum data set), an asment, with an ARD be date) of 4/29/18 coded g scored a 14 out of 15 on the resident was cognitively ecisions. The resident was assistance from staff for all g.  Is notes dated 5/6/18 at 10:20 at around 0945 (9:45 a.m.), by nursing aide that patient ame of physician) visited and gave order to send patient ER (emergency room) for clinical record did not tion that the care plan had regency room with the ducted on 5/17/18 at 9:33 ed practical nurse) #4. The process staff follows when the dot the emergency room, the hospital and tell them at the problem is. I give them of consciousness, pain, at the family wants." When the was sent with the resident, DNR (do not resuscitate),	F	622				

FORM CMS-2567(D2-99) Previous Versions Obsolele

Eveni ID: 0J2611

Facility ID: VA0153

If continuation sheet Page 17 of 222

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STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3) OATE SURVEY COMPLETEO		
		495217	B. WING_			C	
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	FAIR OAKS	•	STREET AOORESS, CITY, STATE, ZI 12475 LEE JACKSON MEMORIAL FAIRFAX, VA 22033		,	
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI) TAG	X (EACH CORRECTIVE A CROSS-REFERENCEO T	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)		
F 622	member) #1, the admidirector of nursing an assurance consultant findings.  1. Parkinson's diseas (PD) is a type of movement when nerve cells in the enough of a brain che soem to run in familie obtained from: https://medlineplus.go.  4a. The facility staff facility a copy of Resident # 113 was a 09/23/14 with a reading diagnoses that include cerebrovascular disease atherosclerotic heart of weakness.  Resident # 113's most data set), a 5 (five)-data set), a 6 (five)-data set), a 6	m. ASM (administrative staff sinistrator, ASM #2 the d ASM #3 the quality were made aware of the e—Parkinson's disease ement disorder. It happens he brain don't produce emical called dopamine. Sic, but most cases do not so. This information was ev/parkinsonsdisease.html siled to provide the receiving dent # 318's care plan goals transfer.  Idmitted to the facility on mission of 03/05/18 with ed but were not limited to ase (1), anemia (2), disease (3) and muscle et at recent MDS (minimum ay assessment with an ARD se date) of 03/12/18, coded oring a 5 (five) on the brief tatus (BIMS) of a score of 0 everely impaired of daily decisions. Resident # juiring extensive assistance	F	522			
	The nurse's "Progress	or activities of daily living.  s Notes," for Resident # 113 02/22/2018. Call placed to					

	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	i i		CONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
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		495217	B. WING			05.	/17/2018
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS	<u>:</u>	124	REET AOORESS, CITY, STATE, ZIP COOE 175 LEE JACKSON MEMORIAL HIGHWAY IRFAX, VA 22033		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG	x	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO E CROSS-REFERENCEO TO THE APPROPRI OEFICIENCY)		(X5) COMPLETION DATE
F 622	(Name of Physician) to send to (Mane of H) Daughter (Name of D) did call and talked wit inform of what to expellanguage/Romanian. understanding. Call p Transportation Comparrival) is 30 minutes. Hospital) ER (emerge to (Name of Hospital) to complete and resident complete and resident asked about the proceresident is transferred stated, "We call and g them with full vital significancy in condition is speak, what their pain oxygen level is." When with the resident to the "DNR (do not resuscit recent x-rays, labs (lat sheet." When asked if sent with the resident, they have behaviors, or going. We tell them if the asked if they provide the stated, "Sometimes when asked if she gooplan on the phone, LP summarize what they stabilize the resident. give them each goal.	o inform and receive order ospital). Call placed to aughter) she is aware. She har mother/resident to ect in her Resident verbalized placed to (Name of any) ETA (estimated time of Call placed to (Name of not proom) and report given Nurse). Paperwork is at is ready for transport."  ducted with LPN (licensed of 5/17/18 at 9:33 a.m. When east staff follows when a to the hospital, LPN #4 ive them report. We send on, diagnosis, what the first if the resident is able to level is and what their of asked what she sends to hospital, LPN #4 stated, ate) form, medication lists, coratory reports) and a face the care plan goals are LPN #4 stated, "Mostly, if depends on how they are they are a fall risk." When their care plan goals, LPN is by phone, not on paper." they are a fall risk." When their care plan goals, LPN is by phone, not on paper." they are a fall risk." When their care plan goals, LPN is by phone, not on paper." they are a fall risk." When their care plan goals, LPN is by phone, not on paper." they are a fall risk." When their care plan goals, LPN is by phone, not on paper." they are a fall risk." When their care plan goals, LPN is by phone, not on paper." they are a fall risk." When their care plan goals, LPN is by phone, not on paper." they are a fall risk." When their care plan goals, LPN is by phone, not on paper." they are a fall risk." When their care plan goals, LPN is summarize but don't	F	322			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING_				C / <b>17/2018</b>	
	PRDVIDER OR SUPPLIER	ES-FAIR OAKS		STREET ADDRESS, CITY, STATE, Z 12475 LEE JACKSON MEMORIAI FAIRFAX, VA 22033		1 00,	17/2016	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ACTION SHOULD BI TO THE APPROPRIA	_	(X5) COMPLETION DATE	
F 622	administrator and A were made aware of No further informat References:  (1) A stroke. When brain stops. A strok attack." If blood flo few seconds, the boxygen. Brain cells damage. This infort website: https://medlineplus.  (2) Low iron. This in the website: https://www.nlm.nih.  (3) A disease in whyour arteries. Plaquup of fat, cholesters substances found in hardens and narrow flow of oxygen-rich information was obhttps://medlineplus.  4b. The facility state documentation from specific needs the fefforts to meet the fineeds the receiving the needs of Reside transfer.	ASM # 2, director of nursing of the findings.  tion was provided prior to exit.  In blood flow to a part of the ke is sometimes called a "brain ow is cut off for longer than a brain cannot get nutrients and is can die, causing lasting rmation was obtained from the s.gov/ency/article/000726.htm .  Information was obtained from the die is a sticky substance made tool, calcium, and other in the blood. Over time, plaque with your arteries. That limits the lablood to your body. This obtained from the website:  Information was obtained.	F	622				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING_				0 1 <b>7/2018</b>	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP 12475 LEE JACKSON MEMORIAL H FAIRFAX, VA 22033		1 00/	17720   0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD B THE APPROPRIA		(X5) COMPLETION OATE	
F 622	documented in part, " (Name of Physician) to send to (Mane of H) Daughter (Name of D) did call and talked wit inform of what to expellanguage/Romanian. understanding. Call p. Transportation Comparrival) is 30 minutes. Hospital) ER (emerge to (Name of Hospital) complete and residen Review of the physician otes dated 01/23/18 evidence documentat facility could not meet those needs and the sfacility could provide to Resident # 113.  On 05/17/18 at 1:58 p conducted with ASM (member) # 6, the nurs to describe what is do is transferred, ASM # we are transferring the On 05/17/18 at approximation (administrator and ASM were made aware of the No further information 5. The facility staff fail #65's comprehensive	02/22/2018. Call placed to o inform and receive order ospital). Call placed to aughter) she is aware. She is a call placed to (Name of any) ETA (estimated time of Call placed to (Name of ncy room) and report given Nurse). Paperwork is it is ready for transport."  an's most recent progress through 05/02/18 failed to it is not the specific needs the facility's efforts to meet the specific needs of the cumented when a resident 6 stated, "We only note why is patient."  kimately 5:50 p.m. ASM is interview is a director of nursing the needs of the needs of the stated, "We only note why is patient."	F	622				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION SUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS	•	STREET ADDRESS, CITY, STATE, ZIP C 12475 LEE JACKSON MEMORIAL HI FAIRFAX, VA 22033	•			
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F 622	Continued From page	e 21	F	622				
	4/13/18. Resident #6 were not limited to dia disorder. Resident #1 (minimum data set), a with an ARD (assess 4/20/18, coded the re- daily decision making Review of Resident # a nurse's note dated a "Patient was awake in received the ordered problem. She reques (tracheostomy) (1) ca was changed without She then complained done and another stu- checked and patient is cannula was in prope stated she wanted to she takes at home bu name but the colour ( doctor) was called an Md was albuterol (2) ( sic) at about (sic) and the pharmacy was ca of the faxed order and (as soon as possible) pharmacy. Patient wa immediately and refus (nebulizer) cursing the when the inhaler wou medication at 0645 (6) neb (nebulizer) treatm walking up and down door. Vs (Vital signs)	65's clinical record revealed 4/23/18 that documented, nost of the night and medications without ted the trach nnula to be changed and problem at 0400 (4:00 a.m.) stating it was not properly ff (sic) was called and was agreeable that the trach r positioning (sic). She then have inhaler like the one t could not remember the sic). The MD (medical d the inhaler description per and the order was obtain d faxed to the pharmacy and lled, confirmed the reception d promised to deliver ASAP						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495217	B. WING		0	C 5/17/2018	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT DF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION OATE	
F 622	anxious and stating pressure) 132/88 p 02 SAT (oxygen satt 61 (liters) via trac (trasuction (sic). 911 w 0720 (7:20 a.m.) and treatment. Patient is she didn't want to go wanted to just be state to convince her to go more check up (sic. 0730 (7:30 a.m.) Cil Patient report given nurse) questions we to her satisfaction. called again and up and order received (emergency departrice) Daughter (name) cate call facility for upon already calling her be patient paperwork with manager at (name of the failed to reveal a dedocumented informationspital staff.  On 5/17/18 at 12:32 conducted with RN in urse who documented 1/23/18). RN #6 was provided to the hospital stafformation condition and information candition and information condition and information condition and information candition candition candition candition and information candition	call 911. Checked VS (blood (pulse) 90 R (respirations) 20 tration) 96 with o2 (oxygen) at acheostomy). Refused to be as called and arrived at about d gave their resp (respiratory) started laughing and stated to to the hospital and that she abilized, They (sic) were able to for more treatment and and finally agreed and left at larification: Note written prior; to (name) RN (registered ere encouraged and answered (Name of physician) was dated of change of condition to send patient to ED ment) for evaluation.	F	622			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			LE CONSTRUCTION		(X3) DATE SURVEY CDMPLETED	
						,	С	
		495217	B. WING			05/	17/2018	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		124	REET ADDRESS, CITY, STATE, ZIP CODE 75 LEE JACKSON MEMORIAL HIGHWAY RFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPRDPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 622	information she proving Resident #65 was traded to a regarding Resident #RN #6 stated nurse on the phone as regarding Resident #RN #6 stated she als included a medication the MAR (medication information about the resident. RN #6 was Resident #65's care phospital. RN #6 stated information needed to did not talk about the phone with hospital scare plan to the plan to the hospital scare plan to the	asked to describe the ded to hospital staff when insferred to the hospital on ad she spoke to a hospital and gave information 65's tracheostomy and diet. The proof of the provided she provided she provided she provided the care staff gives the asked if she provided she provided the care for Resident #65 but care plan goals on the taff or send the resident's ital.  The provided the care plan goals on the taff or send the resident's ital.  The provided plan goals on the taff or send the resident's ital.  The provided plan goals on the taff or send the resident's ital.  The provided plan goals on the taff or send the resident's ital.  The provided plan goals on the taff or send the resident's ital.  The plan goals on the taff or send the resident's ital.  The provided plan goals on the taff or send the resident's ital.  The provided the provided the plan goals on the taff or send the resident's ital.  The provided the provided the plan goals on the taff or send the resident's ital.  The provided the provided the plan goals on the taff or send the resident's ital.  The provided the pr	F	622				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING_			l	C <b>17/2018</b>	
	ROVIDER OR SUPPLIER	S-FAIR OAKS	•	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWA FAIRFAX, VA 22033	.Y	<u> </u>		
(X4) ID PREFIX TAG	JEACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG				(X5) COMPLETION DATE	
F 622	required information receiving provider fo facility-initiated trans and 4/27/18.  Resident #69 was ac 7/8/17 and readmitte that included but wer disease, multiple sold disorder. Resident # (minimum data set) assessment with an adate) of 4/12/18. Recognitively intact scotthe BIMS (Brief Interexam.  Review of Resident # that she had first been 3/28/18. The follothe beginning of the care and refused to ethe patient and finally half coup (sic) of coff and getting weak. Not start on IVF (Intraversal)	illed to evidence that all was provided to the r Resident #69's fer to the hospital on 3/28/18  Imitted to the facility on d on 5/1/18 with diagnoses re not limited to Parkinson's erosis (1), and bipolar 169's most recent MDS assessment was a quarterly ARD (assessment reference sident #69 was coded as ring 15 out of possible 15 on view for Mental Status)  #69's clinical record revealed en transferred to the hospital ewing was documented, "At shift PT (patient) refused AM the part of the provided record revealed fee. At noon pt's lips are dry of (nurse practitioner) ordered venous fluids), D5 (Dextrose) tr75 cc/hr (cubic centimeter /	F					
	came at 1:39 p.m., u Daughter initially war hospital but changed stay with the patient observe her and will	buth) intake. Her daughter pdated on condition. Ints to send patient to the her mind and said she will for couple of hours to decide then. At 3:00 p.m. ransfer the pt (patient) to the						

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			=::		SURVEY PLETED
	I	495217	B. WING				C
NAME OF P	PROVIDER DR SUPPLIER	7772		CTDEET ADI	DRESS, CITY, STATE, ZIP CODE	U5/	/ <b>17/20</b> 18
			ļ				
MANORCA	ARE HEALTH SERVICES	FAIR OAKS		FAIRFAX, V	JACKSON MEMORIAL HIGHWAY VA 22033	_	1
(X4) ID PREFIX TAG	SUMMARY STATEMENT DF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DR LSC IDENTIFYING INFORMATION)		ID PREFI: TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ION SHOULD BE HE APPROPRIATE	
F 622	Continued From page	≥ 25	F	622			
	Review of the acute of 3/28/18 revealed that was provided with the transfer.  1. Contact information responsible for the ca 2. Resident represent contact information.  3. All special instruction ongoing care, as appred. Advance Directive in the transfer.  There was no evident care plan goals were stime of transfer.  Further review of Resident hospital for the second following note was down the transfer and very calling the prediction of the prediction of the second following note was down the transfer and very calling the prediction of the prediction of the second following note was down the second following the second following in the second following note was down the second following the second following note was down the second following the se	care transfer sheet dated the following information e resident at the time of an of the practitioner are of the resident. Itative information including ons or precautions for ropriate. Information.  The that the Resident #69's sent with the resident at the sident #69's clinical record and #69 went out to the the locumented on 4/27/18.					
	meet anyone today ar frequently called out a with no sign of acute of (2) on UTI (urinary track) Signs) bp (blood press rate) - 67, rr (respirato (saturation) 95 % RA ( (temperature) - 96.9 F refused to take the mo- breakfast, staffs attem	nd no Mr. airman. Resident and talked to herself loudly distress. Last day on Ceftin act infection). VS (Vital sure) - 145/80, hr (heart ory rate) -17, 02 sate (sic)					

CENTERS FOR MEDICARE & MEDICAID SERVICES

	TATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NO PLAN OF CORRECTION (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) OATE SURVEY COMPLETEO				
		495217	B. WING			C 05/17/2018	
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET AOORESS, CITY, STATE, ZIP COOE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033			
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)		IO PREFII TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION OATE
F 622	ensure offered, but no member notified, spol about changing status attempted many time drink and eat, resident some milk, daughter a monitor."  The next note dated 4 documented the follow staff) reported that resident refused IVF. resident to the hospital Resident, (sic.) fluids even with a lot of encounted the follow transferred out to (Natevaluation due to Merresident daughter (Nathis morning with resident daughter (Nathis morning with resident daughter (Nathis morning with resident daughter), and 02  Review of the acute of 4/27/18 revealed that was provided with the transfer:  Contact information responsible for the care.  Resident represent contact information.	bet been taken. Family ke to (Name of daughter) s. Daughter visited and to encourage resident to at took medications with at bedsidewill continue to  4/27/18 at 5 p.m., wing: "DCS (direct care sident with an order for IVF age in mental status, refused and decreased p.o. intake Order noted to send al. This writer visited offered but took only 1 sip ouragement."  18 at 6:49 p.m., wing: "Resident was ame of Hospital) for atal Status change with medications and not eating hysician) is aware and ame of Daughter) was here dent. Resident was picked port) at 6:45 p.m. VS (vital spirations), 63 (pulse), 97.3 ata tis 97 % RA (room air)."  the following information a resident at the time of an of the practitioner are of the resident. atative information including	F	622			
	3. All special instruction	ons or precautions for					

CENTERS FOR MEDICARE & MEDICAID SERVICES

		IOENTIFICATION NUMBER		ULTIPLE CONSTRUCTION LOING		(X3) OATE SURVEY COMPLETEO	
		495217	B. WING	B. WING		C 05/17/2018	
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	3-FAIR OAKS	,	STREET AOORESS, CITY, STATE, ZIP COOE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033			
(X4) IO PREFIX TAG	X (EACH OEFICIENCY MUST BE PRECEOEO BY FULL		IO PREFIX TAG	PROVIOER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCEO TO THE API OEFICIENCY)	IOULO BE	(X5) COMPLETION DATE	
F 622	pg		F 62	2		"	
	ongoing care, as app 4. Advance Directive	information.					
		ce that the Resident #69's sent with the resident at the					
	conducted with LPN; information was provitime of transfer to the nurses send the residence and any diagnostic testated the resident's incontact information with sheet. When asked if provided to the hospi stated that sometimes plan goals over the	tal upon transfer, LPN #4 s she will provide some care thone when giving report, ne did not go over the entire ated that nurses did not send cidents to the hospital.  m., ASM (administrative administrator and ASM #2, Nursing) were made aware					
	required information vireceiving provider for						
	4/26/10 and readmitted diagnoses that include	mitted to the facility on ed on 2/06/18 with ed but were not limited to isorder, dementia, and			·		

PRINTED: 05/30/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) OATE SURVEY COMPLETEO		
				In while :		С		
		495217	B. WING	•	<del></del>	05/	17/2018	
	ROVIOER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS	STREET AOORESS, CITY, STATE, ZIP COOE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			-		
(X4) IO PREFIX TAG	(EACH OEFICIENC	TATEMENT OF OEFICIENCIES BY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	FULL PREFIX (EACH COI		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)			
F 622	recent MDS (minimu an annual assessme reference date) of 3/3 coded as severely in scoring 05 out of 15 for Mental Status) excoded as requiring extaff member with ead dependence on one personal hygiene and assistance with two probability and transfers.  Review of Resident of that she had been traced as 15 p.m.: "Reside time, son visiting with nursing station to repromplain to him that think she is having Fl want the Mom to go encourage to let the care of that but he sawant than she should (vital signs) 91/51 (bl (respirations), 98 (pur 02 (oxygen) saturation air), resident already is called and theyword. The next note dated following: "Resident of (Name of Hospital) for	order. Resident #44's most m data set) assessment was nt with an ARD (assessment 31/18. Resident #44 was apaired in cognitive function on the BIMS (Brief Interview am. Resident #44 was extensive assistance from one ting, and toileting; total staff member with dressing, at bathing; and extensive olus staff members with bed as a staff member with dressing, at bathing; and extensive olus staff members with bed as a staff member with dressing, at bathing; and extensive olus staff members with bed as a staff member with dressing, and extensive olus staff members with bed as a staff member with dressing, and extensive olus staff members with bed as a staff member with dressing, and extensive olus staff members with dressing, and extensive olus st	F	622				

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

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Facility IO: VA0153

If continuation sheet Page 29 of 222



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495217	B. WING _			C 05/1 <b>7/2</b> 018	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033		30,,,,,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG		ACTION SHOULD B		
F 622	Continued From page	e 29	F	622			
	2/1/18/18 revealed th was provided with the transfer:  1. Contact information responsible for the cat 2. Resident represent contact information.  3. All special instructiongoing care, as apputed. Advance Directive  There was no evident care plan goals were time of transfer.  Further review of Reservealed that she was with a diagnoses of the admitted back to the fixesident #44's immunity.	are of the resident.  tative information including  ons or precautions for ropriate.					
	time of transfer to the nurses send the resid medication list, recent and any diagnostic te stated that the resider physician contact info face sheet. When ask provided to the hospit stated that sometimes plan goals over the pl LPN #4 stated that sh			,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING_			C 05/1 <b>7/2018</b>		
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		1247	EET ADDRESS, CITY, STATE, ZIP CODE  (5 LEE JACKSON MEMORIAL HIGHWAY  RFAX, VA 22033	<del></del>	1112415	
(X4) ID PREFIX TẠG	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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TON SHOULD BE THE APPROPRIATE		
F 622		e 30 sidents to the hospital.	Ff	522		·		
	staff member) #1, the	m., ASM (administrative administrator and ASM #2, Nursing) were made aware s.						
	plan goals were sent	led to evidence the care with Resident #105 for a er to the hospital on 12/1/17.						
	8/14/15 with a recent with diagnoses that in to: end stage renal fai (a procedure to removallure in which waste removed from the blo (1), obesity, sleep apr	dmitted to the facility on readmission on 12/9/17, ncluded but were not limited ilure requiring hemodialysis ved toxic condition and renal and impurities are sod by a special machine) nea, stroke, high blood epression and seizure						
	assessment reference coded the resident as	al assessment, with an e date (ARD) of 5/4/18, s scoring a 15 on the BIMS ental status score) indicating						
	documented in part," chest pain and hypote medication administratreat high blood press (patient's) blood press Approximately 30 min complained of chest p	ed, 12/1/17 at 9:14 a.m. Resident had an episode of ension after 0500 (5:00 a.m.) ation. Metoprolol (used to sure) (2) was given for pts sure of 150/101, pulse 100. autes later resident pain and headache. Blood d was 93/46, P (pulse) 71.						

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		IOENTIEICATION NUMBER		MULTIPLE CONSTRUCTION UILOING			(X3) OATE SURVEY COMPLETEO	
		495217	B. WING_			05/1	;  7/2018	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET AODRESS, CITY, STATE, 12475 LEE JACKSON MEMORIA FAIRFAX, VA 22033		1 00.1		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IO PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCEO		ON SHOULO BE HE APPROPRIATE		
F 622	take aspirin 81 mg (mand send pt (patient) Resident was sent to stretcher. Resident decement and send pt (patient) Review of the clinical documentation of the hospital with the resident asked about the proceeding of them with full vital significancy in condition is speak, what their pair oxygen level is." Whe with the resident to the "DNR (do not resuscificated," When asked if sent with the resident they have behaviors, going. We tell them if asked if they provide #4 stated, "Sometime When asked if she goplan on the phone, LF summarize what they stabilize the resident. Give them each goal.  The administrative standministrator, ASM #3, the quality as well as the control of	notified and ordered resident iilligrams) stat (immediately) to ER (emergency room). (Name of hospital) ER via id not go to dialysis today."  record failed to evidence information sent to the lent on 12/1/17.  ducted with LPN (licensed in 5/17/18 at 9:33 a.m. When less staff follows when a let to the hospital, LPN #4 give them report. We send in s, diagnosis, what the level is and what their in asked what she sends e hospital, LPN #4 stated, rate) form, medication lists, boratory reports) and a face of the care plan goals are they are a fall risk." When their care plan goals, LPN is by phone, not on paper."  es through the entire care in the stated, "No, we	Fé	622				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(DEATHER ATION AND ADDED		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495217	B. WING _			C 05/17/2018	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CDDE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033		03/11/2010	
(X4) 1D 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 C ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION OATE	
F 622	Continued From pag	ge 32	Fe	522			
	No further information	on was provided prior to exit.					
		ary of Medical Terms for the r, 5th edition, Rothenberg and s.					
	following website:	was obtained from the n.nih.gov/pubmedhealth/PMH etails.					
	plan goals were sen facility initiated trans Resident #97 was at 4/9/18 with a readmidiagnoses that inclusepsis (destruction contamination, infect (paralysis of the low-	er limbs) (2), below the knee e ulcer and osteoarthritis					
	assessment, a Medi with an assessment coded the resident a (brief interview for m	S (minimum data set) care 14 day assessment, reference date of 5/6/18, s scoring a 12 on the BIMS ental status) score, indicating impaired to make cognitive					
	documented in part, with son at the beds Per son and MD (me increased confusion	red, 4/19/18 at 2:11 p.m. "Pt (patient) observed in bed ide through the afternoon. edical doctor), the pt has going on since Sunday.					

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 05/17/2018	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIF 12475 LEE JACKSON MEMORIAL FAIRFAX, VA 22033	_	33.117.2010	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFI TAG		CTION <b>SHOU</b> LD BE O THE APPROPRIA		
F 622	not making much sind fluids) continued per of to assess the ptNew (initials of hospital) Effurther eval (evaluation mental status) and position aware of the plan of continued for the plan of continued for the plan of continued for the hospital. There documentation of what to the hospital. There documented on the form of the process of the clinical documentation of what with the resident on 1.  An interview was continued for the process of the clinical documentation of what with the resident on 1.  An interview was continued for the process of the proce	Speech is clear however be (sic). IVF's (intravenous orderMD in this afternoon of worder received to send to R (emergency room) for on) d/t (due to) AMS (altered possible seizure. Son is pare. Report called into a). Pt left the facility at 4:45 are fer" form failed to evidence at was sent with the resident of were no care plan goals orm.	F	622			

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		IOENTIFICATION NUMBER		PLE CONSTRUCTION		(X3) OATE SURVEY COMPLETEO	
		495217	B. WING_	B. WING		C 05/17/2018	
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET AOORESS, CITY, STATE, ZIP COOR 12475 LEE JACKSON MEMORIAL HIGHT FAIRFAX, VA 22033	Ε	1112010	
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 622	Continued From page	e 34	Fe	22			
	summarize what they stabilize the resident. give them each goal.  The administrative stadministrator, ASM #3, the quality as	PN #4 stated, "No, we need for that time to We summarize but don't aff member (ASM) #1, the 2, the director of nursing and ssurance consultant, were pove concern on 5/17/18 at					
	(1) Barron's Dictionar Non-Medical Reader, Chapman; page 527. (2) Barron's Dictionar Non-Medical Reader, Chapman; page 435. (3) Barron's Dictionar Non-Medical Reader, Chapman; page 422.	before transfer. iers or discharges a	F 6	The statement made on correction are not an ad not constitute an agreen alleged deficiencies here compliance with all Federegulations, the center h	mission to and nent with the ein. To remain eral and State	in	
ļ	(i) Notify the resident representative(s) of the the reasons for the manguage and manner facility must send a corepresentative of the Long-Term Care Ombatility Record the reason	and the resident's the transfer or discharge and tove in writing and in a they understand. The topy of the notice to a Office of the State udsman.		take the actions set forthing plan of corrections.  POC constitutes the center of compliance such that deficiencies cited have be corrected by the date	n in the follow- The following Iter's allegation all alleged Deen or will		

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) OATE SURVEY COMPLETEO		
		495217	B. WING	B. WING		C 05/17/2 <b>018</b>		
	NAME OF PROVIOER OR SUPPLIER  MANORCARE HEALTH SERVICES-FAIR OAKS		<u> </u>	124	REET AOORESS, CITY, STATE, ZIP COOE 475 LEE JACKSON MEMORIAL HIGHWAY NRFAX, VA 22033	1 09/	1772016	
(X4) IO PREFIX TAG				×	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BI CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)	ULO BE COMPLETION		
F 623	and (iii) Include in the noting paragraph (c)(5) of the \$483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, discharge required under the section of the section; (ii) Notice must be materially a resident is transferred (ii) Notice must be materially of individual of the section; (b) The safety of individual of the section; (c) The health of individual of the section; (d) The resident's health of the section; (e) The resident's health of the section; (f) An immediate transfer paragraph (c)(1) (ii) A resident has not days.  §483.15(c)(5) Content notice specified in paramust include the follor (i) The reason for transferred or discharge (iii) The location to what transferred or discharge (iv) A statement of the	graph (c)(2) of this section;  ce the items described in is section.  of the notice.  d in paragraphs (c)(4)(ii) and the notice of transfer or ider this section must be at least 30 days before the facility would at paragraph (c)(1)(i)(C) of widuals in the facility would at paragraph (c)(1)(i)(D) of least time transfer or discharge; in the notice. The written regraph (c)(3) of this section wing:  at soft the notice. The written regraph (c)(3) of this section wing:  at soft the notice. The written regraph (c)(3) of this section wing:  at soft the notice. The written regraph (c)(3) of this section wing:  at soft the notice. The written regraph (c)(3) of this section wing:  at soft the notice. The written regraph (c)(3) of this section wing:  at soft the notice. The written regraph (c)(3) of this section wing:  at soft the notice. The written regraph (c)(3) of this section wing:  at soft the notice. The written regraph (c)(3) of this section wing:  at soft the notice. The written regraph (c)(3) of this section wing:  at soft the notice at least 10 days 1	F	623				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) OATE COMP	SURVEY LETEO
		495217	B. WING _				C <b>17/2018</b>
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET AOORESS, CITY, STATE, ZIP COO 12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033	_	•	
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEQEO BY FULL SC IOENTIFYING INFORMATION)	IQ PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	I SHOULO BI		(X5) COMPLETION CATE
F 623	to obtain an appeal for completing the form a hearing request; (v) The name, addrest telephone number of Long-Term Care Omb (vi) For nursing facility and developmental didisabilities, the mailin telephone number of the protection and addevelopmental disabilities of the Developmental disability of the information in the formation in the effecting the transfer must update the recipas practicable once the becomes available.  §483.15(c)(8) Notice in the case of facility of the administrator of the written notification print to the State Survey Astate Long-Term Care	ts; and information on how orm and assistance in and submitting the appeal ass (mailing and email) and the Office of the State budsman; y residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental eabilities, the mailing and ephone number of the or the protection and als with a mental disorder a Protection and Advocacy unals Act.	F	523			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING				C	
NAME OF P	ROVIDER OR SUPPLIER	700-11		_	STREET ADDRESS, CITY, STATE, ZIP CODE	U5/	17/2018	
***NOBC	* 55 - 125 * TH OFFWOR	0 041/0	1	1	12475 LEE JACKSON MEMORIAL HIGHWAY			
MANURU	ARE HEALTH SERVICES	S-FAIR OAKS	1	F	FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	Continued From pag	ue 37	F	623				
	well as the plan for th	he transfer and adequate						
	483.70(I).	idents, as required at §		It is the practice of the facilit required written notification				
!	Inis REQUIREMENT is not met as evidenced initiated transfer to the resid		initiated transfer to the resident's					
!	by:	* for allthan all an own and anything	nresentative and/or ombudeman					
!		view, facility document review eview, it was determined the			'	ļ	1	
İ	i	provide required written				ļ		
!	notification of a facilit	ty initiated transfer to the						
		ative and/or ombudsman for						
ļ		s in the survey sample, ), 85, 113, 69, 105 and 97.				ļ		
ļ	Residents #-100, 110	, 85, 113, 68, 103 สมน ฮา.				ļ		
ļ	1. The facility staff fa	facility staff failed to provide written  1. Residents #433, #110, #85, #					1	
ļ	notification to the res	sident representative and	sentative and #59, #105 and #97 no longer res					
ļ		ansfer to the hospital on			the facility.  2. Residents who are transferred	. !	1	
ļ	4/27/18 for Resident	#433.			have the potential to be affected.	ļ	1	
ļ	2. The facility staff fa	ailed to provide written			3. Licensed Nurses and Social S	ervice	ļ .	
ļ	notification to the res	sident representative and			department will be re-educated or	n provid		
ļ		ansfer to the hospital on			written notification to responsible		۲P)/	
J	4/12/18 for Resident	#110.			ombudsman on all transfers out of	of the		
J	2 The facility staff fa	ailed to provide written			facility.			
J		sident representative and			4. DON and/or designee will comfive (5) random audits of resident			
		ansfer to the hospital on			charges to ensure that written not		1	
	5/6/18 for Resident#	ł85.			was provided to responsible party		İ	
	4 The feather arest f	- 9 - 3 &			ombudsman. These audits will be			
		ailed to provide written sident representative of a			weekly x four (4) and then monthl	y x two		
		fer for Resident # 113.			(2).	ا		
					The results of these audits will be			
		ailed to provide written			to the Quality Assurance and Ass			
	1	sident representative and			Committee for review and action priate. The committee will determ			
		ansfer to the hospital on			for further audits and/or action.	IIIE NES	a 	
	4/27/18 for Resident	#69.			5. Date of compliance is June 19,	2018		
	6. The facility staff fa	iled to provide written						
		he resident and/or resident				I		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495217	B. WING			1	C 1 <b>7/201</b> 8
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS		12475	ET ADDRESS, CITY, STATE, ZIP CODE S LEE JACKSON MEMORIAL HIGHWAY FAX, VA 22033	1 00/	1772010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI; TAG	<b>,</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	in writing, when he won 12/1/17 for Reside 7. The facility staff fail documentation that the representative and the in writing, when he won 4/19/18 for Reside The findings include:  1. Resident #433 was 4/2/18 and readmitted that included but were failure, anemia, obes The most recent MDS day assessment, with reference date) of 5/1 having scored a 14 or interview for mental swas cognitively intact Review of the nurse's p.m. documented, "Responsive. v/s (vital therapy was 115/59 (18 (respirations) 97.5 saturation at 86% (no 31/min (liters per minu prongs that fit in the reference) and bedside and	e ombudsman were notified, as transferred to the hospital ent #105.  Iled to provide written the resident and/or resident e ombudsman were notified, as transferred to the hospital ent #97.  Is admitted to the facility on the don 5/3/18 with diagnoses ent limited to: respiratory the and diabetes.  Is (minimum data set), a five that and an ARD (assessment 0/18 coded the resident as but of 15 on the BIMS (brief tatus indicating the resident to make daily decisions.  In note dated 4/27/18 at 12:50 esident alert and signs) this morning before colood pressure) 75 (pulse) (temperature) oxygen remail 90 - 100) on Oxygen the via nasal cannula (soft lose to deliver oxygen), mother than the proposition of the proposit	F	523			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		495217	B. WNG _	<del></del>			C /17/2018
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	i-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP 12475 LEE JACKSON MEMORIAL FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		CTION SHOULD B THE APPRDPRI	3E	(X5) COMPLETION OATE
F 623	evidence documentat representative (RR) o notified in writing of the An interview was concarm. With LPN (license When asked about the notify the family when the hospital, LPN #4 so not here and we have them the number of the family received an stated, "No."  On 5/17/18 at approximate interview was conduct member) #7, the social that when a resident is she will create an omb PCC (point click care) ombudsman receives only upon request. On ombudsman only wan involuntary discharges does not notify the omfacility-initiated transferon of 5/17/18 at 5:45 p.r member) #1, the admit director of nursing and	tion that the resident's or the ombudsman were he transfer.  ducted on 5/17/18 at 9:33 hed practical nurse) #4. He process staff follows to he a resident is transferred to stated, "Sometimes they are he to phone them and give he hospital." When asked if hything in writing, LPN #4 himstely 10:45 a.m., an exted with OSM (other staff fall worker. OSM #7 stated hat the his a copy of this notification ops M #7 stated that the hits notifications for s. OSM #7 stated that she hibudsman for every her.  m. ASM (administrative staff fainistrator, ASM #2, the d ASM #3, the quality he were made aware of the	Fé	623	NCY)		
	"INTERDISCIPLINAR" CHECKLISTS" did no	ritten notification to the RR					

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILOI		(X3) OATE SURVEY COMPLETEO		
		495217	B. WING			l	C 17/2018
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		124	REET AOORESS, CITY, STATE, ZIP COOE 475 LEE JACKSON MEMORIAL HIGHWAY IRFAX, VA 22033		1172010
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG	×	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION DATE
F 623	No further information  1. Hypoxia is defined oxygen in organs, tiss information was obtain https://www.ncbi.nlm  17626/  2. The facility staff fail notification to the resident was action or a transport of the transport of the failure, anemia, heart  The most recent MDS with an ARD of 5/3/18 having scored 12 out the resident was modification to the resident was modified that included but were failure, anemia, heart  The most recent MDS with an ARD of 5/3/18 having scored 12 out the resident was modified that included but were failure, anemia, heart  The most recent MDS with an ARD of 5/3/18 having scored 12 out the resident was modified that included but were failure, anemia, heart  The most recent MDS with an ARD of 5/3/18 having scored 12 out the resident was modified that included but were failure, anemia, heart  The most recent MDS with an ARD of 5/3/18 having scored 12 out the resident was code from staff for all activities atting which the resident was set up.  Review of the physician staff for all activities atting which the resident very lethargic, pressure), hypoxic demask) and tachycardiept (patient) transfer to 911."	as the reduction or lack of sues, or cells. This ned from: nih.gov/pmc/articles/PMC32  ed to provide written dent representative and asfer to the hospital on \$110.  dmitted to the facility on lon 4/20/18 with diagnoses a not limited to: chronic heart attack and high cholesterol.  a 14-day assessment, coded the resident as of 15 on the BIMS indicating erately impaired cognitively. The coded the resident as of 15 on the BIMS indicating erately impaired cognitively. The could perform after the ent could	F	523			
	evidence documentati representative (RR) or	on that the resident's r the ombudsman were					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	TPLE CONSTRUCTION		(X3) DATE	SURVEY PLETED
		495217	B. WING			l	C
NAME OF P	ROVIDER OR SUPPLIER	7502   1		STREET ADDRESS, CITY, STATE	, ZIP CODE	05/	17/2018
MANORCA	ARE HEALTH SERVICE	S-FAIR OAKS		12475 LEE JACKSON MEMOR FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI: TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CDRRECTION TE ACTION SHOULD B D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 623	notified in writing of the An interview was corform. When asked the proof the family when a reshospital, LPN #4 state here and we have to the number of the hofamily received anyth "No."  On 5/17/18 at approximaterview was conducted member) #7, the soot that when a resident she will create an or PCC (point click care ombudsman received only upon request. Combudsman only wa involuntary discharged does not notify the or facility-initiated transformation.  On 5/17/18 at 5:45 p member) #1, the addirector of nursing an assurance consultant findings.  No further information.	inducted on 5/17/18 at 9:33 seed practical nurse) #4. cess staff followed to notify sident is transferred to the ted, "Sometimes they are not hone them and give them espital." When asked if the ning in writing, LPN #4 stated,  klmately 10:45 a.m., an cted with OSM (other staff isial worker. OSM #7 stated is transferred to the hospital, houdsman notification form in e). OSM #7 stated that the so a copy of this notification DSM #7 stated that the ints notifications for es. OSM #7 stated that she mbudsman for every fer.  m. ASM (administrative staff ininistrator, ASM #2, the and ASM #3, the quality t were made aware of the  in was obtained prior to exit.  illed to provide written ident representative and insfer to the hospital on	F	523			

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		IOENTIFIC ATION NUMBER		(2) MULTIPLE CONSTRUCTION . BUILOING			(X3) OATE SURVEY COMPLETEO	
		495217	B. WING_					
NAME OF P	ROVIOER OR SUPPLIER	100217	]	STREET AOORESS, CITY, STATE, ZIP	COOE	1 05/	17/2018	
MANORCA	ARE HEALTH SERVICES	S-FAIR OAKS		12475 LEE JACKSON MEMORIAL FAIRFAX, VA 22033				
(X4) IO PREFIX TAG	(EACH OEFICIENC	TATEMENT OF OEFICIENCIES BY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN O ( (EACH CORRECTIVE AC CROSS-REFERENCEO TO OEFICIEN	CTION SHOULOB THE APPROPRIA	_	(X5) COMPLETION OATE	
F 623	Continued From page	e 42	F6	523				
	4/12/18 and readmitted that included but wer disease (1), diabetes anemia.  The most recent MDS end of therapy asses (assessment reference the resident as having the BIMS indicating to intact to make daily do coded as requiring as activities of daily living Review of the nurse's a.m., documented, "A writer was alert (sic) is unresponsive(Na assessed patient and to (name of hospital) further evaluation."  On 5/17/18 at approximate interview was conducted that when a resident she will create an om PCC (point click care ombudsman receives only upon request.	ce date) of 4/29/18 coded g scored a 14 out of 15 on he resident was cognitively decisions. The resident was satisfance from staff for all g.  s notes dated 5/6/18 at 10:20 at around 0945 (9:45 a.m.), by nursing aide that patient ame of physician) visited and gave order to send patient ER (emergency room) for cimately 10:45 a.m., an otted with OSM (other staff ial worker. OSM #7 stated is transferred to the hospital, abudsman notification form in the sa copy of this notification DSM #7 stated that the sa copy of this notification DSM #7 stated that the						
	ombudsman only war involuntary discharge does not notify the or facility-initiated transf Further review of the	nts notifications for es. OSM #7 stated that she nbudsman for every						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONS	(X3) DATE SURVEY COMPLETED		
		495217	B. WING_		······································	1	C (47/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADORESS, CITY, STATE, ZIP CODE	1 05/	17/2018
MANORC	ARE HEALTH SERVICES	-FAIR OAKS			EE JACKSON MEMORIAL HIGHWAY XX, VA 22033		
(X <b>4</b> ) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION OATE
F 623			F	523			
	representative (RR) o notified in writing of th	r the ombudsman were se transfer.					
	a.m. with LPN (license When asked the proof the family when a resi hospital, LPN #4 state here and we have to he the number of the hosfamily received anythis "No."  On 5/17/18 at 5:45 p.s member) #1, the admidirector of nursing and assurance consultant findings.	were made aware of the					
	1. Parkinson's disease (PD) is a type of move when nerve cells in the enough of a brain che Sometimes it is genet seem to run in families obtained from: https://medlineplus.go 4. The facility staff fai notification to the resp	mical called dopamine. ic, but most cases do not s. This information was					
	09/23/14 with a readm diagnoses that include cerebrovascular disea	dmitted to the facility on hission of 03/05/18 with ed but were not limited to use (1), anemia (2), disease (3) and muscle					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS	STRUCTION	(X3) DATE COMP	SURVEY
		495217	B. WING			1	C 1 <b>7/2</b> 01 <b>8</b>
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	S-FAIR OAKS	• "	12475 L	AX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
F 623	data set), a 5 (five)-d (assessment reference Resident # 113 as so interview for mental secondition for making 113 was coded as recof one staff member of one staff member of one staff member of one staff member of the nurse's "Progress documented in part," (Name of Physician) to send to (Mane of Edid call and talked with inform of what to explanguage/Romanian. understanding. Call of the Transportation Comparrival) is 30 minutes. Hospital ER (emerge to (Name of Hospital complete and resider. The "Social Services 03/11/2018 failed to enotification to the omit 113's transfer to the homology of the transportation of the omit 113's transfer to the homology of the party was notified of stated that if the resider representative, she were staffed to the control of the stated that if the resider representative, she were staffed of the stated that if the resider representative, she were staffed to the staffed of the s	st recent MDS (minimum ay assessment with an ARD ce date) of 03/12/18, coded oring a 5 (five) on the brief status (BIMS) of a score of 0 severely impaired of daily decisions. Resident # quiring extensive assistance for activities of daily living.  s Notes," for Resident # 113 '02/22/2018. Call placed to to inform and receive order dospital). Call placed to aughter) she is aware. She th her mother/resident to ect in her  Resident verbalized colaced to (Name of any) ETA (estimated time of any) ETA (estimated time of any). Paperwork is at is ready for transport."  Progress Note" dated evidence documentation of budsman of Resident # hospital on 02/22/18.  m., an interview was (licensed practical nurse) #4.  resident or responsible hospital transfers, LPN #4 lent were their own	F	523			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1'''		DISTRUCTION		SURVEY
		495217	B. WING		· · · · · · · · · · · · · · · · · · ·	1	С
NAME OF P	ROVIDER OR SUPPLIER	433211	B. WING	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	05/	/17/2018
MANORC	ARE HEALTH SERVICE	S-FAIR OAKS		1247	5 LEE JACKSON MEMORIAL HIGHWAY RFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TA <b>G</b>	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	that if the resident's present at the facility and verbally tell then stated that she would that the resident or made aware of the transport or transfer, I not. LPN #4 stated the ombudsman with the ombudsman with the ombudsman with the ombudsman with the ombudsman with the ombudsman with the ombudsman received only upon request. Combudsman only was involuntary dischargedoes not notify the offacility-initiated transport (administrative staff administrator and AS were made aware of the transport	representative were not an over the phone. LPN #4 document in a nursing note esident representative was ransfer. When asked if ten notification to the resident tative documenting the LPN #4 stated that they did not the nurses do not notify a a transfer to the hospital.  Eximately 10:45 a.m., an octed with OSM (other staff sial worker. OSM #7 stated is transferred to the hospital, abudsman notification form in the composition of	F	523			

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER;	I ' '	TIPLE CONSTRUCTION NG		(X3) OATE SURVEY COMPLETEO	
		495217	B. WING				17/2040
NAME OF P	ROVIOER OR SUPPLIER		<u> </u>	STREET AOORESS, CITY, STATE, ZIP COOL	<u></u> E	<u>  U5/</u>	17/2018
				12475 LEE JACKSON MEMORIAL HIGH			
MANORC	ARE HEALTH SERVICES	-FAIR OAKS		FAIRFAX, VA 22033			
(X <b>4</b> ) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	SHOULO BE		(X5) COMPLETION OATE
F 623	website: https://medlineplus.go  (2) Low iron. This info the website: https://www.nlm.nih.g  (3) A disease in which your arteries. Plaque up of fat, cholesterol, substances found in t hardens and narrows flow of oxygen-rich ble information was obtain https://medlineplus.go 5. The facility staff fail notification to the resion ombudsman for a tran 4/27/18 for Resident # Resident #69 was adr 7/8/17 and readmitted that included but were disease, multiple sclet disorder. Resident #6 (minimum data set) as assessment with an A date) of 4/12/18. Res being intact in cognitiv possible 15 on the BII Mental Status) exam.  Review of Resident #6 wer 4/27/18. The following "Resident alert and ve Observed resident at	ov/ency/article/000726.htm .  ormation was obtained from ov/medlineplus/anemia.html  in plaque builds up inside is a sticky substance made calcium, and other the blood. Over time, plaque your arteries. That limits the bood to your body. This med from the website: ov/atherosclerosis.html. ted to provide written dent representative and disfer to the hospital on f69.  mitted to the facility on I on 5/1/18 with diagnoses on to limited to Parkinson's rosis (1), and bipolar f9's most recent MDS disessment was a quarterly RD (assessment reference ident #69 was coded as we function scoring 15 out of MS (Brief Interview for	F 6	623			

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY PLETED
_		495217	B. WING_			1	C 17/2018
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET AODRESS, CITY, STATE, ZIP C 12475 LEE JACKSON MEMORIAL HI FAIRFAX, VA 22033		1 03/	1772016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD B HE APPROPRI		(X5) COMPLETION OATE
F 623	distress. Resident star whom she call an airr reoriented stated that meet anyone today at frequently called out a with no sign of acute (2) on UTI (urinary tra Signs) bp (blood pres rate) - 67, rr (respirate (saturation) 95 % RA (temperature) - 96.9 frefused to take the mbreakfast, staffs attenthe risk of not taking frensure offered, but not member notified, spol about changing status attempted many time drink and eat, resident some milk, daughter a monitor."  The next note dated 4 documented the follow staff) reported that resident refused IVF, resident to the hospita Resident, fluids offere with a lot of encourage.  The last note at 4/27/documented the follow transferred out to (Natevaluation due to Mer	with no signs of acute sted there was someone man coming to see her, she had no appointment to and no Mr. airman. Resident and talked to herself loudly distress. Last day on Ceftin set infection). VS (Vital sure) - 145/80, hr (heart tory rate) -17, 02 sate (sic) (room air), Temp (Fahrenheit). Resident forning medications and her medication and food, but been taken. Family set to (Name of daughter) so Daughter visited and to encourage resident to took medications with at bedsidewill continue to the sident with an order for IVF age in mental status, refused and decreased p.o. intake.  Order noted to send al. This writer visited and took only 1 sip even ement."  18 at 6:49 p.m., wing: "Resident was me of Hospital) for total Status change with medications and not eating	F	523			

STATEMENT OF OEFICIENCIES (X1 ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBED		ULTIPLE CONSTRUCTION LOING		
		495217	B. WNG_			C 05/17/2018	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICE	S-FAIR OAKS	STREET AODRESS, CITY, STATE, ZIP COOE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033			00.117.2010	
(X4) IO PREFIX TAG	(EACH OEFICIEN	TATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE AC CROSS-REFERENCEO TO	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)		
F 623	resident daughter (N this morning with resup by (Name of transigns): 133/65, 20 (n (temperature), and (experiment), and	lame of Daughter) was here sident. Resident was picked sport) at 6:45 p.m. VS (vital espirations), 63 (pulse), 97.3 D2 sat is 97 % RA (room air)."  #69's clinical record failed to personsible party) was her reason for transfer and received a copy of this  .m., an interview was (licensed practical nurse) #4. The resident or responsible hospital transfers, LPN #4	F	523			

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	<u> </u>		C 0 <b>5/17/2</b> 018	
	ROVIDER DR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS	<b>-</b>	STREET ADDRESS, CITY, STATE, ZIP CO 12475 LEE JACKSON MEMDRIAŁ HIG FAIRFAX, VA 22033			11,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	· ·	N SHOULD BI IE APPROPRIA		(X5) COMPLETION DATE
F 623	does not notify the on facility-initiated transfer On 5/17/18 at 6:05 p. staff member) #1, the the DON (Director of of the above concerns. The facility policy title of Patient Transfer/Di part, the following: "V 483.15 (3) (i) stated the discharging a patient, patient and the patient transfer of discharge move in writing in a launderstand. The facility notice to a represental State Long Term-Cardischarge is not involutionable utilized to doctransfer/discharge data reason for transfer. As administration should ombudsman office to wants to receive this in IDT (interdisciplinary to Ombudsman Discharge member responsible for ombudsman's office so completed notification notification is via fax,	nts notifications for es. OSM #7 stated that she inbudsman for every fer.  m., ASM (administrative e administrator and ASM #2, Nursing) were made aware s.  d, "Ombudsman Notification ischarge," documents in Nithin the final rule, section that prior to transferring or the facility must notify the and the reasons for the anguage and manner they ity must send a copy of the artive of the Office of the re Ombudsman. If the untary, the Ombudsman in PCC (point click care ument the te, transfer destination and is noted earlier, center have contacted their state determine how the office notification. Members of the team) can access the ge Notification. The staff for notifying the	F	623			

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		IDENTIFICATION AND MODEL		MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING_			1	C 1 <b>7/2</b> 01 <b>8</b>	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP 12475 LEE JACKSON MEMORIAL I FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B THE APPROPRIA		(X5) COMPLETION DATE	
F 623	(1) Multiple sclerosis disease that affects y damages the myelin surrounds and protect damage slows down between your brain as symptoms of MS. The from The National Inshittps://medlineplus.go.  (2) Ceftin is a cephalot treat bacterial infection obtained from The National Inshittps://www.ncbi.nlm. T0009522/?report=de.  6. The facility staff fail documentation that the representative and the in writing, when he was on 12/1/17 for Reside.  Resident #105 was as 8/14/15 with a recent with diagnoses that in to: end stage renal fail (a procedure to remove failure in which wasteremoved from the block), obesity, sleep apropressure, diabetes, dedisorder.  The most recent MDS assessment, an annual assessment reference resident as scoring a interview for mental st	(MS) is a nervous system our brain and spinal cord. It sheath, the material that its your nerve cells. This or blocks messages and your body, leading to the is information was obtained titutes of Health at ov/multiplesclerosis.html.  Desporin antibiotic used to ins. This information was attional Institutes of Health at inih.gov/pubmedhealth/PMH inih.gov/	F	523				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING	·			77/2040	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW FAIRFAX, VA 22033		<u> </u>	17/2018	
(X <b>4</b> ) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		(X5) COMPLETION OATE	
F 623	Resident #105 was coassistance for most of except eating in which supervision after set to the nurse's note date documented in part, "chest pain and hypote medication administrate treat high blood press (patient's) blood p	oded as requiring extensive of his activities of daily living in he only required up assistance was provided.  Resident had an episode of ension after 0500 (5:00 a.m.) ation. Metoprolol (used to sure) (2) was given for pts sure of 150/101, pulse 100. autes later resident pain and headache. Blood di was 93/46, P (pulse) 71. notified and ordered resident pain and headache. Blood di was 93/46, P (pulse) 71. notified and ordered resident pain and headache. (Name of hospital) ER via id not go to dialysis today."  record failed to evidence the resident and/or resident and/or resident are orioled written are resident of the transfer and the ombudsman was notified the ombudsman was notified the orioled with LPN (licensed in 5/17/18 at 9:33 a.m. When resident are given any in about the transfer, LPN #4 tot always at the bedside, so the them the number at the diff that is documented in N #4 stated, "Yes, we incal record but we don't give	F	523				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495217	B. WING_			1	C /17/2018
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET AODRESS, CITY, STATE, ZIP COI 12475 LEE JACKSON MEMORIAL HIGI FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IOENTIFYING INFORMATION)	IQ PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE DEFICIENCY)			IX5) COMPLETION DATE
F 623	member (OSM) # 7, t #13, a social worker, When asked if they not hospital discharges notify the ombudsman When asked if they he from the ombudsman #7 stated, "They only involuntary discharge their (the ombudsman be notified." When as ombudsman when a notified." When as ombudsman when a notified." When as ombudsman when a notified. "OSM #13 stated of the president or resident reanything in writing at #2 stated, "No, we co background, assessmand that with the resombudsman is notified out an action summan residents go. (Name of would fax it to the omdone anymore. I am notifying the ombudsman is notificated, "No, I can tell notifying the ombudsman is notificating the administrator, ASM #2 ASM #3, the quality a	the social worker and OSM on 5/17/18 at 10:53 a.m. of the onbudsman related of the control of th	F	623			

		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILOING			(X3) OATE SURVEY COMPLETEO		
		495217	B. WING			1	C /1 <b>7/2</b> 01 <b>8</b>	
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		12 <b>4</b> 75 LEE	OORESS, CITY, STATE, ZIP COOE E JACKSON MEMORIAL HIGHWAY C, VA 22033	1 00/	1112010	
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI TAG	<	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION OATE	
F 623			F	523		_		
	(1) Barron's Dictionar Non-Medical Reader, Chapman; page 266. (2) This information w following website: https://www.ncbi.nlm. T0011186/?report=de	nih.gov/pubmedhealth/PMH tails.						
	representative and the	ne resident and/or resident e ombudsman were notified, as transferred to the hospital						
	4/9/18 with a readmis diagnoses that includ sepsis (destruction of contamination, infecti (paralysis of the lower amputation, pressure (degenerative change). The most recent MDS assessment, a Medica with an assessment recoded the resident as (brief interview for me	ed but were not limited to: tissue by bacterial toxins, on) (1), paraplegia r limbs) (2), below the knee ulcer and osteoarthritis es in the joints) (3).  6 (minimum data set) are 14 day assessment, eference date of 5/6/18, scoring a 12 on the BIMS ntal status) score, indicating						
	daily decisions. The requiring extensive as staff members for all of	mpaired to make cognitive esident was coded as a sistance of one or more of her activities of daily living a she required supervision.						

1, .		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		
		495217	B. WING_			1	C 17/2018
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP COI 12475 LEE JACKSON MEMORIAL HIGI 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BI E APPROPRIA	_	(X5) COMPLETION DATE
F 623	after set up assistance.  The nurse's note date documented in part, "with son at the bedsic Per son and MD (medincreased confusion of Upon assessment the her gown repeatedly, not making much since fluids) continued per of to assess the pt New (initials of hospital) Efforther eval (evaluation mental status) and po aware of the plan of confidence of the plan of confidence of the plan of confidence of the resident of documentation the one that transfer.  An interview was confidence of asked if the family or asked if the family or written documentation stated, "No they are not we call them. We give hospital." When asked the clinical record, LP document it in the clin them anything in written.	the was provided.  Sed, 4/19/18 at 2:11 p.m.  Pet (patient) observed in bed de through the afternoon. dical doctor), the pt has going on since Sunday.  Se pt is observed taking off Speech is clear however be (sic). IVF's (intravenous borderMD in this afternoon of vorder received to send to R (emergency room) for son) d/t (due to) AMS (altered besible seizure. Son is seare. Report called into and the facility at 4:45.  Insfer" form, dated 4/19/18, cumentation of what was bor resident representative or inbudsman was notified of about the transfer, LPN #4 to always at the bedside, so the them the number at the diff that is documented in N #4 stated, "Yes, we dical record but we don't give ing."	F 6	23			
	member (OSM) #7, th	the social worker and OSM on 5/17/18 at 10:53 a.m.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495217	B. WING_			C 05/17/2018
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	ODE	1 03/1//2010
MANORCA	ARE HEALTH SERVICES	-FAIR OAKS	ĺ	12475 LEE JACKSON MEMORIAL HI	GHWAY	
		TAIN CANO		FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD 8 HE APPROPRI	
F 623	When asked if they no to hospital discharges	55 otify the ombudsman related , OSM #7 stated, "We only n on unplanned discharged."	F	623		
	When asked if they hat from the ombudsman #7 stated, "They only involuntary discharge their (the ombudsman be notified." When as	ad received instructions regarding discharges, OSM want to be notified of s." OSM #13 stated, "Per ) request they don't want to				
	An interview was conditional staff member (ASM) # on 5/17/18 at 4:16 p.m. resident or resident reanything in writing at the #2 stated, "No, we contackground, assessm send that with the residents go. (Name of would fax it to the omit done anymore. I am in notifying the ombudsment of the residents given written notification.)	ducted with administrative 2, the director of nursing, 1. When asked if the presentative is given the time of the transfer, ASM mplete the SBAR (situation, ent, recommendation) and dent." When asked if the d, ASM #2 stated, "We print y, it dictates where the of former social worker) budsman. It's not being not clear of the process of nan. I will have to check of the process. When or resident representative is on of the transfer, ASM #2				
	notifying the ombudsn The administrative sta administrator, ASM #2 ASM #3, the quality as made aware of the ab 5:52 p.m.	you the nurses are not nan."  ff member (ASM) #1, the street, the director of nursing and surance consultant, were ove concern on 5/17/18 at was provided prior to exit.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		495217	B. WING_			l	C 17/2018
	ROVIDER OR SUPPLIER	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CO 12475 LEE JACKSON MEMORIAL HIG FAIRFAX, VA 22033			
(X <b>4</b> ) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI LE APPROPRIA		(X5) COMPLETION OATE
F 623	Continued From pag	e 56	F€	623		-	
	Non-Medical Reader Chapman; page 527 (2) Barron's Dictional Non-Medical Reader Chapman; page 435 (3) Barron's Dictional Non-Medical Reader Chapman; page 422. Notice of Bed Hold PCFR(s): 483.15(d)(1) §483.15(d) (1) Notice of Section 15 (d) (1) Notice nursing facility transfithe resident goes on nursing facility must plan the resident or resides specifies— (i) The duration of the any, during which the return and resume refacility; (ii) The reserve bed plan, under § 447.40 (iii) The nursing facility bed-hold periods, who where the control of the plan that the reserve bed plan the reserve bed plan the reserve bed plan the reserve bed plan the reserve bed plan the reserve bed plan the reserve bed plan the reserve bed plan the reserve bed plan the reserve bed plan the reserve bed plan the reserve bed plan the reserve bed plan the reserve bed pl	ry of Medical Terms for the , 5th edition, Rothenberg and , ry of Medical Terms for the , 5th edition, Rothenberg and , olicy Before/Upon Trnsfr	Fé	The statement made correction are not an not constitute an agre alleged deficiencies h in compliance with all regulations, the cente take the actions set for plan of correction. The constitutes the center compliance such that ficiencies cited have to corrected by the date	admission ement with erein. To Federal a er has take orth in the ne followir 's allegati all allege open or w	n to and th the remair and Sta en or wi followin g POC on of d de- ill be	n te II ng
	of this section. §483.15(d)(2) Bed-ho the time of transfer of	pecified in paragraph (e)(1)  old notice upon transfer. At					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A, BUILDING

	CONTRACTION	IDENTIFICATION NOMBER.	A, BUILDING	·	COMPLETED
					С
		495217	B. WING		05/17/2018
NAME OF PF	ROVIDER DR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MANORCA	ARE HEALTH SERVICES	FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHWAY	
		TAIR VARO		FAIRFAX, VA 22033	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIC
F 625	Continued From page	57	F 62	5	
	facility must provide to				
	resident representative			ta table of the second	
	specifies the duration			It is the practice of the facilit	y to pro-
		h (d)(1) of this section.		vide bed hold notification.	
		is not met as evidenced			
	-	ew, facility document review			
		iew, it was determined that			
	the facility staff failed t				
İ	•	48 residents in the survey			
	_	3, 110, 85, 113, 69, 44, 105			
				1. Resident #433, #110, #85,	#113, #69,
	1. The facility staff faile	ed to provide behold		#44, #105, and #97 no longer	reside in
	notification to the resid	dent representative for a		the facility.	
		on 4/27/18 for Resident		2. Residents who are transfe	erred
	#433.			have the potential to be affected	
1				3. Licensed Nurses, Admission	
	2. The facility staff faile			Admission Director Co-ordinat	- 1
		dent representative for a		Business Office Manager will I	
	-	on 4/12/18 for Resident		educated on the facility bed he	I
	#110.			4. Administrator and/or design	
	A 70 - 7- 00 - 1 87 9			plete five (5) random audits of	
		ed to provide bed hold		who have transferred to the ho	
		dent representative for a		ensure that they were provide	
	#85.	on 5/6/18 for Resident		written notifications of bed hole	
	#0J.			These audits will be done wee	
	4. The facility staff faile	ed to provide Resident #		(4) and then monthly x two (2)	
ļ		ritten notification of the bed		The results of these audits will	
		esident was discharged to		to the Quality Assurance and	
	the hospital on 02/22/			Committee for review and acti priate. The committee will det	on as appro-
	5. The facility staff faile	ed to provide written		for further audits and/or action	
	documentation of bed				
	Resident/Responsible			5. Date of compliance is June	ະ ເອ, ∠ບ ເວ.
		Resident #69 on 3/28/18			

PRINTED: 05/30/2018

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO	
		495217	B. WING			С
		4552 1	D. WING -		<del></del>	05/17/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET AOORESS, CITY		
MANORCA	ARE HEALTH SERVICES	-FAIR OAKS		12475 LEE JACKSON I	MEMORIAL HIGHWAY	
				FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG			_ ,
F 625	Continued From page	e 58	Fé	525		
	transfer to hospital for 7. The facility staff fail bed hold, to the reside representative upon F the hospital on 12/1/18. The facility staff fail bed hold, to the reside	I hold to the Representative upon Resident #44 on 2/1/18.  Ided to provide a notice of ent or resident Resident #105's transfer to 7.  Ided to provide a notice of ent or resident Resident #97's transfer to				
		dmitted to the facility on I on 5/3/18 with diagnoses				
		e not limited to: respiratory				
	day assessment, with reference date) of 5/1 having scored a 14 or interview for mental st	(minimum data set), a five an ARD (assessment 0/18 coded the resident as at of 15 on the BIMS (brief tatus indicating the resident to make daily decisions.				
	p.m. documented, "Re responsive. v/s (vital stherapy was 115/59 (btherapy was 115/59). The responsible of the respons	note dated 4/27/18 at 12:50 esident alert and signs) this morning before blood pressure) 75 (pulse) (temperature) oxygen rmal 90 - 100) on Oxygen te) via nasal cannula (soft ose to deliver oxygen), md notified RP (responsible				

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) OATE SURVEY COMPLETEO	
		495217	B. WING			C 05/17/2018	
	ROVIOER OR SUPPLIER ARE HEALTH SERVICI	ES-FAIR OAKS	STREET AOORESS, CITY, STATE, ZIP COOE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			3,11,20	
(X4) IO PREFIX TAG	(EACH OEFICIEN	STATEMENT OF OEFICIENCIES NCY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCEO TO T OEFICIENC	TION SHOULO BE THE APPROPRIAT		
F 625	doctor) assessed piresident out to ER (diagnosis of hypoxil resident out to ER (diagnosis of hypoxil representative (RR).  An interview was coa.m. with LPN (licer When asked about notify the family whithe hospital, LPN #not here and we hathem the number of the resident's reprehold notice, LPN #4 time of transfer the family, if they are how when asked if this stated, "If you give give one you don't come you don't come for the family assurance consultating findings.  Review of the facility "INTERDISCIPLINA CHECKLISTS" did regarding providing	and made aware. MD (medical attent and ordered to transfer emergency room) for a (1)."  e clinical record did not attion that the resident's was given a bed hold notice.  Inducted on 5/17/18 at 9:33 ased practical nurse) #4. The process staff follows to the naresident is transferred to 4 stated, "Sometimes they are we to hone them and give the hospital." When asked if sentative was given a bed stated, "If family at bedside at nurse has to give it to the the one we call and tell them."  Was documented, LPN #4 one you document if you don't document it."  p.m. ASM (administrative staff fiministrator, ASM #2, the and ASM #3, the quality nt were made aware of the	F6	225			
		d as the reduction or lack of ssues, or cells. This					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY
		495217	B. WNG			1	С
NAME OF P	ROVIDER OR SUPPLIER	439411	B. WING		OTDET ADDRESS CITY STATE ZID CODE	05/	17/2018
NAME OF F	KOVIDER OR SUFFLIER	•	!		STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORCA	ARE HEALTH SERVICE	S-FAIR OAKS	ļ		12475 LEE JACKSON MEMORIAL HIGHWAY		
	0.000			<u> </u>	FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT DF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ΊX	PROVIDER'S PLAN DF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
F 625	Continued From pag	ge 60	F	625	5		_
	information was obta	=		•			
	notification to the res	ailed to provide bed hold sident representative for a ital on 4/12/18 for Resident					
	Resident #110 was admitted to the facility on 4/4/18 and readmitted on 4/20/18 with diagnoses that included but were not limited to: chronic heart failure, anemia, heart attack and high cholesterol.  The most recent MDS, a 14-day assessment, with an ARD of 5/3/18 coded the resident as having scored 12 out of 15 on the BIMS indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was set up.						
	11:52 p.m., documer patient very lethargic pressure), hypoxic d mask) and tachycard	cian's notes dated 4/12/18 at nted, "Notified by nursing that c, very high BP (blood despite NRM (non-rebreather dic (fast heart rate). Ordered to ER (emergency room) via					
	evidence documenta	e clinical record did not ation that the resident's was given a bed hold notice.					
	a.m. with LPN (licens	nducted on 5/17/18 at 9:33 sed practical nurse) #4. the process staff follows to					

PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CON	STRUCTION	(X3) DATE SURVEY COMPLETED	
		495217	B. WING_			1	C 17/2018
	ROVIDER OR SUPPLIER Are Health Service	S-FAIR OAKS	1.	12475	T ADDRESS, CITY, STATE, ZIP CODE LEE JACKSON MEMORIAL HIGHWAY (AX, VA 22033	1 007	1172010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(	PROVIDER'S PLAN DF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION OATE
F 625	notify the family whe the hospital, LPN #2 not here and we have them the number of the resident's represended notice, LPN #4 time of transfer the resident's represended notice, LPN #4 time of transfer the resident's represended notice, LPN #4 time of transfer the resident's family, if they are how they	en a resident is transferred to a stated, "Sometimes they are we to hone them and give the hospital." When asked if sentative was given a bed stated, "If family at bedside at nurse has to give it to the ame we call and tell them." was documented, LPN #4 one you document if you don't ocument it."  o.m. ASM (administrative staff ministrator, ASM #2, the nd ASM #3, the quality at were made aware of the	F	625			

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

Event ID: 0J2611

Facility ID: VA0153

If continuation sheet Page 62 of 222

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JUN 2 2 2018
VDH/OLC

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) OATE SURVEY COMPLETEO	
		495217	B. WING_			C 0 <b>5/17/2018</b>
	ROVIOER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS	•	STREET AOORESS, CITY, STATE, ZI 12475 LEE JACKSON MEMORIAL FAIRFAX, VA 22033		
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI: TAG		ACTION SHOULO BE TO THE APPROPRIAT	
F 625	the resident as having the BIMS indicating the IMS indicating the intact to make daily dodded as requiring as activities of daily living.  Review of the nurse's a.m., documented, "A writer was alert (sic) his unresponsive(Na assessed patient and to (name of hospital) further evaluation."  Further review of the evidence documentate representative (RR) was a.m. with LPN (licens When asked the proof the family when a reshospital, LPN #4 states hore and we have to the number of the horesident's representation of transfer the nurse how asked if this was door you give one you door you don't document it.  On 5/17/18 at 5:45 p. member) #1, the admidirector of nursing an	ce date) of 4/29/18 coded g scored a 14 out of 15 on the resident was cognitively ecisions. The resident was esistance from staff for all g.  In notes dated 5/6/18 at 10:20 at around 0945 (9:45 a.m.), by nursing aide that patient ame of physician) visited and gave order to send patient ER (emergency room) for clinical record did not tion that the resident's was given a bed hold notice.  Inducted on 5/17/18 at 9:33 and practical nurse) #4.  It is staff followed to notify ident is transferred to the ed, "Sometimes they are not spital." When asked if the tive was given a bed hold it, "If family at bedside at time thas to give it to the family, if and tell them." When umented, LPN #4 stated, "If the time tif you don't give one	F	525		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE		
		495217	B. WING				C <b>17/2</b> 0 <b>1</b> 8
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
	. D.C.			ĺ	12475 LEE JACKSON MEMORIAL HIGHWAY		
MANORCA	ARE HEALTH SERVICES	-FAIR OAKS		FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION OATE
F 625	Continued From page	÷ 63	F	625	5	3 3 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	
	No further information	n was obtained prior to exit.					:
	(PD) is a type of mow when nerve cells in the enough of a brain che Sometimes it is genet seem to run in familie obtained from: https://medlineplus.gc 4. The facility staff fail 113's representative whold policy when the rethe hospital on 02/22/Resident # 113 was a 09/23/14 with a readmediagnoses that include cerebrovascular disease.	emical called dopamine. tic, but most cases do not s. This information was  ov/parkinsonsdisease.html led to provide Resident # written notification of the bed resident was discharged to 1/18.  Idmitted to the facility on nission of 03/05/18 with led but were not limited to					
	data set), a 5 (five)-da (assessment reference Resident # 113 as sec interview for mental st - 15, 5 (five) - being se cognition for making of 113 was coded as req of one staff member for The nurse's "Progress documented in part," (Name of Physician) to to send to (Mane of H	t recent MDS (minimum ay assessment with an ARD be date) of 03/12/18, coded oring a 5 (five) on the brief tatus (BIMS) of a score of 0 everely impaired of daily decisions. Resident # juiring extensive assistance or activities of daily living.  S Notes," for Resident # 113 02/22/2018. Call placed to o inform and receive order ospital). Call placed to aughter) she is aware. She					

PRINTED: 05/30/2018

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/30/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE	SURVEY PLETEO	
		495217	B. WING				C /1 <b>7/2</b> 01 <b>8</b>
NAME OF P	ROVIDER OR SUPPLIER			П	STREET ADORESS, CITY, STATE, ZIP CODE	, 00.	1172010
				l	12475 LEE JACKSON MEMORIAL HIGHWAY		
MANORC	ARE HEALTH SERVICES	-FAIR OAKS		1	FAIRFAX, VA 22033		
/V 4) ID	SUMMADY ST	ATEMENT OF OEFICIENCIES					
(X4) ID PREFIX TAG	(EACH OEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page	÷ 64	F	625	5		
	inform of what to expe						
	language/Romanian. Resident verbalized						
	understanding. Call p						
		any) ETA (estimated time of					
		Call placed to (Name of					
		ncy room) and report given					i
	to (Name of Hospital i	Nurse). Paperwork is					
	complete and residen	t is ready for transport."					
	The "Social Services						
	03/11/2018 failed to e						
	notification to the omb						
	113's transfer to the h						
	Further review of Res	ident #113's clinical record					
		cility staff provided written					
		the bed hold policy to					:
	Resident # 113"s repr						
	On 5/17/18 at 9:33 a.i	•					
		4. When asked if nurses					
		hold policy to the resident					
		t the time of transfer to the					
		ed that if the representative					
	•	ses would call the family					
		bed hold. LPN #4 stated					
		should be following up after at the family wants to hold					
		ed that if the family were					
		provide the bed hold policy					
		#4 stated they will document					
		policy was offered to the					
		if there is no documentation					
	•	y was provided, then the					
İ	•	ot provided to the resident					
		N #4 stated some long term					
		go back to the same bed					
		re not offered a bed hold					
	policy for that reason.	LPN #4 stated that some					

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

Eveni IO: OJ2611

Facility ID: VA0153

If continuation sheet Page 65 of 222

FORM APPROVED

RECEIVED JUN 22 2018 VDH/OLC

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495217	B. WING _		İ		C 17/ <b>2018</b>
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CO 12475 LEE JACKSON MEMORIAL HIG 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 C ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI E APPROPRIA		(X5) COMPLETION OATE
F 625	at the time of transfer On 5/17/18 at approxinterview was conduct member) #7, the social that she was told that to offer the bed hold p OSM #7 stated, "Whe hospital, I do not provissue it." On 05/17/18 at approxidadministrative staff m administrator and ASM were made aware of t No further information References:	mately 10:45 a.m., an ted with OSM (other staff al worker. OSM #7 stated the nurses were supposed solicy at the time of transfer. In a resident goes out to the ide a bed hold policy. I don't eximately 5:50 p.m. ASM nember) # 1, the	F6	525	,		
	brain stops. A stroke i attack." If blood flow few seconds, the brain oxygen. Brain cells ca damage. This informat website: https://medlineplus.go.  (2) Low iron. This information the website: https://www.nlm.nih.go.  (3) A disease in which your arteries. Plaque if up of fat, cholesterol, substances found in the second in	s sometimes called a "brain is cut off for longer than a in cannot get nutrients and in die, causing lasting tion was obtained from the v/ency/article/000726.htm.  Trimation was obtained from by/medlineplus/anemia.html  plaque builds up inside is a sticky substance made					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IQENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SUF COMPLET	
							C ,
		495217	B. WING			05/	/ <b>17/201</b> 8
NAME OF P	ROVIDER OR SUPPLIER				STREET AODRESS, CITY, STATE, ZIP CODE		
MANORO	ARE HEALTH SERVI	CES-FAIR OAKS		1	12475 LEE JACKSON MEMORIAL HIGHWAY		
III)-(III)-(III)	AILE HEAL HOLKIN			1	FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDEO BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION OATE
F 625	Continued From p	age 66	F	625			
	flow of oxygen-rich	n blood to your body. This					
	information was ol	otained from the website:					
	https://medlineplus	s.gov/atherosclerosis.html.					
		failed to provide written					
	documentation of						
		ible Representative upon					
	transfer to nospital and 4/27/18.	I for Resident #69 on 3/28/18					
	anu 4/2//10.						
	Resident #69 was	admitted to the facility on					
		tted on 5/1/18 with diagnoses					
		vere not limited to Parkinson's					
	·	clerosis (1), and bipolar					
		t #69's most recent MDS					
		t) assessment was a quarterly					
		in ARD (assessment reference					
	-	Resident #69 was coded as nitive function scoring 15 out of					
		BIMS (Brief Interview for					
	Mental Status) exa						
		at #69's clinical record revealed					
		first transferred to the hospital					
		bllowing was documented, "At e shift PT (patient) refused AM					
		o eat breakfast. We encourage					
		ally drank 1 cartoon of milk and					
		offee. At noon pt's lips are dry					
		NP (nurse practitioner) ordered					
		fluids), D5 (Dextrose) NS					
		75 cc/hr (cubic centime/hour)					
		c/hr for 2 liters for decreased					
		ke. Her daughter came at 1:39					
		ondition. Daughter initially					
		ent to the hospital but changed					
i		she will stay with the patient for					
	•	observe her and will decide daughter request to transfer					
	inen, at 3,00 b.m.	uaugnter request to transfer					; I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TPLE COI	(X3) DATE SURVEY COMPLETED		
		495217	B. WING			l	C 17/2018
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		\$TREI	ET ADDRESS, CITY, STATE, ZIP CODE	00/	17/2016
MANORO	ARE HEALTH SERVICES	EAID OAKS		12475	LEE JACKSON MEMORIAL HIGHWAY		
MANURU	ARE HEALIH SERVICES	-FAIR OARS		FAIR	FAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		IX5I COMPLETION DATE
F 625	Continued From page	67	F	525			
	the pt (patient) to the	hospital"					
	Resident #69 returned with diagnoses of MS encephalopathy (2).	d to the facility on 4/5/18 changes and					
	revealed that Resider hospital for the secon following note was do and verbally responsibeginning of the shift observed resident reswith no signs of acute there was someone with the was someone was someone with the was someone was someone with the was someone was someone was someone was someone was someone was someone was someone was someone was someone was someone was someone was someone was someone was someone was someone was someone was someon	d time on 4/27/18. The cumented: "Resident alert ve. Observed resident at the kept calling "help me," ted in bed, head elevated distress. Resident stated whom she call an airman oriented stated that she had bet anyone today and no Mr. quently called out and talked no sign of acute distress. on UTI (urinary tract signs) bp (blood pressure) - 67, rr (respiratory rate) curation) 95 % RA (room air), 96.9 F (Fahrenheit). Sake the morning medications of attempted x 3 and of not taking her medication red, but not been taken. End, spoke to (Name of ging status. Daughter many time to encourage eat, resident took emilk, daughter at					
	staff) reported that res						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
		495217	B. WING _			1	C /1 <b>7/2018</b>
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP O 12475 LEE JACKSON MEMDRIAL H FAIRFAX, VA 22033			10.2010
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD B THE APPROPRI		(X5) COMPLETION DATE
F 625	+ + // / / / / / / / / / / / / / / / /	e 68 and decreased p.o. intake.	F6	25			
	resident to the hospit	ed but took only 1 sip even					
	resident refusing her her food, (Name of p resident daughter (Nath this morning with resident by (Name of transings): 133/65, 20 (re(temperature), and 02).  There was no evident of a bed hold policy to	wing: "Resident was					
	on 5/17/18 at 9:33 a conducted with LPN # provided a written bed or responsible party a hospital, LPN #4 state were not present, nur and ask them about a that the social worker the nurse confirms that the bed. LPN #4 state present, nurses would	back to the facility on 5/1/18 UTI (urinary tract infection).					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			CONSTRUCTION	(X3) OATE	SURVEY LETEO
		495217	B. WING				C
NAME OF P	ROVIOER OR SUPPLIER	444211		ST	REET AOORESS, CITY, STATE, ZIP COOE	05/	17/2018
MANORC	ARE HEALTH SERVICE	S-FAIR OAKS			475 LEE JACKSON MEMORIAL HIGHWAY NRFAX, VA 22033		
(X4) IO PREFIX TAG	(EACH OEFICIEN	STATEMENT OF OEFICIENCIES CY MUST BE PRECEDEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFI TAG	x	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION DATE
F 625	family. LPN #4 state that the bed hold po policy probably was or representative. Let term care residents bed after a transfer, hold policy for that resome long care reside policy at the time of On 5/17/18 at approinterview was condumember) #7, the soot that she was told that to offer the bed hold OSM #7 stated, "Whospital, I do not proissue it."  On 5/17/18 at 6:05 p staff member) #1, the DON (Director of the above concerns (1) Multiple sclerosis disease that affects adamages the myelin surrounds and prote damage slows down between your brain a symptoms of MS. The from The National In https://medlineplus.g	the policy was offered to the dif there is no documentation licy was provided, then the not provided to the resident PN #4 stated that some long always go back to the same and are not offered a bed eason. LPN #4 stated that dents are offered a bed hold transfer.  Eximately 10:45 a.m., an acted with OSM (other staff cial worker. OSM #7 stated at the nurses were supposed policy at the time of transfer. It is a resident goes out to the exide a bed hold policy. I don't policy. I don't the eadministrator and ASM #2, if Nursing) were made aware ins.  In (MS) is a nervous system and syour brain and spinal cord. It sheath, the material that cits your nerve cells. This is or blocks messages and your body, leading to the his information was obtained stitutes of Health at gov/multiples clerosis.html.	F	625			
	structure. Encephalo	pathy may be caused by steria, virus, or prion),					

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Even! IO: 0J2611

Facility IO: VAD153

If continuation sheet Page 70 pf 222

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	OF DEFICIENCIES FCORRECTION	(X1) PROVIQER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
						,	c
		495217	B. WING		·····	05/	17/2018
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	S-FAIR OAKS		12	TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEOEO BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIA DEFICIENCY)		(X5† COMPLETION DATE
F 625	tumor or increased p prolonged exposure solvents, drugs, radia chemicals, and certa progressive trauma, j oxygen or blood flow encephalopathy is ar information was obta Institutes of Health at https://www.ninds.nir/Encephalopathy-Info (3) Ceftin is a cephal treat bacterial infectio obtained from The Na https://www.ncbi.nlm. T0009522/?report=def  6. The facility staff fai documentation of bed Resident/Responsible transfer to hospital fo  Resident #44 was ad 4/26/10 and readmitte diagnoses that include	ondrial dysfunction, brain bressure in the skull, to toxic elements (including ation, paints, industrial ain metals), chronic poor nutrition, or lack of to the brain. The hallmark of a latered mental state. This sined from The National at the new poor national state in a latered mental state. This sined from The National at the new poor national poor national institutes of Health at national Institutes of Health at national Institutes of Health at national section in a latered mental section in a late	F	625			
	major depressive distrecent MDS (minimur an annual assessment reference date) of 3/3 coded as severely im scoring 05 out of 15 of Mental Status) ex	order. Resident #44's most m data set) assessment was int with an ARD (assessment 31/18. Resident #44 was apaired in cognitive function on the BIMS (Brief Interview tam.					
	Review of Resident #	#44's clinical record revealed					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495217	B. WNG _			l	C 17/2018
_	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP COD 12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033		1 00/	17/2016
(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 CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 625	that she had been tra 2/1/18. The following p.m., on 2/1/18: "Resitime, son visiting with nursing station to reproduce the same station to him that statink she is having Flowant the Mom to go the encourage to let the Momerous are of that but he same same station and the same station and the same station are stationally stationary. The stationary is called and they would be same stationary to the same stationary in the same stationary is called and they would be same stationary. The next note dated 2 following: "Resident work (Name of Hospital) for coughing and weakness went with her to the him the same stationary to the same stationary to the same stationary to the same stationary that she was with a diagnoses of the same stationary that she had received season on 10/20/17.  On 5/17/18 at 9:33 a.r.	nsferred to the hospital on note was written at 8:15 ident alert and in bed at this her came (sic) to the ort that her (sic) Mom she was getting sick and u like symptoms and he or the Hospital (sic), he was MD (medical doctor) take id no (Name of Doctor) (sic) id if that is what the family go to the Hospital (sic) VS bod pressure), 18 se), 99.8 (temperature) and in is 95 percent RA (room have Tylenol (1). Transport III (sic) be here in an hour."  12/2/18, documented the vas picked up at 8:15 p.m. to revaluation for complains of ess. The son was here and ospital."  12/2/18 commented the vas picked up at 8:15 p.m. to revaluation for complains of ess. The son was here and ospital."  13/2/18 commented the vas picked up at 8:15 p.m. to revaluation for complains of ess. The son was here and ospital."  13/2/18 commented the vas here and ospital. The Resident/Responsible transfer to the hospital end in the Resident #44 was acility on 2/7/18. Review of nizations record revealed the flu vaccine for that flu	F	525			

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Event ID: 0J2611

Facility ID: VA0153

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION MUNICIPE		TIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		495217	B. WING _			C 05/ <b>1</b>	) 17/2018
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, Z 12475 LEE JACKSON MEMORIAI FAIRFAX, VA 22033		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TA <b>G</b>		ACTION SHOULD BE TO THE APPROPRIATE	Ē	(X5) COMPLETION OATE
F 625	provided a written be or responsible party hospital, LPN #4 star were not present, nu and ask them about that the social worke the nurse confirms the bed. LPN #4 star present, nurses wou at the bedside. LPN document in a nursir offered to the family. documentation that the provided, then the provided to the resid #4 stated that some always go back to the and are not offered a reason. LPN #4 state residents are offered of transfer.  On 5/17/18 at approximaterview was condumember) #7, the social that the was told that to offer the bed hold OSM #7 stated, "Whith hospital, I do not provise it."  On 5/17/18 at 6:05 p staff member) #1, the the DON (Director of of the above concern.	at the time of transfer to the at the time of transfer to the atted that if the representative urses would call the family a bed hold. LPN #4 stated or should be following up after that the family wants to hold atted that if the family were all provide the bed hold policy if #4 stated they would any note if the policy were. LPN #4 stated if there is no the bed hold policy was not dent or representative. LPN long term care residents are same bed after a transfer, as bed hold policy for that ed that some long care if a bed hold policy at the time with OSM (other staff call worker. OSM #7 stated at the nurses were supposed policy at the time of transfer. Item a resident goes out to the evide a bed hold policy. I don't out., ASM (administrative e administrator and ASM #2, if Nursing) were made aware as.	F	625			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED			
		495217	B. WING			1	C
	ROVIDER OR SUPPLIER			S 1	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	U5/	17/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 625	the hospital on 12/1/1 Resident #105 was as 8/14/15 with a recent with diagnoses that in to: end stage renal fai (a procedure to remove failure in which waste removed from the blod (1), obesity, sleep apropressure, diabetes, dedisorder.  The most recent MDS assessment, an annual assessment reference resident as scoring a interview for mental st was capable of makin Resident #105 was consistence for most of except eating in which supervision after set under the documented in part, "I chest pain and hypotemedication administrate thigh blood press (patient's) blood press (patient's) blood press (patient's) dood press (patient's) dood press (patient's) and making (mand send pt (patient) to Resident was sent to serve and send pt (patient) to Resident was sent to serve and send pt (patient) to Resident was sent to serve and send pt (patient) to Resident was sent to serve and send pt (patient) to Resident was sent to serve and send pt (patient) to Resident was sent to serve and send pt (patient) to Resident was sent to serve and send pt (patient) to Resident was sent to serve and send pt (patient) to Resident was sent to serve and send pt (patient) to Resident was sent to serve and send pt (patient) to Resident was sent to serve and send pt (patient) to Resident was sent to serve and send pt (patient) to Resident was sent to serve and send pt (patient) to Resident was sent to serve and send pt (patient) to Resident was sent to serve and send pt (patient) to Resident was sent to serve and send pt (patient) to Resident was sent to send pt (patient) to Resident was sent to send pt (patient) to Resident was sent to send pt (patient) to Resident was sent to send pt (patient) to Resident was sent to send pt (patient) to Resident was sent to send pt (patient) to Resident was sent to send pt (patient) to Resident was sent to send pt (patient) to Resident was sent to send pt (patient) to Resident was sent to send pt (patient) to Resident was sent to send pt (patient) to Resident was sent to send pt (patient) to Resident was se	dmitted to the facility on readmission on 12/9/17, noluded but were not limited illure requiring hemodialysis ved toxic condition and renales and impurities are lood by a special machine) nea, stroke, high blood epression and seizure  6 (minimum data set) lal assessment, with an le date of 5/4/18, coded the 15 on the BIMS (brief tatus score) indicating he land daily cognitive decisions. In odd as requiring extensive of his activities of daily living the only required lap assistance was provided.  18 (12/1/17 at 9:14 a.m.) 19 (12/1/17 at 9:14 a.m.) 19 (15 (16 (16 (16 (16 (16 (16 (16 (16 (16 (16	F	625			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) OATE SURVEY COMPLETED		
		495217	B. WING			1	C
NAME OF P	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE	1 05/	17/2018
MANORO	* DE 115 * 1 TH 05 D 40 5	Talp care		1247	75 LEE JACKSON MEMORIAL HIGHWAY		
MANURU	ARE HEALTH SERVICES	S-PAIR UAKS		FAII	RFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH OEFICIENC	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)		tX5j COMPLETJON OATE
F 625	Continued From pag	e 74	F	325			
	of a bed hold policy to Representative upon 12/1/17.  An interview was compractical nurse) #4, of asked if the nurses good bed hold notice, LPN the family over the phold policy if they are asked if they docume a bed hold, LPN #4 so patient - the long term get offered a bed hold papers with the bed if a bed hold policy is document this in the stated, "If you give the document. If you did document it in the protection of the propersion of the protection of the	ce of written documentation of the Resident/Responsible transfer to the hospital on ducted with LPN (licensed in 5/17/18 at 9:33 a.m. When live the resident's family a #4 stated, "The nurses tell mone but given them the bed in at the bedside." When ent if you offered the resident tated, "If it's a long term in care residents don't always in d. Sometimes they take the mold with them." When asked provided/offered, did staff clinical record, LPN #4 is bed hold policy, then you in't give it to them, you don't ogress notes."					
	made aware of the ai 5:52 p.m. No further information (1) Barron's Dictionar	nssurance consultant, were cove concern on 5/17/18 at a was provided prior to exit.					
	Chapman; page 266. (2) This information w following website:	nih.gov/pubmedhealth/PMH					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495217	B. WING			l	C 47/0040
	ROVIDER DR SUPPLIER	<u>.                                  </u>		124	REET ADDRESS, CITY, STATE, ZIP CDDE 475 LEE JACKSON MEMORIAL HIGHWAY NRFAX, VA 22033	<u>  US/</u>	17/2018_
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PRDVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 625	bed hold, to the resid representative upon I the hospital on 4/19/1 Resident #97 was add 4/9/18 with a readmis diagnoses that includ sepsis (destruction of contamination, infecti (paralysis of the lowe amputation, pressure (degenerative change). The most recent MDS assessment, a Medic with an assessment of coded the resident as (brief interview for meshe was moderately in daily decisions. The prequiring extensive as staff members for all except eating in which after set up assistance. The nurse's note date documented in part, with son at the bedsic Per son and MD (medincreased confusion of Upon assessment the her gown repeatedly, not making much since fluids) continued per contamination of the power of the period of the	led to provide a notice of ent or resident Resident #97's transfer to 8.  mitted to the facility on sion on 4/24/18 with ed but were not limited to: tissue by bacterial toxins, on) (1), paraplegia r limbs) (2), below the knee ulcer and osteparthritis in the joints) (3).  6 (minimum data set) are 14 day assessment, eference date of 5/6/18, scoring a 12 on the BIMS ental status) score, indicating impaired to make cognitive esident was coded as sesistance of one or more of her activities of daily living in she required supervision	F	325			

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

EvenI ID: OJ2611

Facility ID: VA0153

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	C	(X3) OATE SURVEY COMPLETEO	
		495217	B. WING_			C 0 <b>5/17/2</b> 01 <b>8</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP CO	!_ OE	03/11/2015	
MANORO	. DE 11541 TH 0551050			12475 LEE JACKSON MEMORIAL HIG	HWAY		
MANORC	ARE HEALTH SERVICES	FAIR UAKS		FAIRFAX, VA 22033			
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH OEFICIENCY)	N SHOULO BE E APPROPRIATI	(X5) COMPLETION DATE	
F 625	Continued From page	∍ 76	F 6	525			
		care. Report called into  2). Pt left the facility at 4:45					
	failed to evidence do	nsfer" form, dated, 4/19/18, cumentation of the bed hold upon transfer to the hospital		,			
	practical nurse) #4, o asked if the nurses gibed hold notice, LPN the family over the phold policy if they are asked if they docume a bed hold, LPN #4 s patient - the long tern get offered a bed hold papers with the bed hif a bed hold policy is document this in the stated, "If you give the	ducted with LPN (licensed in 5/17/18 at 9:33 a.m. When we the resident's family a #4 stated, "The nurses tell none but given them the bed at the bedside." When in tif you offered the resident stated, "If it's a long term in care residents don't always d. Sometimes they take the hold with them." When asked provided/offered, did staff clinical record, LPN #4 is bed hold policy, then you it't give it to them, you don't ogress notes."					
	administrator, ASM # ASM #3, the quality a	aff member (ASM) #1, the 2, the director of nursing and assurance consultant, were pove concern on 5/17/18 at					
	(1) Barron's Dictionar Non-Medical Reader, Chapman; page 527. (2) Barron's Dictionar	n was provided prior to exit.  y of Medical Terms for the 5th edition, Rothenberg and y of Medical Terms for the 5th edition, Rothenberg and					

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	OF DEFICIENCIES F CORRECTION	(Xt) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
						(	0	
		495217	B. WING			05/	17/2018	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
MANORO	ARE HEALTH SERVICES	-FAIR OAKS		1	2475 LEE JACKSON MEMORIAL HIGHWAY			
	1			[ F/	AIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 625	Continued From page	77	F	625				
	Chapman; page 435.							
		y of Medical Terms for the						
		5th edition, Rothenberg and						
	Chapman, page 422.							
	PASARR Screening for		F	645				
SS=E	CFR(s): 483.20(k)(1)-	(3)			The statement made on this plar			
	§483.20(k) Preadmiss	cion Screening for			correction are not an admission		do	
		ntal disorder and individuals			not constitute an agreement with			
	with intellectual disabi				alleged deficiencies herein. To			
		•			in compliance with all Federal ar			
		ng facility must not admit, on			regulations, the center has taker take the actions set forth in the f			
		89, any new residents with:			plan of correction. The following	•	9	
		defined in paragraph (k)(3) ss the State mental health			constitutes the center's allegatio			
	authority has determine				compliance such that all alleged			
		and mental evaluation			ficiencies cited have been or will			
		n or entity other than the			corrected by the date indicate.			
		uthority, prior to admission,	1					
		he physical and mental						
		dual, the individual requires						
	and	rovided by a nursing facility;						
	(B) If the individual red	guires such level of						
	services, whether the							
	specialized services;							
		ty, as defined in paragraph						
	(k)(3)(ii) of this section							
		r developmental disability ned prior to admission-						
		he physical and mental						
		dual, the individual requires						
		rovided by a nursing facility;						
	and							
	(B) If the individual red							
	services, whether the							
	specialized services to	or intellectual disability.						

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Event ID: 0J26tt

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If continuation sheet Page 78 of 222

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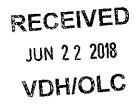
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	ROVIOER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS			RESS, CITY, STATE, ZIP COOE ACKSON MEMORIAL HIGHWAY /A 22033	,	7772010
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F 645	section- (i) The preadmission is paragraph(k)(1) of this for determinations in to a nursing facility of being admitted to the transferred for care in (ii) The State may che preadmission screenis paragraph (k)(1) of this to a nursing facility of (A) Who is admitted to hospital after receiving hospital, (B) Who requires nurse condition for which the hospital, and (C) Whose attending perfore admission to the likely to require less facility services.  §483.20(k)(3) Definitions section— (i) An individual is condisorder if the individual disorder defined in 48 (ii) An individual is conintellectual disability if intellectual disability are is a person with a redescribed in 435.1010. This REQUIREMENT by:  Based on staff intervireview, it was determinensure a level I PASA	ions. For purposes of this acreening program under a section need not provide the case of the readmission of an individual who, after nursing facility, was a hospital. So not to apply the ng program under its section to the admission an individual-to the facility directly from a gracute inpatient care at the sing facility services for the exindividual received care in a physician has certified, the facility that the individual is than 30 days of nursing than 30 days of nursing and has a serious mental and has a serious mental and has a serious mental and has an an action of the individual has an action of this chapter. It is not met as evidenced the facility staff failed to the serious mental and the facility staff failed to the facility staff failed to the facility staff failed to the serious mental and the facility staff failed to the facility staff failed to the facility staff failed to the facility staff failed to the section of the facility staff failed to the section of the facility staff failed to the section of the facility staff failed to the section of the facility staff failed to the section of the facility staff failed to the section of the facility staff failed to the section of the facility staff failed to the section of the facility staff failed to the section of the facility staff failed to the section of the facility staff failed to the section of	F		ne practice of the facility to		

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

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Facility IO: VA0153

If continuation sheet Page 79 of 222



PRINTED: 05/30/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495217	B. WING _			05/	1 <b>7/2</b> 01 <b>8</b>
NAME OF P	ROVIDER OR SUPPLIER		- 1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	ARE HEALTH SERVICES	LEAIR OAKS	1	1	2475 LEE JACKSON MEMORIAL HIGHWAY		
IIIAITO (CO.	TILL HEALTH OLIVIOLO	A AIR OARO	- 1	E	AIRFAX, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 645	Continued From page	⊋79	F6	345			
	for four of 48 resident	ts in the survey sample,			1. Resident #31, level 1 PASARI	R has	
	Residents # 31, # 42,	# 50, and # 37.			been obtained and placed on res		
					chart. Resident #42 level 1 PASA		8
	1. The facility staff fa	iled to ensure Resident			been completed. Resident #50 n		
	#31's level I PASARR	was completed to ensure			resides in the facility. Resident #		
	the resident was eval	uated and receiving care			1 PASARR has been obtained ar		
	and services in the m	ost integrated setting			on resident's chart.	ia piace	u .
	appropriate for the re-	sident's needs.			All residents have the potential	al to bo	
					affected.	שט טו וג	
	•	led to ensure Resident #42's			3. Interdisciplinary Team (IDT) w	ill bo	
		idmission screening and			re-educated to ensure that reside		
		complete to ensure the					
		ed and receiving care and			1 PASARR will be obtained prior	to aumi	ssion
	services in the most in				or completed upon admission if n	οι	
	appropriate for the re-	sident's needs.			admitted with one.	211	
	A TT A 100 . 46 A 1				4. Administrator and/or designee		
		led to ensure Resident #50's	ļ		complete five (5) random audits of		_
		dmission screening and			admissions to ensure that level 1		KR
		complete to ensure the			has been obtained or completed.		
		ed and receiving care and			audits will be done weekly x four	(4) and	
	services in the most in				then monthly x two (2).	_	_
	appropriate for the res	sidents needs.			The results of these audits will be		d-
	4. The facility stoff fail	led to ensure Resident #37's			ed to the Quality Assurance and		
		dmission screening and			ment Committee for review and a		
		complete to ensure the			as appropriate. The committee w		
	•	ed and receiving care and			determine need for further audits	and/or	
	services in the most in	<del>-</del>			actions.		
	appropriate for the res	<del>-</del>			5. Date of compliance is June 19	, 2018.	
	appropriate for the re-	sident's needs.			·		
	The findings include:						
	1 The facility staff fai	iled to ensure Resident					
	•	was completed to ensure					
		uated and receiving care					
i	and services in the m	•					
	appropriate for the res						
	appropriate in the les	Siderita Reeda.					
	Resident # 31 was ad	mitted to the facility on					

STATEMENT OF <b>DE</b> FICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING_			l	C /17/2018	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP ( 12475 LEE JACKSON MEMORIAL H FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD B THE APPROPRIA	_	(X5) COMPLETION DATE	
F 645	03/10/17. Resident were not limited to c disease (1), hyperter behavioral disturbant disease (4) and unstant a substance or known Resident #31's most set), an annual asset (assessment referent Resident # 31 as soci interview for mental - 15, 9 (nine) - being cognition for making 31 was coded as recompleted for activities of daily "Preadmission Screet (PASARR)" docume currently considered process to have seri intellectual disability federal regulation) on Resident # 31 was c "Active Diagnoses" (Psychotic disorder (Psychot	#31's diagnoses included but hronic obstructive pulmonary nsion (2), dementia without ces (3), cerebrovascular pecified psychosis not due to an physiological condition (5).  Trecent MDS (minimum data assment with an ARD see date) of 03/18/18 coded oring a 9 (nine) on the brief status (BIMS) of a score of 0 moderately impaired of daily decisions. Resident # quiring supervision with set up diving. Section A 1500 ening and Resident Review need, "Is the resident by the state level II PASARR ous mental illness and/or/ ("mental retardation" in a related condition?" oded as "No." Section I coded Resident # 31 as other than schizophrenia)."	F	545				

CENTERS FOR MEDICARE & MEDICAID SERVICES

F 645  Continued From page 81 interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked who was responsible for obtaining the PASARRs, ASM # 2 stated, "To my knowledge the social workers from our sister facility who was training the new social workers and that they stated they had not received the train regarding PASARRs, ASM # 2 stated, "To my knowledge the social worker from our sister facility who was training the new social workers at this facility were responsible for the PASARRs." ASM # 2 stated, "I was not aware the PASARRs needed to be done for everyone."  On 05/17/18 at approximately 5:50 p.m. ASM (administrator and ASM # 2, director of nursing were made aware of the findings.  No further information was provided prior to exit.  References: (1) Blockage of the upper airway occurs when the upper breathing passages become narrowed or blocked, making it hard to breathe. Areas in the upper airway that can be affected are the windpipe (trachea), voice box (larynx) or throat (pharynx). This information was obtained from the website: https://medlineplus.gov/ency/article/000067.htm  (2) High blood pressure. This information was obtained from the website: https://www.hm.nih.gov/medlineplus/highbloodpr		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		STRUCTION		SURVEY PLETED
MANORCARE HEALTH SERVICES-FAIR OAKS    12/75 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22833			495217	B. WING				
PREFIX TAG  (EACH DEFICIENCY MAST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 645  Continued From page 81 interview was conducted with ASM (administrative staff member) # 2, director of nursing, When asked who was responsible for obtaining the PASARRS, ASM # 2 stated, "The social workers." When informed of the interview with OSM # 7 and # 13, social workers and that they stated they had not received the train regarding PASARRS, ASM # 2 stated, "Tom the social worker from our sister facility who was training the new social workers at this facility were responsible for the PASARRS. "ASM # 2 turther stated,," I was not aware the PASARR needed to be done for everyone."  On 05/17/18 at approximately 5:50 p.m. ASM (administrative staff member) # 1, the administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.  No further information was provided prior to exit.  References:  (1) Blockage of the upper airway occurs when the upper breathing passages become narrowed or blocked, making it hard to breathe. Areas in the upper airway that can be affected are the windpipe (trachea), voice box (larynx) or throat (pharynx). This information was obtained from the website: https://www.nin.nih.gov/medlineplus/highbloodpr			S-FAIR OAKS	:	12475 [	LEE JACKSON MEMORIAL HIGHWAY	1 00	117/2010
interview was conducted with ASM (administrative staff member) # 2, director of nursing. When akked who was responsible for obtaining the PASARRs, ASM # 2 stated, "The social workers." When informed of the interview with OSM # 7 and # 13, social workers and that they stated they had not received the train regarding PASARRs, ASM # 2 stated, "To my knowledge the social worker from our sister facility who was training the new social workers at this facility were responsible for the PASARRs." ASM # 2 further stated, "I' was not aware the PASARR needed to be done for everyone."  On 05/17/18 at approximately 5:50 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.  No further information was provided prior to exit.  References: (1) Blockage of the upper airway occurs when the upper breathing passages become narrowed or blocked, making it hard to breathe, Areas in the upper airway that can be affected are the windippe (trachea), voice box (larynx) or throat (pharynx). This information was obtained from the website: https://mem.nlm.nih.gov/medineplus.gov/ency/article/000067.htm	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
(3) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was	F 645	interview was conducted asked who was respinal asked who was respinal asked who was respinal asked who was respinal asked who was respinal asked who was respinal asked who was respinal asked who was respinal asked who was respinal asked who was received the train #2 stated, "To my know from our sister facility social workers at this the PASARRS." ASM not aware the PASAR everyone."  On 05/17/18 at approximation of a state of the passion o	cted with ASM (administrative frector of nursing. When onsible for obtaining the stated, "The social workers." is interview with OSM # 7 and and that they stated they had a regarding PASARRs, ASM towledge the social worker of who was training the new is facility were responsible for of # 2 further stated, "I was RR needed to be done for the same of the findings.  In was provided prior to exit, the same of the s	F	545			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495217	B. WNG		ŀ	C 05/17/2018	
	ROVIDER OR SUPPLIER	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CO 12475 LEE JACKSON MEMORIAL HIG FAIRFAX, VA 22033	DE	03/1//2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCEO TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	IX5I COMPLETION DATE	
F 645	obtained from the we https://medlineplus.g  (4) A stroke. When it brain stops. A stroke attack." If blood flow few seconds, the brain stops. Brain cells of damage. This inform website: https://medlineplus.g  (5) Severe mental disthinking and perceptions and har false beliefs, such as plotting against your secret messages. Har perceptions, such as something that is not obtained from the we https://medlineplus.g  2. The facility staff falevel I PASARR (president review) was resident was evaluated services in the most appropriate for the resident # 42 was an 03/04/16. Resident # were not limited to dy	ebsite: pov/ency/article/000739.htm.  plood flow to a part of the is sometimes called a "brain of is cut off for longer than a ain cannot get nutrients and can die, causing lasting ation was obtained from the pov/ency/article/000726.htm.  sorders that cause abnormal ions. People with psychoses y. Two of the main symptoms allucinations. Delusions are to thinking that someone is or that the TV is sending you allucinations are false thearing, seeing, or feeling there. This information was absite: ov/psychoticdisorders.html.  illed to ensure Resident #42's admission screening and complete to ensure the ed and receiving care and integrated setting esident's needs.  dmitted to the facility on f42's diagnoses included but sphagia (1), hypertension chavioral disturbances (3),	F	545			
	gastroesophageal re	flux disease (4) and s not due to a substance or					

	OF DEFICIENCIES CORRECTION	(X I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONS		(X3) DATE	SURVEY PLETED
		495217	B. WING				C 1 <b>7/2018</b>
	ROVIDER OR SUPPLIER ARE HEALTH SERVICI	ES-FAIR OAKS		12475 L	ADDRESS, CITY, STATE, ZIP CODE BE JACKSON MEMORIAL HIGHWAY LX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	K .	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION OATE
F 645	set), a significant of ARD (assessment is coded Resident # 4 interview for mental - 15, 99 - indicating cognitive patterns was coded as being cognition for making 42 was coded as reassistance of one significant days as daily living. Section Screening and Residocumented, "Is the by the state level II serious mental illne ("mental retardation related condition?" "No." Section I "Ac Resident # 42 as "Fischizophrenia)."  Review of Resident reveal the resident's conducted with OSI social worker and C # 7 and # 13 stated month ago." When for obtaining the PA	st recent MDS (minimum data mange assessment with an reference date) of 03/29/18 2 as scoring a 99 on the brief 1 status (BIMS) of a score of 0 the staff assessment for was completed. Resident # 42 g severely impaired of 2 daily decisions. Resident # 42 daily decisions. Resident # 42 daily decisions. Resident # 42 daily decisions are stive to a fine A 1500 "Preadmission ident Review (PASARR)" are resident currently considered PASARR process to have ses and/or/ intellectual disability in federal regulation) or a Resident # 42 was coded as citive Diagnoses" coded Psychotic disorder (other than a #42's clinical record failed to	F	545			
	interview was condustaff member) # 2, o	roximately 3:50 p.m., an ucted with ASM (administrative director of nursing. When ponsible for obtaining the					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING_			C 05/1 <b>7/2018</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033		05/17/2018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N <b>SHO</b> ULD BE APPR <b>O</b> PRIA		
F 645	When informed of the # 13, social workers not received the trai # 2 stated, "To my k from our sister facili social workers at this the PASARRS." AS not aware the PASA everyone."  On 05/17/18 at appreciation of the worker and a ware of the worker and a ware of the worker and a were made aware of the worker and a were made aware of the worker and the	e stated, "The social workers." The interview with OSM # 7 and and that they stated they had an regarding PASARRS, ASM mowledge the social worker by who was training the new sefacility were responsible for M # 2 further stated, "I was are needed to be done for toximately 5:50 p.m. ASM member) # 1, the SM # 2, director of nursing for the findings.  The information was ebsite:  gov/medlineplus/swallowingdi  Bure. This information was ebsite:  gov/medlineplus/highbloodpr  Imptoms and behavioral purpor and prominent mentia. They include depression, anxiety aggression, disinhibition, ces. Approximately 30% to dementia suffer from such so there are complex	F6	345			

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	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		IPLE CDN\$TRUCTION	(X3) DATE SURVEY COMPLETED	
		495217	B. WING _			C 05/17/2018
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP COL 12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033		00/1/2010
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	
F 645	abnormalities. This if from the website: https://www.ncbi.nlm. 81717/.  (4) Stomach contents the esophagus and irri was obtained from the https://www.nlm.nih.g.  (5) Severe mental dis thinking and perceptions touch with reality are delusions and halfalse beliefs, such as plotting against you or secret messages. Halfalse beliefs, such as plotting against you or secret messages. Halfalse beliefs, such as plotting against you or secret messages. Halfalse beliefs, such as plotting against you or secret messages. Halfalse beliefs, such as plotting against you or secret messages. Halfalse beliefs, such as plotting against you or secret messages. Halfalse beliefs, such as plotting against you or secret messages. Halfalse beliefs, such as plotting against your or secret messages. Halfalse beliefs, such as plotting against your or secret messages. Halfalse beliefs, such as plotting against your or secret messages. Halfalse beliefs, such as plotting against your or secret messages. Halfalse beliefs, such as plotting against your or secret messages. Halfalse beliefs, such as plotting against your or secret messages. Halfalse beliefs, such as plotting against your or secret messages. Halfalse beliefs, such as plotting against your or secret messages. Halfalse beliefs, such as plotting against your or secret messages. Halfalse beliefs, such as plotting against your or secret messages. Halfalse beliefs, such as plotting against your or secret messages. Halfalse beliefs, such as plotting against your or secret messages. Halfalse beliefs, such as plotting against your or secret messages. Halfalse beliefs, such as plotting against your or secret messages. Halfalse beliefs against your or secret messages. Halfalse beliefs against your or secret messages. Halfalse beliefs against your or secret messages. Halfalse beliefs against your or secret messages. Halfalse beliefs against your or secret messages. Halfalse beliefs against your or secret messages. Halfalse beliefs against your or secret messages.	nih.gov/pmc/articles/PMC31  to leak back, or reflux, into itate it. This information website: ov/medlineplus/gerd.html.  orders that cause abnormal ons. People with psychoses. Two of the main symptoms ducinations. Delusions are thinking that someone is rethat the TV is sending you ducinations are false onearing, seeing, or feeling there. This information was osite: ov/psychoticdisorders.html.  ed to ensure Resident #50's dmission screening and complete to ensure the d and receiving care and ontegrated setting sident's needs.  mitted to the facility on hission on 09/27/17. Oses included but were not diabetes (1), hypertension behavioral disturbances (3), ux disease (4) and not due to a substance or	F6	645		

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	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		<b>495217</b>	B. WNG			l	C
NAME OF P	ROVIDER OR SUPPLIER	400217	D. WING	_	STREET ADDRESS, CITY, STATE, ZIP CODE	05/	17/2018
	ARE HEALTH SERVICES	FAIR OAKS		1	12475 LEE JACKSON MEMORIAL HIGHWAY 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 QATE
F 645	set), a quarterly asset (assessment reference Resident # 50 as scot interview for mental s - 15, 3 (three) - being cognition for making of 50 was coded as required of one staff member of Section A 1500 "Prea Resident Review (PA resident currently compassed to the staff member of section A 1500 "Prea Resident Review (PA resident currently compassed to the staff of the	recent MDS (minimum data ssment with an ARD ce date) of 04/06/18 coded ring a 3 (three) on the brief tatus (BIMS) of a score of 0 severely impaired of daily decisions. Resident # uiring extensive assistance for activities of daily living, dmission Screening and SARR)" documented, "Is the sidered by the state level II have serious mental illness stability ("mental retardation" or a related condition?" aded as "No." Section I boded Resident # 50 as other than schizophrenia)."  50's clinical record failed to evel I PASARR.  a.m., an interview was (other staff member) # 7, M # 13, social worker. OSM We just started about a sked who was responsible ARR, OSM # 7 and #13 en covered in our training."	F	645			

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Facility ID: VA0153

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PRINTED: 05/30/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY ANO PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495217 B. WING 05/17/2018 NAME OF PROVIDER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 12475 LEE JACKSON MEMORIAL HIGHWAY MANORCARE HEALTH SERVICES-FAIR OAKS FAIRFAX, VA 22033 SUMMARY STATEMENT OF OFFICIENCIES (X4) ID Ю PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH OEFICIENCY MUST BE PRECEOEO BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULO BE TAG REGULATORY OR LSC IOENTIFYING INFORMATION) CROSS-REFERENCEO TO THE APPROPRIATE DATE TAG OEFICIENCY) F 645 | Continued From page 87 F 645 # 2 stated, "To my knowledge the social worker from our sister facility who was training the new social workers at this facility were responsible for the PASARRs." ASM # 2 further stated, "I was not aware the PASARR needed to be done for everyone." On 05/17/18 at approximately 5:50 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit, References: (1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 001214.htm. (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr essure.html. (3) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(4) Depression may be described as feeling sad. blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		TIPLE CON	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495217	B. WING			1	C
NAME OF D	ROVIDER OR SUPPLIER	433217	D. 11110			05/	17/2018
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
MANORCA	ARE HEALTH SERVICES	S-FAIR OAKS			LEE JACKSON MEMORIAL HIGHWAY		
				FAIR	FAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TD THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 645	website: https://medlineplus.g  (5) Severe mental disthinking and perceptilose touch with realitare delusions and hafalse beliefs, such as plotting against you descret messages. Haperceptions, such as something that is not obtained from the wehttps://medlineplus.g  4. The facility staff fallevel I PASARR (prearesident review) was resident was evaluated services in the most appropriate for the resident #37 was as 10/31/16. Resident #37 was as 10/31/16. Resident #37 was as 10/31/16. Resident #37 was gastroesophageal resunspecified psychosis known physiological Resident #37's most set), a significant chata ARD (assessment recoded Resident #37 interview for mental set 15, 99 - indicating the cognitive patterns was was coded as being set.	pov/ency/article/003213.htm.  sorders that cause abnormal ions. People with psychoses by. Two of the main symptoms are at thinking that someone is or that the TV is sending you allucinations are false hearing, seeing, or feeling there. This information was absite:  pov/psychoticdisorders.html.  illed to ensure Resident #37's admission screening and complete to ensure the ed and receiving care and integrated setting isident's needs.  dmitted to the facility on #37's diagnoses included but existly (1), hypertension (2), ional disturbances (3), flux disease (4) and is not due to a substance or condition (5).  recent MDS (minimum data ange assessment with an ference date) of 03/23/18 as scoring a 99 on the brief status (BIMS) of a score of 0 the staff assessment for its completed. Resident # 37	F	645			

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	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING				С
NAME OF P	ROVIDER OR SUPPLIER	490217	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	05/	17/2018
	ARE HEALTH SERVICES	-FAIR OAKS		1	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION OATE
F 645	one staff member for Section A 1500 "Prear Resident Review (PAresident Review (PAresident currently compassed in federal regulation) in Resident # 37 was compassed in federal regulation (Passident # 37 was compassed in federal regulation) in Resident # 37 was compassed in Federal Resident # 37 was compassed in Federal Review of Resident # 37 was compassed in Federal Review of Resident # 30 was conducted with OSM social worker and OSM social worker and OSM social worker and OSM social worker and Sederal When as for obtaining the PASA stated, "It has not been on 05/17/18 at approximaterview was conducted with own was responsed who was responsed informed of the # 13, social workers and received the train # 2 stated, "To my know from our sister facility social workers at this stated workers at this stated PASARRS." ASM	uiring limited assistance of activities of daily living. dmission Screening and SARR)" documented, "Is the sidered by the state level II nave serious mental illness sability ("mental retardation" or a related condition?" ded as "No." Section I oded Resident # 37 as other than schizophrenia)."  37's clinical record failed to evel I PASARR.  a.m., an interview was (other staff member) # 7, M # 13, social worker. OSM We just started about a sked who was responsible ARR, OSM # 7 and #13 in covered in our training."	F	645			

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Facility ID: VA0153

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	OF DEFICIENCIES FCORRECTION	IOENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) OATE SURVEY COMPLETEO	
		495217	B. WING			C 05/17/2018	
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADORESS, CITY, STAT 12475 LEE JACKSON MEMO FAIRFAX, VA 22033	·	00/11/2010	
(X4) IO PREFIX TAG	(EACH OEFICIEN	TATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULO BE CEO TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
F 645	(administrative staff administrator and AS were made aware of No further information References: (1) Fear. This information website: https://www.nlm.nih.#summary.  (2) High blood press obtained from the website: https://www.nlm.nih.essure.html.  (3) Psychological synabnormalities are concharacteristics of desymptoms such as desymptoms such as desymptoms, agitation, and sleep disturbance 90% of patients with behavioral disorders interactions between psychological symptoms abnormalities. This from the website: https://www.ncbi.nlm.81717/.  (4) Stomach content the esophagus and in was obtained from the https://www.nlm.nih.gov.	eximately 5:50 p.m. ASM member) # 1, the SM # 2, director of nursing if the findings.  In was provided prior to exit.  In ation was obtained from the gov/medlineplus/anxiety.html  In a tion was obtained from the gov/medlineplus/highbloodpr  In a tion was obtained from the gov/medlineplus/highbloodpr  In a tion was obtained mentia. They include epression, anxiety aggression, disinhibition, was a cognitive deficits, oms, and behavioral information was obtained  In a to leak back, or reflux, into critate it. This information	F	645			

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Eveni IO: 0J2611

Facility IO: VA0153

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	OF DEFICIENCIES FCORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETEO
		495217	B. WING				C
		495217	D. WING			05/	17/2018
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MANORCA	ARE HEALTH SERVICES	-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY				
				F	AIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH OEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION OATE
F 656 SS=E	thinking and perceptic lose touch with reality are delusions and halfalse beliefs, such as plotting against you o secret messages. Halperceptions, such as something that is not obtained from the well https://medlineplus.gc Develop/Implement CFR(s): 483.21(b)(1)  §483.21(b) Comprehe §483.21(b)(1) The faci implement a compreh care plan for each resident rights set for §483.10(c)(3), that incobjectives and timeframedical, nursing, and needs that are identificant assessment. The comdescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that wunder §483.24, §483. provided due to the reunder §483.10, includ treatment under §483 (iii) Any specialized serehabilitative services provide as a result of	cons. People with psychoses of. Two of the main symptoms Illucinations. Delusions are thinking that someone is or that the TV is sending you Illucinations are false hearing, seeing, or feeling there. This information was besite: by/psychoticdisorders.html. comprehensive Care Plan  ensive Care Plans cility must develop and tensive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable that shall and psychosocial that and psychosocial that in the comprehensive the prehensive care plan must the comprehensive the psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not the sident's exercise of rights ing the right to refuse conditions.		645	The statement made on this plan correction are not an admission on the constitute an agreement with alleged deficiencies herein. To rin compliance with all Federal an regulations, the center has taken take the actions set forth in the following constitutes the center's allegation compliance such that all alleged ficiencies cited have been or will corrected by the date indicated.	the the emain d State or will bllowing POC of de-	

	OF DEFICIENCIES CORRECTION	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405247	B. WING			C	
		495217	B. WING			05/1	17/2018
	rovider or supplier Are Health Services	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE  12475 LEE JACKSON MEMORIAL HIGHWAY  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 B CRDSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	rationale in the reside (iv) In consultation wit resident's representa (A) The resident's go desired outcomes.  (B) The resident's prefuture discharge. Fact whether the resident's community was asselocal contact agencie entities, for this purpo (C) Discharge plans in plan, as appropriate, requirements set fortisection.  This REQUIREMENT by:  Based on observation interview, facility docurecord review, it was staff failed to develop comprehensive person eight of 48 residents. Residents #5, #19, #4 and #423.  1. The facility staff fait #5's comprehensive administration.  2. The facility staff fait #19's comprehensive administration.  3. The facility staff fait #40's comprehensive tests.	ent's medical record.  In the resident and the tive(s)- als for admission and  eference and potential for dilities must document is desire to return to the seed and any referrals to is and/or other appropriate in accordance with the in in paragraph (c) of this  is not met as evidenced in, resident interview, stafful ument review and clinical determined that the facility is and/or implement the interview sample, 40, #427, #37, #47, #109  led to implement Resident im	F	656	It is the practice of the facility to develop and/or implement comphensive person-centered care person-centered care person-centered care person-centered and pair medication has been administered and administered and carefiled and administered aprescribed rate. Resident #40, labas been clarified and lab to be per ordered. Resident #427 care was immediately revised. Resided doctor was notified and parameter medication was clarified. Resident #40ctor was immediately notified and compared ident not receiving medication. For the control of the	care care ded as has at the ab order drawn e plan ent #37, ers for ent #47 flect the 109, of res- No new 423 orde	er

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILDI		CONSTRUCTION		LETED
		495217	B. WING		<del></del>		C 17/2018
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS		124	REET ADDRESS, CITY, STATE, ZIP CODE 175 LEE JACKSON MEMORIAL HIGHWAY IRFAX, VA 22033		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	medications.  5. The facility staff fair 37's comprehensive of metoprolol (1).  6. The facility staff fair address the use of a Resident #47.  7. The facility staff fair Resident #109's compadministration of Backs.  8. The facility staff fair Resident #423's compadministration of the III.  The findings include:  1. The facility staff fair #5's comprehensive of administration.  Resident #5 was administration.  Resident #5 was administration.  Resident #5 was administration.  Resident #5 was administration.  Resident #5 was administration.  Resident #5 reported days.  Review of Resident #5 reported days.  Review of Resident #5 physician's order date.	led to implement Resident # care plan for the use of led to develop a care plan to hand splint and helmet for led to implement /follow prehensive care plan for the lofen.  Iteld to implement /follow prehensive care plan for the lofen.  Iteld to implement /follow prehensive care plan for the lofen.  Iteld to implement /follow prehensive care plan for the lofen.  Iteld to implement Resident leare plan for pain medication little to the facility on leaves a logical series included but labetes, muscle weakness lesident #5's most recent leset), a quarterly assessment ment reference date) of	F	956	<ol> <li>All residents have the potential affected.</li> <li>Interdisciplinary Team (IDT) or re-educated to develop and/or implement comprehensive care for all residents.</li> <li>DON and/or designee will confive (5) random audits of resident ensure that comprehensive care has been implemented. These awill be done weekly x four (4) and monthly x two (2).</li> <li>The results of these audits will be warded to the Quality Assurance Assessment Committee for review action as appropriate. The committee for action as appropriate. The committee for action.</li> <li>Date of compliance is June 1</li> </ol>	plan mplete its to e plan audits id then e for- e and ew and mittee udits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495217	B. WING _			C 05/17/2018	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CO 12475 LEE JACKSON MEMORIAL HIG 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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD B HE APPROPRIA		N
F 656	Resident #5's May 20 medication administra "Capsagel Gel 0.0250 (bilateral) knees topic On 5/9/18, the eMAR initials and the code "Nurse Notes." The Madministration report topically applied to be every day in May 201 nurse's note dated 5/"Capsagel Gel 0.0250 topically one time a dorder placed."  Resident #5's compre 7/16/16 documented, painAdminister pain orders"  On 5/15/18 at 12:10 pconducted with Resident was knee pain but every day and that he the facility.  On 5/17/18 at 8:36 at conducted with LPN (LPN #1 was asked with eMAR meant. LPN #1 note." LPN #1 was sident was not given. LPN #2	ees one time a day for pain.  118 eMAR (electronic ation record) documented, (Capsaicin) Apply to bilat ally one time a day for pain." documented a nurse's 5" that indicated, "Hold/See lay 2018 eMAR location of documented Capsagel was oth of Resident #5's knees 8 except for 5/9/18. A 19/18 documented, (Apply to bilat knees ay for pain Pharmacy aware ethensive care plan dated "Generalized medication per physician  o.m., an interview was ent #5. The resident stated t she gets a pill and cream elips her pain.  ethers for signing the above as no longer employed at	F6	356			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495217	B. WING			l	17/2018
	ROVIDER OR SUPPLIER	S-FAIR OAKS		12	TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033	1 03/	1772010
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	and it says it's on ord pharmacy and they so next run then notify the LPN #1 was asked the care plan. LPN #1 stream to be updated was asked the process care plan is followed. The care plan is followed. The care plan is followed. The care plan in profile. If you are not always go and read it on 5/17/18 at 5:09 p. staff member) #1 (the director of nursing above findings.  The facility document "INTERDISCIPLINAR documented, "The facility documented acompreheasurable objective patient's medical, nur psychosocial needs the comprehensive assess. No further information (1) Capsagel is used condition in which join This information was https://ahrq-ehc-applimedia/pdf/osteoarthrical.	d, "Sometimes if we do click er and you call the ay they will bring it on the ne MD (medical doctor)." He purpose of a resident's ated, "We do care plan for a laso if there is anything that on a patient's care." LPN #1 as for ensuring a resident's LPN #1 stated, "So we do place on the patient's sure of something you can be."  In M., ASM (administrative administrator) and ASM #2 and were made aware of the administrator) and care identified in the sament"  It it it it includes a sand timeframes to meet a sing, mental, and that are identified in the sament"  In was provided prior to exit.  It to treat osteoarthritis, a and stiff. obtained from the website: cation.s3.amazonaws.com/tis-pain_consumer.pdf  Itel to implement Resident	F	656			

CENTERS FOR MEDICARE & MEDICAID SERVICES

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		SURVEY LETED
	<b>495</b> 217	B. WING			1	C 1 <b>7/2</b> 0 <b>18</b>
ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	S-FAIR OAKS	•	12	2475 LEE JACKSON MEMORIAL HIGHWAY		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL					(X5) COMPLETION DATE
administration.  Resident #19 was ad 8/26/17. Resident #1 were not limited to he and high blood press recent MDS (minimulassessment with an Adate) of 3/4/18, coder cognitively intact. Se Resident #19 received Review of Resident #19 received Review of Resident #19 received three liters via nasal as hortness of breath. comprehensive care documented, "Cardia hyperlipidemia (high blood pressure) ordered"  On 5/15/18 at 12:28 Resident #19 was colying in bed with a nathe nasal cannula was concentrator. The ox administered to Resident #19 was colying in bed with a nathe nasal cannula was concentrator. The ox administered to Resident #19 was colying in bed with a nathe nasal cannula was concentrator. The ox administered to Resident #19 was positioned at the and the bottom of the three-liter line. At this how much oxygen show made aware of this side.	dmitted to the facility on 19's diagnoses included but eart failure, high cholesterol sure. Resident #19's most m data set), a quarterly ARD (assessment reference d the resident as being ection O documented ed oxygen therapy.  #19's clinical record revealed ated 4/24/18 for oxygen at cannula every shift for Resident #19's plan dated 12/5/17 ac disease related to cholesterol), Hypertension )Administer oxygen as  p.m., observation of inducted. The resident was asal cannula in her nose, as attached to an oxygen was being dent #19 at a rate in between a half liters as evidenced by in the concentrator flow ween the three-liter line and iter line. The top of the ball at three and a half liter line is time, Resident #19 asked he was receiving and was urveyor's observation.	F	656			
thought she was supp	posed to receive between					
	ROVIDER OR SUPPLIER  SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From page administration.  Resident #19 was ad 8/26/17. Resident #7 were not limited to he and high blood press recent MDS (minimulassessment with an Adate) of 3/4/18, code cognitively intact. Se Resident #19 received Review of Resident #19 received Review of Resident #19 received three liters via nasal shortness of breath. Comprehensive care documented, "Cardia hyperlipidemia (high chigh blood pressure) ordered"  On 5/15/18 at 12:28   Resident #19 was colying in bed with a na The nasal cannula was concentrator. The oxadministered to Resident #19 was colying in bed with a na The nasal cannula was concentrator. The oxadministered to Resident #19 was colying in bed with a na The nasal cannula was concentrator. The oxadministered to Resident #19 was colying in bed with a na the nasal cannula was concentrator. The oxadministered to Resident #19 was colying in bed with a na the middle of the balt was positioned at the and the bottom of the three-liter line. At this how much oxygen shade aware of this s Resident #19 voiced	ARE HEALTH SERVICES-FAIR OAKS  SUMMARY STATEMENT OF OEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 96 administration.  Resident #19 was admitted to the facility on 8/26/17. Resident #19's diagnoses included but were not limited to heart failure, high cholesterol and high blood pressure. Resident #19's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/4/18, coded the resident as being cognitively intact. Section O documented Resident #19 received oxygen therapy.  Review of Resident #19's clinical record revealed a physician's order dated 4/24/18 for oxygen at three liters via nasal cannula every shift for shortness of breath. Resident #19's comprehensive care plan dated 12/5/17 documented, "Cardiac disease related to hyperlipidemia (high cholesterol), Hypertension (high blood pressure)Administer oxygen as	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES-FAIR OAKS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 96  administration.  Resident #19 was admitted to the facility on 8/26/17. Resident #19's diagnoses included but were not limited to heart failure, high cholesterol and high blood pressure. Resident #19's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/4/18, coded the resident as being cognitively intact. Section O documented Resident #19 received oxygen therapy.  Review of Resident #19's clinical record revealed a physician's order dated 4/24/18 for oxygen at three liters via nasal cannula every shift for shortness of breath. Resident #19's comprehensive care plan dated 12/5/17 documented, "Cardiac disease related to hyperlipidemia (high cholesterol), Hypertension (high blood pressure)Administer oxygen as ordered"  On 5/15/18 at 12:28 p.m., observation of Resident #19 was conducted. The resident was lying in bed with a nasal cannula in her nose. The nasal cannula was attached to an oxygen concentrator. The oxygen was being administered to Resident #19 at a rate in between three and three and a half liter as evidenced by the middle of the ball in the concentrator flow mater positioned between the three-liter line and the three and a half liter line. The top of the ball was positioned at the three and a half liter line and the bottom of the ball was positioned at the three and a half liter line and the britem line in the concentrator. Resident #19 asked how much oxygen she was receiving and was made aware of this surveyor's observation. Resident #19 voiced concern because she	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES-FAIR OAKS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 96  administration.  Resident #19 was admitted to the facility on 8/26/17. Resident #19's diagnoses included but were not limited to heart failure, high cholesterol and high blood pressure. Resident #19's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/4/18, coded the resident as being cognitively intact. Section O documented Resident #19'received oxygen therapy.  Review of Resident #19's clinical record revealed a physician's order dated 4/24/18 for oxygen at three liters via nasal cannula every shift for shortness of breath. Resident #19's comprehensive care plan dated 12/5/17 documented, "Cardiac disease related to hyperlipidemia (high cholesterol), Hypertension (high blood pressure)Administer oxygen as ordered"  On 5/15/18 at 12:28 p.m., observation of Resident #19 was conducted. The resident was lying in bed with a nasal cannula in her nose. The nasal cannula was attached to an oxygen concentrator. The oxygen was being administered to Resident #19 at a rate in between three and three and a half liter line. The top of the ball was positioned between the three-liter line and the three and a half liter line. The top of the ball was positioned at the three and a half liter line and the bottom of the ball was positioned at the three and a half liter line and the bottom of the ball was positioned at the three and a half liter line and the bottom of the ball was positioned at the three and a half liter line and the bottom of the ball was positioned at the three and a half liter line and the bottom of the ball was positioned at the three and a half liter line and the bottom of the ball was positioned at the three and a half liter line and the bottom of the ball was positioned at the three liter line and the bottom of the ball was positioned at the three-liter line	A SUILDING  A SUILDING  B. WIND  STREET ADDRESS, CITY, STATE, 2IP CDDE  1247 SEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 2233  SUMMAY STATEMENT OF OPPOSITENCIES  FAIFFAX, VA 22333  D. PROVIDER'S FLAN OF CORRECTION  (EACH CORRECTIVE AND FORD  FOR STATEMENT OF OPPOSITENCIES  IN PROVIDER'S FLAN OF CORRECTION  (EACH CORRECTIVE AND FORD  FOR STATEMENT OF OPPOSITENCIES  IN PROVIDER'S FLAN OF CORRECTION  (EACH CORRECTIVE AND FORD  FOR STATEMENT OF CORRECTION  (EACH CORRECTIVE AND FORD  FOR STATEMENT OF CORRECTION  (EACH CORRECTIVE AND FORD  FOR STATEMENT OF CORRECTION  (EACH CORRECTIVE AND FORD  FOR STATEMENT OF CORRECTION  (EACH CORRECTIVE AND FORD  FOR STATEMENT OF CORRECTION  (EACH CORRECTIVE AND FORD  FOR STATEMENT OF CORRECTION  (EACH CORRECTION  (	ABUILDING  495217  8. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  1275 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033  SUMMARY STATEMENT OF DEFICIENCIES GEACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 96 administration.  Resident #19 was admitted to the facility on 8/26/17. Resident #19's diagnoses included but were not limited to heart failure, high cholesterol and high blood pressure. Resident #19's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/4/18, coded the resident as being cognitively intact. Section O documented Resident #19's clinical record revealed a physician's order dated 4/24/18 for oxygen at three liters via nesal cannula every shift for shortness of breath. Resident #19's comprehensive care plan dated 1/25/17 documented, "Cardiac disease related to hypertipletemin (high cholesterol), Hypertension (high blood pressure)Administer oxygen as ordered"  On 5/15/18 at 12:28 p.m., observation of Resident #19 was conducted. The resident was lying in bed with a nasal cannula in her nose. The nasal cannula was attached to an oxygen concentrator. The oxygen was being administered to Resident #19 at a rate in between three and there and a half liter ine and the bottom of the ball was positioned at the three-liter line. At this time, Resident #19 asked how much oxygen she was receiving and was made aware of this surveyor's observation, Resident #19 voiced concern because she

	OF DEFICIENCIES F CORRECTION	(X1) PR <b>OV</b> IDER/SUPPLIER/CLIA IDENTIFICATI <b>O</b> N NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		405047		P MNC		С		
		495217	B. WNG			05/	/17/2018	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		1:	TREET ADDRESS, CITY, STATE, ZIP CODE  2475 LEE JACKSON MEMORIAL HIGHWAY  AIRFAX, VA 22033			
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TIVE ACTION SHOULD BE COM CED TO THE APPROPRIATE		
F 656	aware this surveyor woon 5/15/18 at 12:29 pronducted with LPN (LPN #8 was asked for Resident #19 was supstated Resident #19's be set at a rate of three to observe Resident #LPN #8 observed the knob on the flow meter middle of the ball in the three-liter line. We the ball was on the the middle of the ball liter line.  On 5/17/18 at 8:36 and conducted with LPN (LPN #1 was asked the care plan. LPN #1 state continuity of care and needs to be updated of was asked the process care plan is followed. have the care plan in profile. If you are not always go and read it.  On 5/17/18 at 5:09 put staff member) #1 (the (the director of nursing above concern.)	esident #19 was made would get a nurse.  D.m., an interview was (licensed practical nurse) #8. or the rate of oxygen posed to receive. LPN #8 is oxygen was supposed to see liters. LPN #8 was asked #19's oxygen concentrator. concentrator and turned the ser. LPN #8 stated the ser flow meter should be on then asked if the middle of ree liter line, LPN #8 stated was a little above the three me., an interview was licensed practical nurse) #1. e purpose of a resident's ated, "We do care plan for also if there is anything that on a patient's care." LPN #1 is for ensuring a resident's LPN #1 stated, "So we do place on the patient's sure of something you can	F	656				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER		) MULTIPLE CONSTRUCTION BUILDING		
		495217	B. WING_	B. WNG		C 05/1 <b>7/2</b> 018	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVIO	ES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHT FAIRFAX, VA 22033		1 00	1772010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BI	(X5) COMPLETION DATE	
F 656	10/1/16. Resident were not limited to generalized anxiet Resident #40's mo set), a quarterly as (assessment reference the resident's cognical Review of Resident a physician's order practitioner on 4/1 Decrease the frequevery other Monda Resident #40's Matreatment administ "PT/INR every other 14 day(s)." Further clinical record revellabs dated 4/30/18 every week instead Resident #40's con 11/28/17 document r/t (related to) anerordered and notify  On 5/17/18 at 8:36 conducted with LP LPN #1 was asked care plan. LPN #1 continuity of care aneeds to be update was asked the pro-	admitted to the facility on #40's diagnoses included but high blood pressure, y disorder and diabetes. st recent MDS (minimum data sessment with an ARD ence date) of 3/26/18, coded hition as severely impaired.  It #40's clinical record revealed reigned by the nurse 7/18 that documented, "4. Juncy of INR (1) testing to by. Next one is 4/30/18" by 2018 eTAR (electronic ration record) documented, er Monday in the morning every review of Resident #40's realed multiple results of PT/INR p. 5/7/18 and 5/14/18 (obtained dof every other week).  Imprehensive care plan dated ted, "Hematological condition miaObtain Lab results as physician of results"  In a.m., an interview was N (licensed practical nurse) #1. If the purpose of a resident's stated, "We do care plan for and also if there is anything that end on a patient's care." LPN #1 cess for ensuring a resident's end. LPN #1 stated, "So we do	F	956			

STATEMENT OF OFFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILOING B. WING						(X3) OATE SURVEY COMPLETEO	
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NAME OF D	DOLLOS OF STREET	495217	B. WING			05/17/2018	
	ROVIOER OR SUPPLIER	SES ENID ONKS		STREET AOORESS, CITY, STATE, ZIP COO 12475 LEE JACKSON MEMORIAL HIGH			
MANORCARE HEALTH SERVICES-FAIR OAKS			FAIRFAX, VA 22033				
(X4) I <b>O</b> PREFIX TAG	IX (EACH OFFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU			I SHOULO BE	tX5) COMPLETION OATE		
F 656	conducted with RN was asked to revie order for PT/INRs. PT/INR was obtain the next PT/INR stated the next PT on 5/14/18. RN #8 reason, a PT/INR stated he needed notes.  On 5/17/18 at 1:35 conducted with RN	d it."  12 p.m., an interview was  13 (registered nurse) #5. RN #5  14 Resident #40's physician  15 RN #5 was made aware a  16 need on 4/30/18 and asked when  16 nould have been done. RN #5  17 RN should have been done  18 was asked if there was a  18 was obtained on 5/7/18. RN #5  19 p.m., an interview was  18 #5 and ASM (administrative	F	656			
	stated, "According an opportunity to uphysician's discret clarify his stateme, physician's order vPT/INR to be obta saw a weekly trend through the chart. a physician's order stated the nurses adoctor is addressir signature written of confirmed Resider obtained as ordere opportunity to importunity to impor	the director of nursing). RN #5 to the policy, there is always update labs based on the ion." RN #5 was asked to int. ASM #2 stated the was supposed to read for the ned every 14 days and she id of labs when she looked ASM #2 stated she did not see for weekly PT/INRs. ASM #2 are calling the doctor and the ing the labs as noted by the in the lab results. ASM #2 it #40's PT/INRs were not id and stated there was an ove the lab process.  Ition was presented prior to exit.  Itime (PT) is a test used to help is a bleeding disorder or disorder; the international in iting the calculated from a PT					

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION  (X1) PROVIDER'SUPPLIER'CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING_			C
	NAME OF CORRECTION    A95217   A95217			STREET ADDRESS, CITY, STATE, ZIP O 12475 LEE JACKSON MEMORIAL HI FAIRFAX, VA 22033		05/17/2018
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF  ( (EACH CORRECTIVE ACT  CROSS-REFERENCED TO 1  DEFICIENCY	TON SHOULD B THE APPROPRI	
F 656	result and is used to blood-thinning medi warfarin (Coumadin clots." This informa website: https://labtestsonline	o monitor how well the cation (anticoagulant)  ®) is working to prevent blood tion was obtained from the	Fé	556		
	address Resident #- medications.  Resident #427 was 5/3/18 with diagnoss limited to: HIV, right disorder (1) and mu  Review of the most set), an admission a (assessment referent the resident as havi the BIMS (brief inter indicating the reside make daily decision requiring assistance daily living.  Review of the May 2 documented, "Comp MG (milligrams) Giv a day for Antiviral ur self-administration, home."	admitted to the facility on es that included but were not knee replacement, bipolar scle weakness.  recent MDS (minimum data assessment, with an ARD note date) of 5/10/18 coded ng scored a 15 out of 15 on view for mental status) and was cognitively intact to so the resident was coded as a from staff for all activities of 2018 physician's orders plera Tablet (2) 200-25-300 es 1 tablet by mouth one time asupervised Patient's own stock from				
	administration recor	2018 medication d documented, "Complera fG (milligrams) Give 1 tablet				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COME	SURVEY PLETED
		495217	B. WING	B. WING		C 05/17/2018	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS	<b>1</b>	STREET ADDRESS, CITY, STATE, ZIP C 12475 LEE JACKSON MEMORIAL HI FAIRFAX, VA 22033		<u>1 00</u>	
(X4) ID PREFIX TAG			ID PREFI: TAG	PROVIDER'S PLAN DF X (EACH CORRECTIVE ACT CRDSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE		(X5) COMPLETION OATE
F 656	stock from home." It v MAR that the medica self-administered eac Review of the 5/4/18 assessment documer safe to administer me Review of the care pl evidence a plan of ca self-administer the me An interview was comp.m. with LPN (licens resident's nurse. Whe care plans, LPN #10 sus what the resident r When asked who use stated, "We use them and we get their signa the patient's care plar information was adde stated, "After we do the their ADL (activities of medications, and skirt a resident would have self-administering the #10 stated, "Yes."  An interview was come a.m. with LPN #2. Whe had care plans, LPN #3 a plan of care in place same treatment." Whe plan, LPN #2 stated, " managers, even the Co	day for Antiviral ministration. Patient's own was documented on the tion had been th day.  self-administration need that the resident was edications to self.  an initiated on 5/3/18 did not are for the resident to edications.  ducted on 5/16/18 at 3:44 ed practical nurse) #10. the en asked why residents had estated, "The care plan tells needs for their health." at the care plans, LPN #10 is We review that with them eature and we work towards n." When asked what type of did to the care plan, LPN #10 ne assessment, can look at	F	556			

PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
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		495217	B. WING	_		05/	17/2018	
NAME OF PI	ROVIDER OR SUPPLIER			٤	STREET ADDRESS, CITY, STATE, ZIP CODE			
MANORCA	ARE HEALTH SERVICES	LFAIR NAKS		1	12475 LEE JACKSON MEMORIAL HIGHWAY			
III/MONG.				ן ו	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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TION SHOULD BE THE APPROPRIATE		
F 656	put in the care plan, LPN #2 stated, "We put almost everything that pertains to the patient." When asked if a care plan would be developed for a resident who was self-administering their medication, LPN #2 stated, "Yes."		F	656	3			
	p.m. with ASM (admir the director of nursing residents had care pla direct the plan of care When asked who use stated, "Everyone, if s update the care plan to a care plan would be who was self-adminis	ducted on 5/17/18 at 1:56 nistrative staff member) #2, g. When asked why ans, ASM #2 stated, "To e from the beginning to end." ed the care plan, ASM #2 something changes, they to reflect it." When asked if developed for a resident stering medication, ASM #2						
		2, the director of nursing, ssurance consultant were						
	documented, "COMPI PLANNING REQUIRE develop and implement person-centered care includes measurable of to meet a patient's me psychosocial needs the comprehensive assess care plan must describ services that are to be	RY CARE PLANNING" REHENSIVE CARE EMENTS: the facility must ent a comprehensive e plan for each patient that objectives and timeframes edical, nursing, mental, and hat are identified in the essment. The comprehensive fibe the following:the e furnished to maintain the ticable physical, mental, and						
	No further information	n was obtained prior to exit.						

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

Eveni ID: OJ26 [1

Facility ID: VA0153

If conlinuation sheet Page 103 of 222

JUN 2 2 2018 VDH/OLC

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION  (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) OATE SURVEY COMPLETEO		
		495217	B. WNG_		l	C 05/17/2018	
	ROVIOER OR SUPPLIER ARE HEALTH SERVIC	ES-FAIR OAKS		STREET AOORESS, CITY, STATE, Z 12475 LEE JACKSON MEMORIA FAIRFAX, VA 22033	UP COOE	<del></del>	
(X4) IQ PREFIX TAG	IX (EACH OEFICIENCY MUST BE PRECEOEO BY FULL		IO PREFI) TAG	1	ACTION SHOULO BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	Continued From pa	ge 103	F	356			
	health condition that mood, energy, and often appears in lat adulthood, although time of life. This infinity://ghr.nlm.nih.g.  2. Complear Commedicine approved Administration (FD/infection in adults a and older who have before and who have before and who have RNA copies per mL copies/mL or less, from: https://aidsinfo.nih.gent  5. The facility staff of the staff o	Bipolar disorder is a mental at causes extreme shifts in behavior. This disorder most be adolescence or early a symptoms can begin at any promation was obtained from: gov/condition/bipolar-disorder applera is a prescription by the U.S. Food and Drug A) for the treatment of HIV and children 12 years of age a never taken HIV medicines are a viral load (number of HIV of blood) of 100,000 This information was obtained gov/drugs/441/complera/0/paticalled to implement Resident # de care plan for the use of					
	10/31/16. Resident were not limited to a dementia with beha gastroesophageal r	admitted to the facility on #37's diagnoses included but anxiety (2), hypertension (3), vioral disturbances (4), eflux disease (5) and sis not due to a substance or Il condition (6).					
	set), a significant of ARD (assessment if coded Resident # 3 interview for mental - 15, 99 - indicating	st recent MDS (minimum data nange assessment with an reference date) of 03/23/18 7 as scoring a 99 on the brief status (BIMS) of a score of 0 the staff assessment for					

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING			(X3) DATE SURVEY COMPLETED		
		495217	B. WING _		<del></del>	l	C 17/2018	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION OATE	
F 656	cognition for making 37 was coded as recone staff member for the POS (physician 2018 and signed by documented, "Metor (milligram). Give 0.5 day for HTN (hypert Hold for SBP(systoli pressure is given as represents the press the heart beats called (less than) 120 and 60."  The eMARs (electror records) dated Marc 2018 documented, "(milligram). Give 0.5 day for HTN (hypert Hold for SBP (systol than) 120 and HR (review of the eMAR documented: 03/05/18 - SBP 112 03/09/18 - SBP 118 03/19/18 - SBP 118 03/19/18 - SBP 119 03/28/18 - SBP 119 03/28/18 - SBP 103	severely impaired of g daily decisions. Resident # quiring limited assistance of or activities of daily living.  It's order sheet) dated May the physician 0n 05/13/18 polol Tablet 25 MG atablet by mouth one time a dension). 0.5 tablet=12.5 mg. ic blood pressure [blood at 2 numbers. The first number aster in your blood vessels as and systolic pressure] (7)) < HR (heart rate) < (less than)  In the physician on 05/13/18 polol Tablet = 12.5 mg. ic blood pressure [blood at 2 numbers. The first number aster in your blood vessels as and systolic pressure] (7)) < HR (heart rate) < (less than)  In the physician on 0.5 tablet=12.5 mg. ic blood pressure) < (less than) and HR 2018 place of the physician of	F6	56				
	documented:	. adiou / ipi ii 20 10						

PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION  (X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) OATE SURVEY COMPLETED	
		495217	B. WING_	B. WING			C / <b>17/2018</b>
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	S-FAIR OAKS		12475	T ADDRESS, CITY, STATE, ZIP CODE LEE JACKSON MEMORIAL HIGHWAY FAX, VA 22033	<u>1 00</u> ,	1172010
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEOEO BY FULL		ID PREFIX TAG	(	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	IX5I COMPLETION DATE
F 656	04/13/18 - SBP 115 a 04/22/18 - SBP 111 a 04/23/18 - SBP 111 a 04/23/18 - SBP 111 a Review of the eMAR documented: 05/06/18 - SBP 117 a 05/16/18 - SBP 115 a The care plan for Rei of 07/21/2018 docum disease related to Hy Under "Interventions' medication per physi 11/01/2016." On 05/17/18 at 8:56 a conducted with LPN a 1. LPN # 1 was aske resident # 37 dated M 2018. When asked a for SBP (systolic block 120 and HR (heart ra medication metoprolo parameters needed to medication. When ask the medication when met, LPN # 1 stated to eMARs dated 03/05/- 03/19/18, 03/21/18, 0 04/23/18, 05/06/18 ai "The medication show reviewing the cardiac LPN # 1 was asked if metoprolol was to tre issues. LPN # 1 state care plan was being to	and HR 88 coded 5. and HR 70 coded 5. and HR 73 coded 5. dated May 2018 and HR 77 coded 5. and HR 80 coded 5. sident # 37 with a target date ented, "Focus. Cardiac perlipidemia, Hypertension." It documented, "Administer cian orders. Date initiated: a.m., an interview was (licensed practical nurse) # and to review the eMARs for March and April and May bout the parameters of Hold and pressure) < (less than) te) < (less than) 60" for the bl, LPN # 1 stated that both to be met to hold the sked if it was correct to hold only one parameter was No." After reviewing the 18, 03/09/18, 03/14/18, 3/28/18, 04/13/18, 04/22/18, and 05/16/18, LPN # 1 stated, alld have been given." After care plan for Resident # 37,	F	356			

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

Event IO; OJ2611

Facility ID: VA0153

If continuation sheet Page 106 of 222

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		(X2) MULT A. BUILOII	TIPLE CONSTRUCTION  NG	O	(X3) DATE SURVEY COMPLETEO	
		495217	B. WING_			C 0 <b>5/17/2018</b>
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICE	S-FAIR OAKS		STREET AOORESS, CITY, STATE, Z 12475 LEE JACKSON MEMORIA FAIRFAX, VA 22033		35/17/2010
(X4) IO PREFIX TAG			ID PREFI) TAG	(EACH CORRECTIVE CRO\$\$-REFERENCED	N OF CORRECTION ACTION SHOULO BE TO THE APPROPRIATI IENCY)	(X5) COMPLETION DATE
F 656	conducted with ASM member) # 2, director procedure for implem care plan. When asl of the care plan ASM care given to the rest cardiac care plan for asked if the medicating Resident # 37's card "Yes." When asked followed if the medico 03/09/18, 03/14/18, 04/13/18, 04/22/18, 05/16/18, ASM # 2 s On 05/17/18 at approximate approximate to the medication of	p.m., an interview was (administrative staff or of nursing regarding the menting and following the ked to describe the purpose I # 2 stated, "To reflect the ident." After reviewing the Resident # 37, ASM # 2 was on of metoprolol was to treat iac issues. ASM # 2 stated, if the care plan was being ation was held on 03/05/18, 03/19/18, 03/21/18, 03/28/18, 04/23/18, 05/06/18 and tated, "No."  eximately 5:50 p.m. ASM member) # 1, the isM # 2, director of nursing the findings.  In was provided prior to exit.  combination with other high blood pressure. It also is na (chest pain) and to or a heart attack. Metoprolol ination with other heart failure. Metoprolol is in ns called beta blockers. It bod vessels and slowing blood flow and decrease information was obtained	Fé	656		

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	FIPLE CONSTRUCTION NG	0	(X3) DATE SURVEY COMPLETED			
		495217	B. WING	B. WING		C 05/17/2018		
	ROVIDER DR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE 12475 LEE JACKSON MEMOF FAIRFAX, VA 22033		03/1//2010		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		X (EACH CORRECTI' CROSS-REFERENCE	PROVIDER'S PLAN OF CDRRECTIDN (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 656	Continued From page	107	F	656				
	website:	ation was obtained from the ov/medlineplus/anxiety.html						
	obtained from the wel	re. This information was osite: ov/medlineplus/highbloodpr						
	abnormalities are concharacteristics of dem symptoms such as depsychosis, agitation, and sleep disturbance 90% of patients with obehavioral disorders. Interactions between psychological sympto abnormalities. This infrom the website:	nentia. They include pression, anxiety aggression, disinhibition, es. Approximately 30% to elementia suffer from such There are complex cognitive deficits,						
	the esophagus and irr was obtained from the	to leak back, or reflux, into itate it. This information website:  ov/medlineplus/gerd.html.						
	thinking and perceptic lose touch with reality are delusions and hall false beliefs, such as plotting against you of secret messages. Hall perceptions, such as	orders that cause abnormal ons. People with psychoses of the main symptoms ducinations. Delusions are thinking that someone is a that the TV is sending you ducinations are false one aring, seeing, or feeling there. This information was						

	OF DEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) OATE COMF	SURVEY PLETEO
		495217	B. WNG				l	C /17/2018
NAME OF PI	ROVIOER OR SUPPLIER				STREET AODRESS, CITY, STATE, ZIP COOE		1 03/	17/2010
					12475 LEE JACKSON MEMORIAL HIGHW	AY		
MANURU	ARE HEALTH SERVICES	-FAIR UAKS			FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (OENTIFYING INFORMATION)	iO PREFI. TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI OEFICIENCY)	HOULO B		(X5) COMPLETION DATE
F 656	Continued From page	e 108	F	656	6			
	obtained from the wel							
	https://medlineplus.go	ov/psychoticdisorders.html.						
	(7) This information w	as obtained from the						
	website:							
		nih.gov/2016/01/blood-press						
	ure-matters 6 The facility staff fail	led to develop a care plan to						
		hand splint and helmet for						
	Resident #47.	•						
	Resident #47 was add	mitted to the facility on						
		s that included but were not						
		ematoma (a collection of						
		ra mater and above the						
		of the meninges in the brain surgery, hemiplegia						
		e) (2), depression, bipolar						
	disorder) a mental dis	sorder characterized by						
		d depression) (3), seizures,						
	and high blood pressu	ure.						
İ	The most recent MDS							
	•	ssion assessment, with an						
		e date of 4/10/18, coded the "6" on the BIMS (brief						
	<del>-</del>	tatus) score, indicating he						
		d to make daily cognitive						
		nt was coded as requiring						
	extensive assistance							
		ally dependent upon one or or all of his activities of daily			·			
	living. In Section J - H							
	resident was coded as							
		dmission to the facility on						
	4/3/18.							
		le of Resident #47 during						
	the initial tour of the fa	acility on 5/15/16, at						

NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-FAIR OAKS  (K4) ID PREFIX TAG  CONTINUED (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)  F 656  Continued From page 109 approximately 11:30 a.m., he was in his bed being assisted by a staff member with his helmet on and his-hand splint on his left hand.  Observation was again made of Resident #47 on 5/16/18 at 8:23 a.m. The resident was in the dining room in a Geri-chair. He had a helmet on and a splint on his left hand.  Review of the comprehensive care plan, dated 4/4/18, failed to evidence documentation related to the use of a hand splint and the use of a helmet. The care plan dated 4/4/18 documented in part, "Focus: Surgical site to parietal area at head due to cranictomy." The "Interventions" documented, "Administer treatments per physician orders. Report evidence of infection			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
MANORCARE HEALTH SERVICES-FAIR OAKS  (X4) ID PREFIX (A 22033  (X4) ID PREFIX (A 22033  (X4) ID PREFIX (A 22033  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 656  Continued From page 109 approximately 11:30 a.m., he was in his bed being assisted by a staff member with his helmet on and his hand splint on his left hand. Observation was again made of Resident #47 on 5/16/18 at 8:23 a.m. The resident was in the dining room in a Geri-chair. He had a helmet on and a splint on his left hand.  Review of the comprehensive care plan, dated 4/4/18, failed to evidence documentation related to the use of a hand splint and the use of a helmet. The care plan dated 4/4/18 documented in part, "Focus: Surgical site to parietal area at head due to craniotomy." The "Interventions" documented, "Administer treatments per physician orders. Report evidence of infection			495217	B. WING _			_	8	
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 656  Continued From page 109 approximately 11:30 a.m., he was in his bed being assisted by a staff member with his helmet on and his hand splint on his left hand. Observation was again made of Resident #47 on 5/16/18 at 8:23 a.m. The resident was in the dining room in a Geri-chair. He had a helmet on and a splint on his left hand.  Review of the comprehensive care plan, dated 4/4/18, failed to evidence documentation related to the use of a hand splint and the use of a helmet. The care plan dated 4/4/18 documented in part, "Focus: Surgical site to parietal area at head due to craniotomy." The "Interventions" documented, "Administer treatments per physician orders. Report evidence of infection			S-FAIR OAKS		12475 LEE JACKSON MEMORIAL I				
approximately 11:30 a.m., he was in his bed being assisted by a staff member with his helmet on and his hand splint on his left hand.  Observation was again made of Resident #47 on 5/16/18 at 8:23 a.m. The resident was in the dining room in a Geri-chair. He had a helmet on and a splint on his left hand.  Review of the comprehensive care plan, dated 4/4/18, failed to evidence documentation related to the use of a hand splint and the use of a helmet. The care plan dated 4/4/18 documented in part, "Focus: Surgical site to parietal area at head due to craniotomy." The "Interventions" documented, "Administer treatments per physician orders. Report evidence of infection	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFD	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIA	COMPLI	ETION	
such as purulent drainage, swelling, localized heat, increased pain, etc. Notify physician prn (as needed)."  Review of the clinical record, failed to evidence a physician order for the helmet or the splint.  An interview was conducted with LPN (licensed practical nurse) #1 on 5/16/18 at 1:59 p.m. LPN #1 was asked if a resident with a hand splint would have a care plan addressing the use of the splint. LPN #1 stated, "Yes." When asked if the use of a helmet would be care planned, LPN #1 stated, "Yes." When asked who completed the care plans, LPN #1 stated, "The nurses and the unit managers."  An interview was conducted with RN (registered nurse) #5 on 5/16/18 at 2:07 p.m. When asked if use of a splint, would be care planned, RN #5 stated, "Yes." When asked use of a helmet, would be care planned, RN #5 stated, "Yes." RN #5	F 656	approximately 11:30 being assisted by a so on and his/hand splir Observation was aga 5/16/18 at 8:23 a.m. dining room in a Geri and a splint on his leid Review of the compre 4/4/18, failed to evide to the use of a hand helmet. The care plain part, "Focus: Surgi head due to craniotor documented, "Admin physician orders. Resuch as purulent drain heat, increased pain, needed)."  Review of the clinical physician order for the An interview was compractical nurse) #1 or #1 was asked if a reswould have a care plasplint. LPN #1 stated use of a helmet would stated, "Yes." When a care plans, LPN #1 sunit managers."  An interview was compused in the plans, LPN #1 stated and the plans, LPN #1 sunit managers."	a.m., he was in his bed staff member with his helmet in on his left hand. In made of Resident #47 on The resident was in the inchair. He had a helmet on the finand.  The hand a helmet on the hand inchair. He had a helmet on the hand.  The resident was in the inchair. He had a helmet on the hand.  The resident was in the inchair. He had a helmet on related splint and the use of a individual and the use of a individual area at my." The "Interventions" interest treatments per port evidence of infection in age, swelling, localized etc. Notify physician print (as in the helmet or the splint.  The record, failed to evidence a like helmet or the splint.  The record with LPN (licensed in 5/16/18 at 1:59 p.m. LPN is ident with a hand splint an addressing the use of the did be care planned, LPN #1 asked who completed the tated, "The nurses and the inducted with RN (registered at 2:07 p.m. When asked if the care planned, RN #5 asked use of a helmet, would	F	356				

PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) OATE SURVEY COMPLETEO		
		495217	B. WING	· · · · · · · · · · · · · · · · · · ·		C 0 <b>5/17/2</b> 018	
	ROVIOER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET AODRESS, CITY, STATE, ZIP C 12475 LEE JACKSON MEMORIAL HI FAIRFAX, VA 22033			
(X4) IO PREFIX TAG	(EACH OEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCEO TO T OEFICIENC	TON SHOULO BE THE APPROPRIA		
F 656	if he saw the use of plan, RN #5 stated, An interview was co 5/17/18 at 12:22 p.n the care plan, LPN # would care for the re uses the care plan, provides care to the The administrator, ASM ASM #3, the quality made aware of the a 5:52 p.m.  No further information (1) Barron's Dictional Non-Medical Reade Chapman; pages 26 7. The facility staff from Resident #109's contadministration of Barron's Dictional Resident #109's contadministration of Barron's Dictional Resident #109 was 4/30/18 with the diagmultiple sclerosis and fracture of the left are (Minimum Data Set) assessment with an Reference Date) of coded as being cogridally life decisions. requiring total care from the left care from the left care from the left care fracture of the lef	a helmet or splint on the care "No, he did not."  Inducted with LPN #3 on In. When asked the purpose of #3 stated it was how they esident. When asked who LPN #3 stated, "Anyone who resident."  Inducted with LPN #3 on In. When asked the purpose of It is stated it was how they esident. When asked who LPN #3 stated, "Anyone who resident."  In the induction of nursing and assurance consultant, were above concern on 5/17/18 at  In the induction of the induction of the coloren.  In the induction of t	F 6	56			

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mobility, dressing and eating; and as incontinent

Event IO: 0J2611

Facility IO: VA0153

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTIO IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED
		495217	B, WING	<del></del>	C
	PROVIDER OR SUPPLIER		S 1:	TREET ADDRESS, CITY, STATE, ZIP CODE  2475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033	05/17/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 656	of bowel and bladder. On 5/16/18 at 9:26 a. #1 was observed prependications for Residuals and pubble on the medicatablet (5 mg), and the were to give 15 mg (3 single half tab and pu Pepcid [2] 20 mg, one Zoloft [3] 25 mg, one Multivitamin [4], one to Vitamin D3 [5], 1000 to Zoloft 50 mg, one tab observed noting that to orders for the Zoloft. and noted that the 25 previously pulled was resident was to get the observed removing that the cup and discarding the 25 mg of zoloft and dispensing a 50 mg zoup now contained 75 Baclofen. RN #1 there medications to the reserved 75 mg of Zoloft on the 25 mg of zoloft and spensing a 50 mg zoup now contained 75 Baclofen. RN #1 there medications to the reserved 75 mg of Zoloft on the zoloft of the dinical physician's order sheer review revealed an or Baclofen for 15 mg, the Control of the dinical physician's order sheer review revealed an or Baclofen for 15 mg, the Control of the dinical physician's order sheer review revealed an or Baclofen for 15 mg, the Control of the dinical physician's order sheer review revealed an or Baclofen for 15 mg, the Control of the dinical physician's order sheer review revealed an or Baclofen for 15 mg, the Control of the dinical physician's order sheer review revealed an or Baclofen for 15 mg, the Control of the dinical physician's order sheer review revealed an or Baclofen for 15 mg, the Control of the Control	m., RN (registered nurse) paring the following dent #109:  milligrams) tab (tablet). Each ation card contained a half e pharmacy label directions 3 halves). RN #1 removed a ut it in the medication cup. e tab tab units, one tab o. At this time, RN #1 was there were two different She reviewed the orders o mg dose she had is discontinued and that the ne 50 mg. RN #1 was then ne half tab of Baclofen from ng it. RN #1 did not remove nd was then observed coloft tablet into the cup. The form of Zoloft and no n administered the sident. Resident #109 eloft (instead of the ordered fen.  all record revealed the et (POS) for May 2018. This order dated 5/4/18 for the	F 656		

		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILOING			
		495217	B. WING_			C 05/1 <b>7/2</b> 01 <b>8</b>		
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	S-FAIR OAKS		STREET AOORESS, CITY, STAT 12475 LEE JACKSON MEMO FAIRFAX, VA 22033				
(X4) 10 PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	10 PREFII TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION TIVE ACTION SHOULO BE SEO TO THE APPROPRIA FFICIENCY)			
F 656	5/2/18 for "At risk for musculoskeletal prob spasm secondary to This care plan includ "Administer medication intervention was dated on 5/17/18 at 12:20 LPN #3 (Licensed Probable that the care plan was Baclofen.  No further information [1] Baclofen acts on the decreases the number spasms caused by modern conditions of the spasms caused by modern conditions and the spasms caused by modern conditions of the spasms caused by modern conditions of the spasms caused by modern caused (Prescription (Sores on the lining of intestine); gastroeson (GERD, a condition in acid from the stomach injury of the esophage mouth and stomach] stomach produces to acidOver-the-count used to prevent and stomach produces to acidOver-the-count used to prevent and stomach produces to acidOver-the-count spasms care plan include the prevent and stomach produces to acidOver-the-count used to prevent and stomach produces to acidOver-the-count used to prevent and stomach produces to acidOver-the-count used to prevent and stomach produces to acidOver-the-count used to prevent and stomach produces to acidOver-the-count used to prevent and stomach produces to acidOver-the-count used to prevent and stomach produces to acidOver-the-count used to prevent and stomach produces to acidOver-the-count used to prevent and stomach produces to acidOver-the-count used to prevent and stomach produces to acidOver-the-count used to prevent and stomach produces to acidOver-the-count used to prevent and stomach produces to acidOver-the-count used to prevent and stomach produces to acidOver-the-count used to prevent and stomach produces to acidOver-the-count used to prevent and stomach produces to acid	plan revealed one dated complications due to plems r/ (related to) muscle MS (multiple sclerosis)." ed an intervention for on per physician order." This ed 5/2/18.  p.m., in an interview with actical Nurse) she stated is not followed for the mass provided.  The spinal cord nerves and er and severity of muscle sultiple sclerosis or spinal or relieves pain and improves from ov/druginfo/meds/a682530.h  The stomach or small on perfect the stomach or small on perfect the stomach or small on perfect the stomach or small on perfect the stomach or small on perfect the stomach or small on perfect the stomach or small on perfect the stomach or small on perfect the stomach or small on perfect the stomach or small on perfect the stomach or small on the stomach or small on the stomach or small on the stomach or small on the stomach or small on the stomach or small on the stomach or small on the stomach or small on the stomach or small on the stomach or small on the stomach or small on the stomach or small on the stomach or small on the stomach or small on the stomach or small on the stomach or small on the stomach or small on the stomach or small on the stomach or small on the stomach or small or stomach or small or stomach or small or stomach or small or stomach or small or stomach or small or stomach or small or stomach or small or stomach or small or stomach or small or stomach or small or stomach or small or stomach or small or stomach or small or small or stomach or small	F	656				

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	ROVIOER OR SUPPLIER  ARE HEALTH SERVIC	ES-FAIR OAKS		STREET AOORESS, CITY, STATE, ZIP C 12475 LEE JACKSON MEMORTAL HI FAIRFAX, VA 22033		,	
(X4) IO PREFIX TAG	(EACH OEFICIE	STATEMENT OF OEFICIENCIES NCY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCEO TO T OEFICIENC	TON SHOULO BI THE APPROPRIA		_
F 656	[3] Zoloft is used to obsessive-compuls thoughts that won't perform certain act attacks (sudden, ur fear and worry abo posttraumatic stress psychological symptrightening experied disorder (extreme for performing in fronormal life). It is also symptoms of premaincluding mood switch breast tenderness. Information obtained https://medlineplustml [4] Multivitamin/mir combination of vita sometimes have otherbs. They are also simply vitamins. Mir recommended amount when they cannot continuitients from food Information obtained https://medlineplusons.html [5] Vitamin D3 help Calcium is one of the bone. A lack of vita	at from agov/druginfo/meds/a687011.ht at treat depression, sive disorder (bothersome ago away and the need to ions over and over), panic nexpected attacks of extreme ut these attacks), as disorder (disturbing botoms that develop after a nace), and social anxiety fear of interacting with others and of others that interferes with so used to relieve the enstrual dysphoric disorder, angs, irritability, bloating, and ad from agov/druginfo/meds/a697048.htm.  The ingredients, such as a called multis, multiples, or altis help people get the bounts of vitamins and minerals or do not get enough of these	F6	56			

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION  (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) OATE SURVEY COMPLETEO				
		495217	B. WING_			l	C 1 <b>7/2</b> 01 <b>8</b>
	ROVIOER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS		12475	T AOORESS, CITY, STATE, ZIP COOE  LEE JACKSON MEMORIAL HIGHWAY  FAX, VA 22033	1 03/	17/2016
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI) TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION DATE
F 656	immune systems. Information obtained https://vsearch.nlm.ni meta?v%3Aproject=nmedlineplus-bundle&d 2500842.1377447934 502114951  8. The facility staff fa Resident #423's compadministration of the IResident #423 was as 5/2/18 with the diagnostroke, high cholester Disease, chronic pain most recent MDS (Minadmission assessment Reference Date) of 5/coded as cognitively in life decisions. The rerequiring extensive confidering extensive confi	from h.gov/vivisimo/cgi-bin/query- nedlineplus&v%3Asources= query=vitamin+d&_ga=2.19 h.1502114951-734861906.1  illed to implement /follow brehensive care plan for the Lidocaine patch.  dmitted to the facility on boses of but not limited to bol, diabetes, Parkinson's , and choric embolism. The nimum Data Set) was an hit with an ARD (Assessment 9/18. The resident was hitact in ability to make daily sident was coded as hit for all areas of activities hit monthment of bowel and  M. RN (Registered Nurse) boaring the following ent #423:  g (milligrams), one tab  %, applied to left shoulder tab etab	F	556			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495217	B. WING_		<del></del>	C 0 <b>5/17/2</b> 01 <b>8</b>
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		STREET ADDRESS, CITY, ST 12475 LEE JACKSON MEN FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	( (EACH CORRE CRO\$S-REFERE	S PLAN OF CORRECTION COTIVE ACTION SHOULD BI INCED TO THE APPROPRIA DEFICIENCY)	
F 656	Sheet (POS) revealed the Lidocaine patch at 5/4/18 for Lidocaine patch at 5/4/18 for Lidocaine patch and remove per sche for Lidocaine patch at topically at bedtime, and topically at bedtime, and topically at bedtime, and topically at bedtime, and topically at bedtime, and topically at bedtime, and topically at bedtime, and topically at bedtime, and topically at bedtime, and topically at the second topical and topically at the second topical and	2018 Physician's Order d that there were orders for as follows: An order dated patch "Apply to left shoulder urs for pain management adule." An order dated 5/2/18 Apply to right shoulder for Pain Remove patch for lated 5/2/18 for Lidocaine shoulder topically one time a for 12 hours, off for 12 for for the right a.m., in an interview with RN at the patch for the right the order was discontinued. The order for the patch for the patch for the patch for the patch for the patch for the right and the computer and stated as a current d the computer and stated as a current order. There wided that the order had RN #2 did not offer the fine right shoulder.  Tolan revealed one dated ain r/t disease process" and tion, "Administer pain cian orders." This	F	656		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495217	B. WING_				C <b>17/20</b> 18	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS	•	12475	ET ADDRESS, CITY, STATE, ZIP CODE LEE JACKSON MEMORIAL HIGHWAY FAX, VA 22033	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ULL PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From page No further information		Fé	356	·			
	constipation. Information obtained https://medlineplus.goml  [2] Lidocaine patches Information obtained	ov/druginfo/meds/a601112.ht are used for pain.						
	[3] Plavix is used alor serious or life-threate and blood vessels in stroke, heart attack, cused to prevent serio problems with the her people who have per circulation in the blooto the legs).	art and blood vessels in pheral arterial disease (poor disease) that supply blood						
	rheumatoid arthritis (a of the lining of the joir caused by breakdown systemic lupus erythe the immune system a and causes pain and rheumatologic conditi immune system attact Nonprescription aspir and to relieve mild to	in is used to reduce fever						

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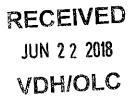
	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE : COMPI	
				_	<del></del>		;
		495217	B. WING			05/	17/2018
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS		12	REET AODRESS, CITY, STATE, ZIP COOE 475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033		,
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION DATE
F 656	attacks in people who the past or who have occurs when the hear oxygen)to reduce to who are experiencing experienced a heart a strokes (strokes that oblocks the flow of blocks the flow of blocks the flow of blocks blood to the brain is be people who have had mini-stroke in the pas Information obtained in https://medlineplus.gottml	cle achesto prevent heart have had a heart attack in angina (chest pain that t does not get enough he risk of death in people or who have recently attackto prevent ischemic occur when a blood clot od to the brain) or that occur when the flow of locked for a short time) in this type of stroke or t from ov/druginfo/meds/a682878.h	F	656			
F 657 SS=E	tml  (2) Barron's Dictional Non-Medical Reader, Chapman; page 266.  (3) Barron's Dictional Non-Medical Reader, Chapman; page 73.  Care Plan Timing and CFR(s): 483.21(b)(2)(6)  §483.21(b) Comprehe §483.21(b)(2) A complete (i) Developed within 7 the comprehensive as	from ov/druginfo/meds/a600027.h  ry of Medical Terms for the 5th edition, Rothenberg and ry of Medical Terms for the 5th edition, Rothenberg and I Revision i)-(iii) ensive Care Plans orehensive care plan must	F	857	The statement made on this plan correction are not an admission on the constitute an agreement with leged deficiencies herein. To recompliance with all Federal and regulations, the center has taken will take the actions set forth in the plan of correction. The following constitutes the center's allegation	to and d the al- main in State and or he follow	

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Event IO: OJ2611

Facility IO: VAD153

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STATEMENT OF DE FICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		405947	B. WING				
		495217	B. WING			05/	17/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORCA	ARE HEALTH SERVICES	-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHWAY			
MANORO	AND HEAD IN OUR FIOLO	-I AIR OARO		1	FAIRFAX, VA 22033		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(22)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	i	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	DATE
					)		
F 657	0	.440	_				
F 00/			F	657	compliance such that all allege	d de-	
	includes but is not lim				ficiencies cited have been or w		
	(A) The attending phy				corrected by the date indicated		
		with responsibility for the			corrected by the date indicated	,	
	resident.						
	(C) A nurse aide with resident.	responsibility for the				ļ	
		and nutrition services staff,					
	· ,	ticable, the participation of					
		esident's representative(s).					
		pe included in a resident's					
	•	participation of the resident					
		resentative is determined					
	not practicable for the						
	resident's care plan.	•					
		staff or professionals in					
		ned by the resident's needs					
	or as requested by the	e resident.					
	(iii)Reviewed and revi	sed by the interdisciplinary					
	team after each asses	ssment, including both the					
	comprehensive and q	uarterly review					
	assessments.						
		is not met as evidenced			It is the practice of the facility f	o re-	
	by:				view and/or revise care plans.	_ !	
		terview, staff interview,			,		
		ew, and clinical record					
		ned that the facility staff					
		r revise the care plan for					
	four of 48 residents in						
	Resident #53, 40, 419	and 105.					
	4. The feeling stoff fall	ad to rouing Danidant 452's					
		ed to revise Resident #53's					
		plan when she was placed					
	on an anti-anxiety me	dication.					
İ	2 The facility staff fail	ed to review and revise					
		ed to review and revise ehensive care plan when					
	the physician prescrib						
	medication on 5/10/18						
	madeduction of the top to	··					
			1				1

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495217 B. WING 05/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY MANORCARE HEALTH SERVICES-FAIR OAKS FAIRFAX, VA 22033 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 657 Continued From page 119 F 657 3. The facility staff failed to review and revise the comprehensive care plan for the use of continuous positive airway pressure (CPAP) for Resident #419. Resident #53 care plan was revised 4. The facility staff failed to review and revise the to reflect the use of anti-anxiety. comprehensive care plan for the use of a CPAP\* Resident #40 care plan was reviewed machine for Resident #105. and revised to reflect the use of antianxiety. Resident #419 care plan The findings include: was revised to reflect the home use of CPAP. Resident #105 care plan was 1. Resident #53 was admitted to the facility on reviewed and revised to reflect the non 3/23/18 with diagnoses that included but were not use of the CPAP. limited to Alzheimer's disease, anxiety disorder, 2. All residents have the potential to be and muscle weakness. Resident #53's most affected. recent comprehensive MDS (minimum data set) assessment was an admission assessment with 3. Interdisciplinary team (IDT) was rean ARD (assessment referenced date) of 3/30/18, educated on reviewing and revising Resident #53 was coded as being severely resident care plans to reflect resident's impaired in cognitive function scoring 99 out of current status. possible 15 on the BIMS (Brief Interview for 4. DON and/or designee will complete Mental Status exam). Resident #53 was coded five (5) random audits of care plans as requiring extensive assistance from one staff of residents with new orders/change of

Review of Resident #53's clinical record revealed a note from the NP (Nurse practitioner) that documented the following: "Chief Complaint-Insomnia, agitation. 81 v.o (sic) (year old) female with alzheimer's (sic) dementia, off Xanax last week...Night staff informed me that patient is not sleeping. Appears sleepy this morning. Staff also noticed and reported patient to be getting agitated again, was physically aggressive towards the staff this morning...Will reorder Xanax 0.25 mg g 12 (every twelve) hours prn (as needed) for 30 days."

The following nursing note was documented on

The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits.

condition to ensure that care plan has been reviewed/revised as appropriate.

These audits will be done weekly x four

(4) and then monthly x two (2).

and/or action.

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member with meals.

Eveni ID: 0J2611

Facility ID: VA0153

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PRINTED: 05/30/2018

RECEIVED JUN 2 2 2018 **VDH/OLC** 

PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495217	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	1002	1	STE	REET ADDRESS, CITY, STATE, ZIP CODE	05/	1 <b>7/2</b> 01 <b>8</b>
MANORCA	ARE HEALTH SERVICES	-FAIR OAKS			475 LEE JACKSON MEMORIAL HIGHWAY		
		····		FA	IRFAX, 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION OATE
F 657	Practitioner) today will resident being anxiou new orders given for 1 0.25 mg q (every) 12 effectiveness and it will the 30 days, Resident motified of new orders.  Review of Resident # (physician order summedocumented the follow (1) 0.25 MG (milligrath hours as needed for A order was initiated on 5/3/18. This order was on 5/3/18. "Xanax Tab Give 0.25 mg every 1: Anxiety for 14 days."  Review of Resident # (medication administrates and times: 5/14 at 8:51 a.m.  Review of Resident # plan dated 3/24/18 and evidence a care plan for 4/4/18: "Verbal/physic related to: Cognitive in diagnoses. Goal: Will Interventions: Approached bedside. Remove from is disruptive/unaccept.	s seen today the NP (Nurse th (sic) complaints of s and not sleeping at night, resident to restart Xanax hours for 30 daysto see ould be re-evaluated after the POA (power of attorney)."  53's most recent POS mary) dated 5/1/18 wing order: "Xanax Tablet ms) Give 0.25 mg every 12 taxiety for 30 days." This 5/2/18 and discontinued on sechanged to the following older 0.25 MG (milligrams) 2 hours as needed for  53's May 2018 MAR atton record) revealed that discontinued that discontinued that discontinued that discontinued on sechanged to the following /18 at 8:15 a.m. and 8/16/18  53's comprehensive care discontinued on all agitation/aggression mpairment, Alzheimer's not strike others. In slowly and slightly to in public area when behavior able."	Fe	557	5. Date of Compliance is June 7	19,2018	
	On 5/17/18 at 1:58 p.r	n., an interview was					

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Event ID; OJ2611

Facility ID: VA0153

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JUN 2 2 2018 VDH/OLC

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING			C	
	ROVIDER OR SUPPLIER	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWA FAIRFAX, VA 22033		05/17/2018	
(X <b>4</b> ) ID PREFIX TAG	(EACH DEFICI	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 657	When asked if it we to be accurate, LP #3 stated that the new orders or chall LPN #3 stated that care plan. When a see anti-anxiety medic would monitor for a side effects of the these interventions residents on anti-anxiety medic would monitor for a side effects of the these interventions residents on anti-al On 5/17/18 at 6:05 staff member) #1, the DON (Director of the above concern the facility policy the planning," documented above the care plan is implicated interventions a plan needs to be resulted in the communication too members that help careThe nursing information about the and goals. It contains the contains the contains the contains and will and goals. It contains the contains the contains the contains and goals. It contains the contai	N (licensed practical nurse) #3. as important for the care plan N #3 stated that it was. LPN care plan was updated with any nige in the resident's condition. It any nurse could update the asked if she would expect to edications on the residents stated that she would. When litbred for a resident on ation, LPN #3 stated that she any changes in behavior and medication. LPN #3 stated that is should be on the care plan for enxiety medication.  p.m., ASM (administrative the administrator and ASM #2, of Nursing) were made aware erms.  Ittled, "Interdisciplinary Care into in part, the following: "As plemented, members of the am need to evaluate whether are effective or whether the care	F	657			

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES FCORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	A. BUILOII	TIPLE CONSTRUCTION  NG	(X:	3) OATE SURVEY COMPLETEO
		495217	B. WING_			C 05/17/2018
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET AODRESS, CITY, STATE, ZIP CO 12475 LEE JACKSON MEMORIAL HIG FAIRFAX, VA 22033		03/11/2016
(X4) IO PREFIX TAG	(EACH OEFICIEN	TATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF C X (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 657	revise and update the there are changes in with new orders"  (1) Xanax is used to and panic disorder. In that depresses the conformation was obtain stitutes of Health. https://www.ncbi.nlm. T0008896/?report=d.  2. The facility staff faresident #40's comparting the physician prescrimedication on 5/10/10. Resident #40 was as 10/1/16. Resident #40 was as 10/1/16. Resident #40's most set), a quarterly asse (assessment referent the resident's cognition. The physician's order do 0.5 milligrams by most set). Review of Resident #40's most set). Review of Resident #40's most set), a quarterly asse (assessment referent the resident's cognition. Review of Resident #40's most set), a quarterly asse (assessment referent the resident's cognition.	careexpect to review, e care plan regularly, when a condition, treatments, and relief symptoms of anxiety (Anax is a benzodiazepine entral nervous system. This sined from The Nationalnih.gov/pubmedhealth/PMH etails  illed to review and revise prehensive care plan when bed an anti-anxiety 18.  dmitted to the facility on 40's diagnoses included but igh blood pressure, disorder and diabetes. recent MDS (minimum data essment with an ARD ce date) of 3/26/18, coded on as severely impaired.  #40's clinical record revealed and 5/10/18 for Xanax (1) buth at bedtime for anxiety for Resident #40's May 2018 edication administration resident was administered im 5/10/18 through 5/15/18. #40's comprehensive care sailed to document information	F	357		

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Event (0: 0J2611

Facility ID: VA0153

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CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

495217

FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

PRINTED: 05/30/2018

05/17/2018

NAME OF PROVIOER DR SUPPLIER

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY

(X2) MULTIPLE CONSTRUCTION

A. BUILDING\_

B. WNG\_

MANORO	ARE HEALTH SERVICES-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	!D	_	PROVIDER'S PLAN OF CORRECTION (X5)			
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFI: TAG		V7			
F 657	Continued From page 123	F	65	57			
	On 5/16/18 at 4:34 p.m., an interview was conducted with RN (registered nurse) #7 (MDS coordinator) and RN #8 (MDS coordinator). RN #7 and RN #8 were asked about the process staff follows for reviewing and revising care plans. RN #7 stated the nurses and MDS department create care plans within 48 hours of a resident's admission. RN #7 stated the nurses and MDS department are also responsible for updating the care plans. RN #7 was asked if a care plan should be updated when a resident receives a new physician's order for an anti-anxiety medication. RN #7 stated the MDS department updates the care plan if they are made aware of the new order but the nurse managers can update the care plan too. RN #7 was asked to show this surveyor where Resident #40's use of anti-anxiety medication was addressed on the resident's care plan. RN #7 reviewed the care plan and confirmed the use of anti-anxiety medication was not addressed on the care plan. RN #7 stated the use of anti-anxiety medication was previously addressed on the care plan because the resident had previously received the medication but the use was resolved from the care plan when the medication was previously discontinued. RN #7 was asked how long it should take to review and revise the care plan when an anti-anxiety medication is restarted. RN #7 stated the nurse who received the new order should have updated the care plan should have been updated by todays date (5/16/18), RN #7 stated yes. RN #7 was asked the purpose of the care plan and stated, "It should be a patient centered care plan so that everybody is aware of what we are doing for the patient."						

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	OF DEFICIENCIES					
AND PLAN O	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA )DENTIFICATION NUMBER:	(X2) MULTIPI A. BUILOING	E CONSTRUCTION		SURVEY PLETED
		495217	B. WING			C / <b>17/2018</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, C)TY, STATE, Z)P COOE	•	
MANORC	ARE HEALTH SERVICES	-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) )D PREF)X TAG	(EACH DEF)C)ENC	ATEMENT OF OEF)C)ENC)ES Y MUST BE PRECEDED BY FULL SC)DENTIFYING)NFORMATION)	)D PREF)X TAG	PROVIOER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	)X5) COMPLETION DATE
F 657	Continued From page	e 124	F 65	7		
	When asked if a residupdated when an antiprescribed, LPN #1 stawho is responsible for LPN #1 stated, "The rithe unit manager and asked when the care LPN #1 stated, "As so On 5/17/18 at 5:09 pustaff member) #1 (the director of nursing above concern.  No further information (1) Xanax is used to the information was obtain	licensed practical nurse) #1. lent's care plan should be leanxiety medication is tated, "Yes." When asked rupdating the care plan, nurse who took the order, I believe MDS." When plan should be updated, con as you take the order."  m., ASM (administrative administrator) and ASM #2 g) were made aware of the awas presented prior to exit.				
	comprehensive care p	led to review and revise the plan for the use of rway pressure (CPAP) for				
	5/3/18 with diagnoses limited to: heart disea diabetes, sleep apnea	dmitted to the facility on that included but were not se, muscular dystrophy (1), a and high blood pressure.				

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(assessment reference date) of 5/10/18, coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status)

Event)0:0J2611

Facility)D: VAD153

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	EMENT OF DEF(C(ENC(ES   (X1) PROV(DER/SUPPL(ER/CL(A   (X2) MULT(PLE CONSTRUCT(ON   A, BU(LD(NG (X3) DATE   COMP		SURVEY LETED				
		495217	B. WING_			·	C <b>17/2</b> 0 <b>18</b>
	ROV(DER OR SUPPL(ER ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, C(TY, STATE, Z(P CODE 12475 LEE JACKSON MEMORIAL H(GHW FAIRFAX, VA 22033		, 33	
(X4) (D PREF(X TAG	(EACH DEF(C(ENC)	ATEMENT OF DEF(C(ENC(ES Y MUST BE PRECEDED BY FULL SC (DENT(FY(NG (NFORMAT(ON)	(D PREF(X TAG	(EACH CORRECT(VE ACT(ON :	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 657	make daily decisions. requiring assistance fidaily living.  During an interview of a.m. with Resident #4 "And I don't have to uthe Review of Resident # plan initiated on 5/4/1 Has/At risk for respiral sleep apnea. Interven physician orders."  Review of the May 20 not evidence docume CPAP.  An interview was concumed the concument of the may 20 not evidence documed CPAP.  An interview was concumed the concument of the may 20 not evidence documed CPAP.  An interview was concument of the concument of the may 20 not evidence documed the concument of the may 20 not evidence documed the concument of the may 20 not evidence documed the ma	t was cognitively intact to The resident was coded as rom staff for all activities of  Inducted on 5/16/18 at 9:22 19, the resident stated, se the CPAP (2) anymore."  419's comprehensive care 8 documented, "Focus. tory impairment related to tions. CPAP use per  18 physician's orders did intation of an order for  ducted on 5/17/18 at 12:14 en asked why residents 43 stated, "Basically so we tints a picture for everybody the resident." When asked lid be revised, LPN #3 changes." When asked was care planned for the tot have any physicians 1#3 stated, "Okay that care ated,"  ducted on 5/17/18 at 1:56 distrative staff member) #2, . When asked if a care plan a resident who did not have	F 6	<u> </u>			·
		one, ASM #2 stated, "Yes."					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	I ' '		CONSTRUCTION	L COMBLE	
			71. 20.20.			(	
		495217	B. WING		<u> </u>	05/	1 <b>7/2</b> 01 <b>8</b>
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	S-FAIR OAKS	•	124	REET AOORESS, CITY, STATE, ZIP COOE 175 LEE JACKSON MEMORIAL HIGHWAY IRFAX, VA 22033	ACKSON MEMORIAL HIGHWAY	
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F 657	documented, "A combe — reviewed and reteam after each assecomprehensive, quair review assessments."  No further information  1. Muscular dystroph (MD) refers to a groud diseases characterizmuscle loss that progof MD appear in infarothers may not appearage. This information https://www.nichd.nihdys  2. CPAP — It involves includes a mask or onose or your nose arthe mask, a tube that machine's motor, and the tube. CPAP is us breathing disorders it may be used to treat underdeveloped lung obtained from: https://www.nhlbi.nih4. The facility staff fa comprehensive care machine for Residen  *CPAP (continuous pron-ventilator technic and often improves the likely to help patients)	Prehensive care plan must evised by the interdisciplinary essment, including both the terly, and significant change "  In was provided prior to exit.  In was	F	957			

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OF DEFICIENCIES FCORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	IDENTIFICATION NUMBER			(X3) OATE SURVEY COMPLETEO	
	495217	B. WING			C E/17/2019	
ROVIDER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP CO	•	5/17/2018	
			12475 LEE JACKSON MEMORIAL HIG	SHWAY		
ARE HEALIH SERVICE	S-FAIR OAKS		FAIRFAX, VA 22033			
SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)		IO PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCEO TO TI	ON SHOULO BE HE APPROPRIATE	(X5) COMPLETION DATE	
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edema. (1)						
8/14/15 with a recer with diagnoses that to: end stage renal f (a procedure to rem failure in which wast removed from the bl (2), obesity, sleep a	nt readmission on 12/9/17, included but were not limited ailure requiring hemodialysis oved toxic condition and renal tes and impurities are ood by a special machine) pnea, stroke, high blood					
assessment, an ann assessment referen resident as scoring a interview for mental was capable of mak Resident #105 was assistance for most except eating in whi	aual assessment, with an ce date of 5/4/18, coded the a 15 on the BIMS (brief status score) indicating he ing daily cognitive decisions. coded as requiring extensive of his activities of daily living ch he only required					
with a revision on 4/ "Focus: Has/At risk related to sleep appropriet has transient breathing] during sle sore throat." The "In part, "C-PAP use per A CPAP machine was #105's room on 5/15 was conducted with	4/17, documented in part, for respiratory impairment ea (a condition in which the t periods of apnea [not eep) (3), cough, allergy and terventions" documented in r physician orders."  as observed in Resident 5/18 at 3:14 p.m. An interview Resident #105 on 5/15/18 at					
	ROVIDER OR SUPPLIER  SUMMARY S (EACH OEFICIEN REGULATORY OF  Continued From page edema. (1)  Resident #105 was 8/14/15 with a recer with diagnoses that to: end stage renal f (a procedure to rem failure in which wast removed from the bl (2), obesity, sleep a pressure, diabetes, disorder.  The most recent MD assessment, an ann assessment referen resident as scoring a interview for mental was capable of mak Resident #105 was assistance for most except eating in whis supervision after set The comprehensive with a revision on 4/ "Focus: Has/At risk: related to sleep appropriate thas transient breathing] during sleep appropriate thas transient breathing during sleep appropriate thas transient breathing. The "In part, "C-PAP use per A CPAP machine was #105's room on 5/15 was conducted with 3:14 p.m. When ask	ARE HEALTH SERVICES-FAIR OAKS  SUMMARY STATEMENT OF OFFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 127 edema. (1)  Resident #105 was admitted to the facility on 8/14/15 with a recent readmission on 12/9/17, with diagnoses that included but were not limited to: end stage renal failure requiring hemodialysis (a procedure to removed toxic condition and renal failure in which wastes and impurities are removed from the blood by a special machine) (2), obesity, sleep apnea, stroke, high blood pressure, diabetes, depression and seizure	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES-FAIR OAKS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 127 edema. (1)  Resident #105 was admitted to the facility on 8/14/15 with a recent readmission on 12/9/17, with diagnoses that included but were not limited to: end stage renal failure requiring hemodialysis (a procedure to removed toxic condition and renal failure in which wastes and impurities are removed from the blood by a special machine) (2), obesity, sleep apnea, stroke, high blood pressure, diabetes, depression and seizure disorder.  The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment, an annual assessment, with an assessment reference date of 5/4/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status score) indicating he was capable of making daily cognitive decisions. Resident #105 was coded as requiring extensive assistance for most of his activities of daily living except eating in which he only required supervision after set up assistance was provided.  The comprehensive care plan dated, 11/12/15 with a revision on 4/4/17, documented in part, "Focus: Has/At risk for respiratory impairment related to sleep apnea (a condition in which the patient has transient periods of apnea [not breathing] during sleep) (3), cough, allergy and sore throat." The "Interventions" documented in part, "C-PAP use per physician orders."  A CPAP machine was observed in Resident #105's room on 5/15/18 at 3:14 p.m. An interview was conducted with Resident #105 on 5/15/18 at 3:14 p.m. When asked if he uses the CPAP	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES-FAIR OAKS  SUMMARY STATEMENT OF DERICIENCIES (RACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 127 edema. (1)  Resident #105 was admitted to the facility on 8/14/15 with a recent readmission on 12/9/17, with diagnoses that included but were not limited to: end stage renal failure requiring hemocialysis (a procedure to removed toxic condition and renal failure in which wastes and impurities are removed from the blood by a special machine) (2), obesity, sleep apnea, stoke, high blood pressure, diabetes, depression and seizure disorder.  The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/4/18, coded the resident #105 was coded as requiring extensive assistance for most of his activities of daily living except eating in which he only required supervision after set up assistance was provided.  The comprehensive care plan dated, 11/12/15 with a revision on 4/4/17, documented in part, "Focus: Has/At risk for respiratory impairment related to sleep apnea (a condition in which the patient has transient periods of apnea (not breathing) during sleep) (3), cough, allergy and sore throat." The "Interventions" documented in part, "C-PAP use per physician orders."  A CPAP machine was observed in Resident #105s room on 5/15/18 at 3:14 p.m. An interview was conducted with Resident #105 on 5/15/18 at 3:14 p.m. When asked if he uses the CPAP	A BULLOING  A STREET ADDRESS, CITY, STATE, ZIP CODE  AND STREET ADDRESS, CITY, STATE, ZIP CODE  12475 LEE JACKSON MEMORIAL HIGHWAY FARFAX, VA 22033  SUMMARY STATEMENT OF CERCICINCIES (EACH OERCICINCY MIST ER PRECEDOE DE YPILL REGULATORY OR ISC IDENTIFYING INFORMATION)  CONTINUED From page 127 edema. (1)  Resident #105 was admitted to the facility on 8/14/15 with a recent readmission on 12/9/17, with diagnoses that included but were not limited to: end stage renal failure requiring hemodialysis (a procedure to removed from the blood by a special machine) (2), obesity, sleep apnea, stroke, high blood pressure, diabetes, depression and seizure disorder.  The most recent MDS (minimum data set) assessment, an annual assessment reference date of 5/4/18, coded the resident as corning a 15 on the BIMS (prief interview for most of his activities of daily living except eating in which he only required supervision on 4/4/17, documented in part, "Focus: Has/At risk for respiratory impariment related to sleep apnea (a condition in which the patient has transient periods of apnea [not breathing] during sleep) (3), cough, allergy and sore throat." The "Interventions" documented in part, "C-PAP use per physician orders."  A CPAP machine was observed in Resident #105 or on 5/15/18 at 3:14 p.m. An interview was conducted with Resident #105 or on 5/15/18 at 3:14 p.m. An interview was conducted with Resident #105 or of 15/18 at 3:14 p.m. An interview was conducted with Resident #105 or of 15/18 at 3:14 p.m. An interview was conducted with Resident #105 or of 15/18 at 3:14 p.m. An interview was conducted with Resident #105 or of 15/18 at 3:14 p.m. An interview was conducted with Resident #105 or of 15/18 at 3:14 p.m. An interview was conducted with Resident #105 or of 15/18 at 3:14 p.m. An interview was conducted with Resident #105 or of 15/18 at 3:14 p.m. An interview was conducted with Resident #105 or of 15/18 at 3:14 p.m. An interview was conducted with Resident #105 or of 15/18 at 3:14 p.m. An interview was conducted with Resi	

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STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G		(X3) OATE SURVEY COMPLETEO		
		495217	B. WING				
	ROVIDER OR SUPPLIER	-FAIR OAKS		STREET AOORESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHV FAIRFAX, VA 22033		05/1 <b>7/2018</b>	
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F 657	practical nurse) #3 on When asked why a re #3 stated, "It's how we When asked who use stated, "Anyone who of When asked who upd stated, "I would revise The MDS people upda LPN #3 was asked if the revised if a resident who LPN #3 stated, "Yes." stated, "We have to perform the resident which was asked to revie and stated there was #1 was asked to revie Resident #105. Once "The care plan should doesn't have an order An interview was conducted with LPN #3. "The care plan should doesn't have an order An interview was conducted with an order for a C-PAP could not find one. Whorder for a C-PAP matchine be on the care something I have to in	ducted with LPN (licensed 5/17/18 at 12:22 p.m. sident has a care plan, LPN e care for the resident." s the care plan, LPN #3 cares for the resident." ates the care plans, LPN #3 e it if something changed. At them and look at them." The care plan would be the care plan would be the rendered with the care plan would be the rendered with the care plan would be the rendered with the care plan would be the rendered with the care plan would be the rendered with the care plan would be the rendered was the physician orders and the physician orders no order for the use of a wed the physician orders no order for a C-PAP. LPN with the care plan for completed, LPN #1 stated, the be updated since he for it."  I ducted with RN (registered with the care plan for asked if the resident has machine, RN #5 stated he men asked if there is no chine, should the C-PAP re plan, RN #5 stated, "It's evestigate." When asked	F	657			
	"The care plan is the	are plans, RN #5 stated, engine of nursing care plan, we can't do				:	

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	OF OEFICIENCIES CORRECTION	(X I) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
		495217	B. WING_		C 05/17/2018
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET AOORESS, CITY, STATE, ZIP COOE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	00/11/2010
(X <b>4</b> ) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC (OENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTIO ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROP OEFICIENCY)	BE COMPLÉTION
F 657	the resident." When a plan, RN #5 stated, "plan, RN #5 stated, "plan."  On 5/17/18 at 5:08 p. writer and stated the Since it was discontinhave been updated.  The administrative standministrator, ASM #3, the quality a made aware of the abs. 5:52 p.m.  No further information (1) The Merck Manual 639.	ent. It guides us to care for asked who uses the care The nurses use the care	Fé	557	
F 658 SS=E	Non-Medical Reader, Chapman; page 266. (3) Barron's Dictionar Non-Medical Reader, Chapman; page 534. Services Provided Me CFR(s): 483.21(b)(3)(3)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	5th edition, Rothenberg and y of Medical Terms for the 5th edition, Rothenberg and eet Professional Standards (i) ehensive Care Plans d or arranged by the facility, inprehensive care plan,	Fé	The statement made on this pleasurection are not an admission not constitute an agreement with alleged deficiencies herein. To in compliance with all Federal a regulations, the center has take take the actions set forth in the plan of correction. The following constitutes the center's allegatic compliance such that all allege ficiencies have been or will be by the date indicated.	n to and do th the premain and State en or will following ng POC on of d de-
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FORM CMS-2567(02-99) Previous Versions Obsolele

Event (O: OJ2611

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NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-FAIR OAKS    STREET ACORESS, CITY, STATE, ZIP CODE 12476 LEE JACKSON MEMORIAL HIGHWAY FAIRRAX, VA 20033		OF DEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		PLE CONSTRUCTION  G	COM	
MANORCARE HEALTH SERVICES-FAIR CAKS  (X4) 10 PREFIX TAG  (X4) 10 PREFIX TAG  (X4) 10 PREFIX TAG  (X4) 10 PREFIX TAG  (X5) 10 SUMMARY STATEMENT OF OEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROPERTY AGE CONTINUED AND THE PROPERTY AGE CONTINUED AND THE PROPERTY AGE CONTINUED AND THE PROPERTY AGE COMPLETION SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE COMPLETION OF CROSS-REFERENCE OT THE APPROPRIATE COMPLETION OF CROSS-REFERENCE OT THE APPROPRIATE COMPLETION OF CROSS-REFERENCE OT THE APPROPRIATE COMPLETION OF CROSS-REFERENCE OT THE APPROPRIATE COMPLETION OF CROSS-REFERENCE OT THE APPROPRIATE COMPLETION OF CROSS-REFERENCE OT THE APPROPRIATE COMPLETION OF CROSS-REFERENCE OT THE APPROPRIATE COMPLETION OF CROSS-REFERENCE OT THE APPROPRIATE COMPLETION OF CROSS-REFERENCE OT THE APPROPRIATE COMPLETION OF CROSS-REFERENCE OT THE APPROPRIATE COMPLETION OF CROSS-REFERENCE OT THE APPROPRIATE COMPLETION OF CROSS-REFERENCE OT THE APPROPRIATE COMPLETION OF CROSS-REFERENCE OT THE APPROPRIATE COMPLETION OF CROSS-REFERENCE OT THE APPROPRIATE COMPLETION OF CROSS-REFERENCE OT THE APPROPRIATE COMPLETION OF CROSS-REFERENCE OT THE APPROPRIATE COMPLETE AND THE APPROPRIATE			<b>4952</b> 17	B. WING		.   .	-
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document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to follow professional standards of practice for seven of 48 residents in the survey sample, Residents #370, #37, #110 #427, #47, #105, and #97.  1. The facility staff failed to transcribe a physician's order for bacitracin to Resident #370's treatment administration record.  2. The facility staff failed to clarify Resident # 37's medication orders for metoprolol (1).  3. The facility staff failed to ensure the physician's order for a fluid restriction was documented for Resident #110.  4. Facility staff failed to store Resident #427's medication in a properly labeled container and to ensure the resident was self-administering the medication.  F 658  professional standards.  1. Resident #370 no longer resides in facility. Resident #37, medication order was clarified. Resident #110 documentation of fluid restriction was completed. Resident #427, medication was stored safely and returned to resident upon discharge. Resident #47, doctor was notified and order obtained for splint/ helmet. Resident #105, nurse was reeducated on not signing medications out for unavailable residents. Resident #97, doctor clarified medication.  2. All residents #370 no longer resides in facility. Resident #370 mo longer resides in facility. Resident #370 no longer resides in facility. Resident #370 mo longer resides in facility. Resident #370 mo longer resides in facility. Resident #370 mo longer resides in facility. Resident #370 mo longer resides in facility. Resident #370 mo longer resides in facility. Resident #370 mo longer resides in facility. Resident #370 mo longer resides in facility. Resident #370 mo longer resides in facility. Resident #370 mo longer resides in facility. Resident #370 mo longer resides in facility. Resident #370 mo longer resides in facility. Resident #370 mo longer resides in facility. Resident #370 mo longer resides in facility. Resident #370 mo longer resides in facility.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEOED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SECTIO	HOULO BE	COMPLETION
order for the use of a hand splint and a helmet for Resident #47.  6. The facility staff documented a medication was administered to Resident #105 when the resident was out of the facility for dialysis.  7. The facility staff failed to clarify two different pain medication's instructions for administration for Resident #97.  The findings include:  for residents who are not available.  4. DON and/or designee will complete five (5) random audits of residents EMAR to ensure that orders are transcribed correctly, instructions clarified, and documentation of resident when not available.  These audits will be done weekly x four (4) and then monthly x two (2).	F 658	document review, clir course of complaint ir determined that the fa professional standard residents in the surve #37, #110 #427, #47,  1. The facility staff fail physician's order for treatment administration and treatment administration orders for a fluid restrict Resident #110.  4. Facility staff failed from the resident with the re	aical record review and in the investigation, it was acility staff failed to follow as of practice for seven of 48 by sample, Residents #370, #105, and #97.  Ided to transcribe a pacitracin to Resident #370's ion record.  Ided to clarify Resident # 37's metoprolol (1).  Ided to ensure the physician's ection was documented for to store Resident #427's early labeled container and to was self- administering the ided to obtain a physician hand splint and a helmet for cumented a medication was dent #105 when the resident for dialysis.  Ided to clarify two different	F 6	1. Resident #370 no longer facility. Resident #37, medi was clarified. Resident #11 ation of fluid restriction was Resident #427, medication safely and returned to resid discharge. Resident #47, d notified and order obtained helmet. Resident #105, nureducated on not signing me out for unavailable residents. Resident #97, doctor clarified 2. All residents have the posifiected. 3. Licensed Nurses will be transcribing medications coinstructions before administications and not signing out for residents who are not as 4. DON and/or designee w five (5) random audits of residents who are residents who are residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits of residents who are not as 4. DON and/or designee w five (5) random audits	resides in cation order of document completed, was stored ent upon octor was for splint/rese was redications in the complete of the complete in the complete idents EM/anscribed ed, and document available.	on, of fying s

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING				C 17/2018	
NAME OF P	RÖVIDER OR SUPPLIER	L .		ST	FREET ADDRESS, CITY, STATE, ZIP CDDE	1 03/	-	
MANORC	ARE HEALTH SERVICE	S-FAIR OAKS			2475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033			
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F 658	#370's treatment address treatment address to the every 12 hours X (tir and RP (responsible A physician's order c part, "Bacitracin oint Bid (twice a day) till Resident #370's Aprimedication administration of the electronic treatment to reveal document and the every 12 hours X (tir and RP (responsible A physician's order c part, "Bacitracin oint Bid (twice a day) till Resident #370's Aprimedication administration (electronic treatment to reveal the physician's order of the electronic treatment to reveal documental medications were adorder).	bacitracin (1) to Resident ministration record.  admitted to the facility on 370's diagnoses included but labetes, high blood pressure Resident #370's most recent set), a five day Medicare ARD (assessment reference led the resident's cognitive on making as modified a difficulty in new situations  4/21/17 documented, MD (medical doctor) and MC (Discontinue) Flomax (2). to Left Arm open area BED bactrim (sic) DS (double t PO (by mouth) now and nes) 6 doses total. Patient	F	658	These audits will be forward Quality Assurance and Asse Committee for review and a appropriate. The committee termine need for further audiactions.  5. Date of compliance is June 1.00 per per per per per per per per per per	essment ction as will de- its and/o		

	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILO		ONSTRUCTION		X3) OATE SURVEY COMPLETEO	
		<b>4</b> 95217	B. WING	•			C	
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES			124	REET AOORESS, CITY, STATE, ZIP COOE 75 LEE JACKSON MEMORIAL HIGHWAY RFAX, VA 22033	<u>  US</u> /	17/2018	
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRI/ OEFICIENCY)		(X5) COMPLETION DATE	
F 658	document information the resident's left arm  On 5/17/18 at 1:13 p. conducted with RN (now as asked how staff of the physician's order should be on the MAF order should "pop up it is scheduled. RN # order for Resident #3 transcribed onto the office of the director of nursing above findings.  The facility document TREATMENT ADMIN documented, "Orders electronically entered nurse. The licensed responsible for accuratinitiation of orders"  No further information (1) Bacitracin is used injuries from becomin was obtained from the https://medlineplus.gottml  (2) Flomax is used to	m., an interview was egistered nurse) #1. RN #1 ensures a physician's order med. RN #1 stated the uld be entered into the hen asked if the order R or TAR, RN #1 stated the on the electronic TAR when 1 confirmed the physician's 70's bacitracin was not eMAR or eTAR.  m., ASM (administrative administrator) and ASM #2 g) were made aware of the titled, "MEDICATION AND ISTRATION GUIDELINES" are transcribed or then noted by the licensed nurse noting an order is ate transcription and was provided prior to exit. to prevent minor skin g infected. This information	F	658				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL <sup>-</sup> A, BUILOI		(X3) DATE SURVEY COMPLETED			
		495217	B. WING	B. WING		l	0
NAME OF PI	ROVIDER OR SUPPLIER	400211	5, , , , , ,	STRI	EET ADDRESS, CITY, STATE, ZIP CODE	J 05/	17/2018
					75 LEE JACKSON MEMORIAL HIGHWAY		
MANORCA	ARE HEALTH SERVICES	-FAIR OAKS		FAII	RFAX, VA 22033		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION OATE
F 658	Continued From page	133	F	558			
	https://medlineplus.go tml	ov/druginfo/meds/a698012.h					
	certain bacterial infect obtained from the well https://medlineplus.go tml	ov/druginfo/meds/a684026.h led to clarify Resident # 37's					
	10/31/16. Resident # were not limited to an dementia with behavion gastroesophageal refl	lux disease (5) and some or					
	set), a significant chan ARD (assessment ref- coded Resident # 37 a interview for mental st - 15, 99 - indicating the cognitive patterns was was coded as severel						
	2018 and signed by the documented, "Metopo (milligram). Give 0.5 the day for HTN (hyperter Hold for SBP (systolic pressure is given as 2	order sheet) dated May ne physician on 05/13/18 blol Tablet 25 MG ablet by mouth one time a nsion). 0.5 tablet=12.5 mg. blood pressure [blood numbers. The first number are in your blood vessels as					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		495217	B. WING_			C 05/1 <b>7/2</b> 01 <b>8</b>	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP COI 12475 LEE JACKSON MEMORIAL HIGI FAIRFAX, VA 22033		30, , , , 20 , 5	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES THE MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 658	the heart beats called	e 134 d systolic pressure] (7)) < dR (heart rate) < (less than)	F 6	558			
	records) dated March 2018 documented, "If (milligram). Give 0.5 day for HTN (hyperte Hold for SBP 120 and than) 60." Review of the eMAR documented: 03/05/18 - SBP 112 a 03/09/18 - SBP 118 a 03/19/18 - SBP 106 a 03/21/18 - SBP 119 a 03/28/18 - SBP 103 a	and HR 79 coded 5 (five). and HR 84 coded 5. and HR 83 coded 5. and HR 84 coded 5. and HR 72 coded 5. and HR 61 coded 5. eMAR dated March 2018 Codes. 5=Hold."					
	04/13/18 - SBP 115 a 04/22/18 - SBP 111 a 04/23/18 - SBP 118 a Review of the eMAR documented: 05/06/18 - SBP 117 a 05/16/18 - SBP 115 a On 05/17/18 at 8:56 a conducted with LPN 1. LPN # 1 was aske resident # 37 dated M 2018. When asked a	and HR 70 coded 5. and HR 73 coded 5. dated May 2018 and HR 77 coded 5.					

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) OATE SURVEY COMPLETEO	
		495217	B. WING	B. WNG		C	
NAME OF P	ROVIOER OR SUPPLIER	400211		STREET AOORESS, CITY, STATE, ZIP COOE		05/17/2018	
10 4112 01 11	TO THE TOTAL OF THE TELET			12475 LEE JACKSON MEMORIAL HIGHWA	Δ.		
MANORC	ARE HEALTH SERVICE	S-FAIR OAKS		FAIRFAX, VA 22033	``		
04/10	SUMMARYS	STATEMENT OF OFFICIENCIES	10	PROVIDER'S PLAN OF CORE	ECTION	OVE.	
(X4) IO PREFIX TAG	(EACH OEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI: TAG		HOULO BE	(X5) COMPLETION DATE	
F 658	Continued From pag	ge 135	F	658			
F 658	120 and HR (heart remedication metoproparameters needed medication. When a the medication when met, LPN # 1 stated eMARs dated 03/05/03/19/18, 03/21/18, 04/23/18, 05/06/18 a stated, "The medical LPN # 1 did not say physician's order be On 05/17/18 at 10:5 (administrative staff practitioner. After refor metoprolol and the 03/09/18, 03/14/18, 04/13/18, 04/22/18, 05/16/18 for Reside parameter should reblood pressure) < (legar trate) < (less the clarified the order. In On 05/17/18 at 3:50 conducted with ASM member) # 2, direct procedure for clarify # 2 stated, "If the nurrorder the nurse would artification of the order dated 03/05/18, 03/03/21/18, 03/28/18, 03/28/18, 03/21/18, 03/28/18, 03/2	rate) < (less than) 60" for the lol, LPN # 1 stated that both to be met to hold the asked if it was correct to hold in only one parameter was 1"No." After reviewing the 1/18, 03/09/18, 03/14/18, 03/28/18, 04/13/18, 04/22/18, and 05/16/18, LPN # 1 stion should have been given." anything about the sing clarified.  10 a.m., an interview with ASM member) # 6, nurse eviewing the physician's order the eMARs dated 03/05/18, 03/19/18, 03/21/18, 03/28/18, 04/23/18, 05/06/18 and 1 # 37, ASM # 6 stated, "The ead hold for SBP (systolic less than) 120 and/or HR han) 60, nursing should have	F (	558			
	·	should have been clarified." roximately 5:50 p.m. ASM					

		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) OATE SURVEY COMPLETEO	
			5 114110	D MANO		С	
		495217	B. WING			05/	17/2018
NAME OF P	ROVIOER OR SUPPLIER			\$1	TREET AOORESS, CITY, STATE, ZIP COOE		
MANORC	ARE HEALTH SERVICES	-FAIR OAKS		12	2475 LEE JACKSON MEMORIAL HIGHWAY		
				F/	AIRFAX, VA 22033		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL .SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION DATE
F 658	were made aware of the No further information References: (1) Used alone or in comedications to treat housed to prevent anging improve survival after also is used in combination medications to treat housed to prevent a class of medications works by relaxing block heart rate to improve	nember) # 1, the M # 2, director of nursing the findings.  n was provided prior to exit.  combination with other igh blood pressure. It also is a (chest pain) and to a heart attack. Metoprolol	F	658			
	from the website: http https://medlineplus.go tml  (2) Fear. This information website: https://www.nlm.nih.g #summary.  (3) High blood pressure obtained from the well https://www.nlm.nih.g essure.html.  (4) Psychological symabnormalities are concharacteristics of dem symptoms such as depsychosis, agitation, and sleep disturbance	ation was obtained from the ov/medlineplus/anxiety.html  are. This information was bsite: ov/medlineplus/highbloodpr  aptoms and behavioral mon and prominent hentia. They include aggression, anxiety aggression, disinhibition, as. Approximately 30% to dementia suffer from such					

PRINTED: 05/30/2018 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ C 495217 B. WING 05/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY MANORCARE HEALTH SERVICES-FAIR OAKS FAIRFAX, VA 22033 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 658 Continued From page 137 F 658 interactions between cognitive deficits, psychological symptoms, and behavioral abnormalities. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC31 81717/. (5) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (6) Severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing, or feeling something that is not there. This information was obtained from the website: https://medlineplus.gov/psychoticdisorders.html. (7) This information was obtained from the website: https://newsinhealth.nih.gov/2016/01/blood-press ure-matters 3. The facility staff failed to document the amount of fluids Resident #110 consumed to ensure the amount of fluids consumed was within the fluid restrictions ordered by the physician.

Resident #110 was admitted to the facility on 4/4/18 and readmitted on 4/20/18 with diagnoses that included but were not limited to: chronic heart failure, anemia, heart attack and high cholesterol.

PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495217	B. WNG_	B. WING		C 05/17/2018		
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS		12 <b>4</b> 75 LI	ADDRESS, CITY, STATE, ZIP CODE EE JACKSON MEMORIAL HIGHWAY X, 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 658	with an ARD of 5/3/18 having scored a 12 printerview for mental signs was moderately imparesident was coded a staff for all activities of eating which the resident was set up.  Review of the May 20 documented, "Fluid Review of the May 20 treatment administrated in the evidence documentated in the evidence documentated fluid restriction.  Further review of the evidence documentated fluid restriction.  An interview was conformated asked what about the resident on a fluid restriction. The nursing and certain a nurse monitors how in When asked if the amis documented, LPN (name of software)." I Resident #110's MAR LPN #8 stated, "They showing up on her Mare asked in the mental stated, "They showing up on her Mare asked in the stated, "They showing up on her Mare asked in the stated, "They showing up on her Mare asked in the stated, "They showing up on her Mare asked in the stated, "They showing up on her Mare asked in the stated, "They showing up on her Mare asked in the stated, "They showing up on her Mare asked in the stated, "They showing up on her Mare asked in the stated, "They showing up on her Mare asked in the state	S, a 14 day assessment, a coded the resident as at of 15 on the BIMS (brief tatus) indicating the resident ired cognitively. The sequiring assistance from a faily living except for dent could perform after the could perfor	F	558				

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

Event ID; OJ2611

Facility ID: VA0153

If continuation sheet Page 139 of 222

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STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION  (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILOING			(X3) OATE SURVEY COMPLETEO	
		495217	B. WING			05/	) 1 <b>7/2</b> 01 <b>8</b>
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS	!	STREET ADORESS, CIT 12475 LEE JACKSON FAIRFAX, VA 22033	MEMORIAL HIGHWAY	1 001	1172010
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULO B ERENCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION DATE
F 658	An interview was coma.m. with RN (register manager. When aske staff follows for a resirence of the follows for a resirence of the follows for a resirence of the follows for a resirence of the follows for a resirence of the follows for a resirence of the follows the follows the follows the follows the follows the follows of the follows the follows of the follows of the follows of the follows of the follows of the facility's RESTRICTIONS" did documenting the residuation of follows of the follows of the facility staff fair medication in a proper failed to ensure the readministering the medication of the follows of the facility register of the follows of the facility staff fair medication in a proper failed to ensure the readministering the medication of the facility register of the facility of the facility staff fair medication in a proper failed to ensure the readministering the medication of the facility register of the facility	ducted on 5/18/18 at 9:12 red nurse) #2, the unit d what about the process dent on a fluid restriction, urses keep track of it and uter for them to see and what they are supposed to d to review Resident #110's y 2018. RN #2 stated, "It's ing here." When asked if a resident was within the #8 stated, "No."  a.m. ASM (administrative director of nursing was dings.  a policy titled, "FLUID not specifically address dent's intake of fluids.  a was obtained prior to exit.  led to store Resident #427's rrly labeled container and esident was self- dication.  dmitted to the facility on a that included but were not nee replacement, bipolar cle weakness.  excent MDS (minimum data sessment, with an ARD are date) of 5/10/18 coded g scored a 15 out of 15 on	F	558			

STATEMENT OF DEFICIENCIES (X ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) OATE SURVEY COMPLETEO	
		495217	B. WING	B. WING			C 1 <b>7/2</b> 01 <b>8</b>	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		124	EET ADORESS, CITY, STATE, ZIP COOE 75 LEE JACKSON MEMORIAL HIGHWAY RFAX, VA 22033	1 03/	11720   0	
(X4) IO PREFIX TAG	(EACH OEFICIEN	STATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCED TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION DATE	
F 658	make daily decision requiring assistance daily living.  Review of the May 2 documented, "Comp MG (milligrams) Giv a day for Antiviral ur self-administration. In home."  Review of the May 2 administration recorn Tablet 200-25-300 Mby mouth one time a unsupervised self-action had bee.  An interview was copp.m., with RN (regis resident's day shift recess staff follows self-administering the stated, "We get a dochow staff knew if the medication, RN #10 if Resident #427 wa ordered, RN #10 stated, was self-administering the resident's MAR and was self-administering the staff were giving the #10 stated, "We have manager was trying manager was trying the self-administering the #10 stated, "We have manager was trying the manager was trying the self-administering the #10 stated, "We have manager was trying the self-administering the manager was trying the self-administering the #10 stated, "We have manager was trying the self-administering the manager was trying the self-administering the manager was trying the self-administering the manager was trying the self-administering the self-administering the manager was trying the self-administerin	ant was cognitively intact to as. The resident was coded as a from staff for all activities of a from staff for all activities of a from staff for all activities of a from staff for all activities of a from staff for all activities of a formal activities of a from staff for all activities of a from a f	F	558				

CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION IG		(X3) DATE COMP	SURVEY
		495217	B. WNG_		<u></u>	1	C / <b>17/2</b> 0 <b>18</b>
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS			, CITY, STATE, ZIP CODE SON MEMORIAL HIGHWAY 2033	, 56	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	a.m. with RN #2, the process staff follows self-administered the "We assess to make medication safely." We the medication was the #2 stated, "He (Resid medication with him a us. We don't usually a bring in their medication verified the medication "I did. I googled it. We his medication locked On 5/18/18 at 8:40 a. see the resident's me medication bottle with the way. RN #2 state when I told him I was right upper comer wiresident's name. At the "Aripiprazole (3) 5 mg the name of the mediself-administering. The were peach colored a imprinted on it. An Interview was deter #2 was asked how stamedication. RN #2 did An interview was con a.m. with LPN #8, the asked how she knew resident had was Corwas told." When asked stated, "The resident	unit manager, regarding the when a resident ir medication. RN #2 stated, sure they can take the then asked if staff ensured aken, RN #2 stated yes. RN tent #427) had his and didn't want to give it to allow them (residents) to ion." When asked who in was correct, RN #2 stated, a give it to him now so I have I up."  m., a request was made to dication. RN #2 brought a in the label torn off most of id, "The resident tore it off going to lock it up." In the ten in pencil was the ine bottom of the label was, if (milligrams)." This was not cation the resident was the tablets inside the bottle and oblong with a "GSI" ernet look up on "Pill finder" he surveyors and the mined to be Complear. RN aff would know that the dele was the correct	F	558			

PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391

	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		IPLE CONSTRUCTION		OATE SURVEY COMPLETEO
		495217	B. WING_			C
NAME OF PI	ROVIDER OR SUPPLIER	100211		STREET AOORESS, CITY, STATE, ZIP COOE	l :	05/17/2018
MANORCA	ARE HEALTH SERVICI	ES-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHV FAIRFAX, VA 22033	VAY	
(X4) IO PREFIX TAG	(EACH DEFICIEN	STATEMENT OF OEFICIENCIES ICY MUST BE PRECEOEO BY FULL R LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE A OEFICIENCY)	SHOULO BE	IX5) COMPLETION OATE
F 658	him, I believe he ha asked what she did medication was the "If I'm uncomfortabl manager."  On 5/18/18 at 9:12 and stated, "Come have gotten a corre  On 5/18/18 at 11:15 staff member) #1, the director of nursi findings.  Review of the facilit "SELF-ADMINISTR documented, "To exconsistently take the appropriate time, a taking their medicate. No further informatication, that look or sound a container labeling, in deficits, and inapprodesign. This information, this information in the selection of the selection. In the selection of t	me. I didn't want to argue with d some bi-polar." When if she was not sure the correct one, LPN #8 stated, e I always contact my unit  a.m. RN #2 came to this writer to think about it we should ct label (on the bottle)."  b a.m. ASM (administrative ne administrator and ASM #2, ng were made aware of the	Fe	558		
		e adolescence or early symptoms can begin at any				

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

Evenl IO: 0J2611

Facility IO: VA0153

If continuation sheet Page 143 of 222

JUN 2 2 2018 VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495217	B. WING	<u> </u>	,	C 5/17/2018	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW FAIRFAX, VA 22033		•	3/11/20 (8	
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	time of life. This informattps://ghr.nlm.nih.gov.  2. Complear — Complemedicine approved by Administration (FDA) infection in adults and and older who have report and who have RNA copies per mL or copies/mL or less. The from:  https://aidsinfo.nih.govent  3. Aripiprazole Ariptogether with other maconditions such as, bitomanic-depressive) Tobtained from: https://www.ncbi.nlm.T0000157/  5. The facility staff faitorder for the use of a Resident #47.  Resident #47 was add 4/3/18 with diagnoses limited to: subdural he blood beneath the duarachnoid membrane brain) (1), status post (paralysis on one side disorder) a mental disdisorder) a mental disdisorder)	mation was obtained from: v/condition/bipolar-disorder  lera is a prescription y the U.S. Food and Drug for the treatment of HIV d children 12 years of age sever taken HIV medicines a viral load (number of HIV f blood) of 100,000 is information was obtained v/drugs/441/complera/0/pati  biprazole is used alone or edicines to treat mental ipolar I disorder	F 68	58			

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA (X2) MULT IOENTIFICATION NUMBER: A. BUILON		IPLE CONSTRUCTION NG		(X3) OATE SURVEY COMPLETEO	
		495217	B. WING			C 05/17/2018	
NAME OF P	ROVIOER OR SUPPLIER		1	STREET AOORESS, CITY, STATE, ZIP COOR		05/17/	/2018
	ARE HEALTH SERVICES	-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHN FAIRFAX, VA 22033			
(X4) IO PREFIX TAG			IO PREFI; TAG	(EACH CORRECTIVE ACTION	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)		(X5) COMPLETION DATE
F 658	The most recent MDS assessment, an admi assessment reference resident as scoring a interview for mental s was severely impaired decisions. The reside extensive assistance members to being tot more staff members fliving. In Section J - Fresident was coded a without injury, since a 4/3/18.  Observation was made the initial tour of the faapproximately 11:30 a being assisted by a stand hand splint on the again made of Reside a.m. The resident was Geri-chair. He had a his left hand.  Review of the clinical physician order for the Review of the compres 4/4/18, failed to evide to the use of a hand shelmet. The care plant in part, "Focus: Surgic head due to cranioton documented, "Adminiphysician orders. Repsuch as purulent drain	signification (a) series of the member with helmet on eleft hand. Observation was ent #47 on 5/16/18 at 8:23 in the dining room in a helmet on and a splint on record, failed to evidence a e helmet or the splint.	F	658			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495217	B. WING _			C 05/17/2018	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, 12475 LEE JACKSON MEMORIA FAJRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IĐ PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BI D TO THE APPROPRIA CIENCY)		
F 658	Helmet at all times (F An interview was commember (OSM) #11, on 5/16/18 at 1:23 p.r should be a physician splint, OSM #11 state to say how many hou off, daytime or nighttin An interview was comphysical therapist, on asked if there should helmet, OSM #12 state the orders for that.  An interview was commursing assistant) #10 When asked how held evices a resident ne "Splints, they either corders it." When asked CNA #10 stated, "The resident needs it for a apply it at all times, in how he knows this, Chave to tell us and the system." When asked supposed to be used, it should be on at all the An interview was compractical nurse) #1, or #1 was asked if there needed for splints. LF	ducted with other staff the occupational therapist, m. When asked if there in for a resident wearing a d, "It should have an order rs on and how many hours me use."  ducted with OSM #12, the 5/16/18 at 1:26 p.m. When be an order for the use of a ted that nursing should do  ducted with CNA (certified 0, on 5/16/18 at 1:30 p.m. knows what type of assistive eds, CNA #10 stated, ome here with it or therapy d about the use of a helmet, ere should be an order if the purpose. I was told to chair, in bed." When asked NA #10 stated, "The nurses ere is a kardex in the I when the splint is CNA #10 stated, "I was told imes."  ducted with LPN (licensed in 5/16/18 at 1:59 p.m., LPN a physician's order was PN #1 stated, "Yes, it should	F 6				
	supposed to be used, it should be on at all the An interview was compractical nurse) #1, or #1 was asked if there needed for splints. LF say why, the frequence	CNA #10 stated, "I was told imes."  ducted with LPN (licensed n 5/16/18 at 1:59 p.m., LPN a physician's order was					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING	B. WING		C 05/17/2018		
NAME DF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	17/2016	
MANORC	ARE HEALTH SERVICES	S-FAIR NAKS		1:	2475 LEE JACKSON MEMORIAL HIGHWAY			
MANORO	ARE HEALTH SERVICES			F	AIRFAX, VA 22033			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			IX5) COMPLETION OATE	
F 658	Continued From pag	e 146	F	658				
	use of a helmet. LPN asked what the order stated, "It should have the helmet should be asked to pull up Resion her computer. Whorder for a helmet or have it on the kardex and nurses see that, important for Resider LPN #1 stated, "The frequent falls. It's to head." When asked helmet is checked, Levery shift and PRN asked if there should	be a physician order for the I #1 stated, "Yes." When it is should include, LPN #1 we why he has it, and when it on and off." LPN #1 was ident #47's physician orders iten asked if she saw an splint, LPN #1 stated, "We it under the tasks, the CNA" When asked why it is int #47 to have his helmet. The helmet is because he has prevent him from hitting his into most offen the skin under the PN #1 stated, "Frequently, (as needed)." LPN #1 was be an order for Resident stated yes, there should be						
	nurse) #5, the unit m p.m. When asked if a for the use of a helm When asked why Re helmet, RN #5 stated He had surgery on hi Resident #47 should stated, "Anytime he i on." When asked if a there be an order, RI asked what the order "To be applied at all the things of the administrator, ASM #ASM #3, the quality asked was the quality as a sked was the administrator.	aff member (ASM) #1, the t2, the director of nursing and assurance consultant, were						
	"To be applied at all the administrative standministrator, ASM #ASM #3, the quality a	aff member (ASM) #1, the 2, the director of nursing and						

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STATEMENT OF OEFtCtENCTES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLTA (X2) MULTIPLE CONSTRUCTION tOENTIFICATION NUMBER:  A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495217	B. WING		-		C 05/17/2018	
	ROVIDER OR SUPPLIER	S-FAIR OAKS		٠	STREET AODRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	1 03	1112016	
(X4) tO PREFtX TAG				tO PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCEO TO THE APPROPR OEFICIENCY)		BE	(X5) COMPLETION DATE	
F 658	Continued From pag	ge 14 <b>7</b> on was provided prior to exit.	F	658	3			
	Non-Medical Reade Chapman; pages 26 (2) Barron's Diction Non-Medical Reade Chapman; page 266 (3) Barron's Diction	ary of Medical Terms for the r, 5th edition, Rothenberg and						
	-	ocumented a medication was ident #105 when the resident y for dialysis.						
	8/14/15 with a recer with diagnoses that to: end stage renal f (a procedure to rem failure in which wast removed from the bl (1), obesity, sleep a	admitted to the facility on at readmission on 12/9/17, included but were not limited failure requiring hemodialysis oved toxic condition and renal less and impurities are ood by a special machine) pnea, stroke, high blood depression and seizure						
	assessment, an ann assessment referen resident as scoring a interview for mental was capable of mak Resident #105 was	OS (minimum data set) rual assessment, with an ce date of 5/4/18, coded the a 15 on the BIMS (brief status score) indicating he ing daily cognitive decisions. coded as requiring extensive of his activities of daily living ch he only required						

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Event tD: OJ2611

Facitity tO: VAD153

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		495217	B. WING_			C 0 <b>5/17/2</b> 018	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZI 12475 LEE JACKSON MEMORIAI FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES  ID  PROVIDER'S PLAN OF CORRECTION  ACH DEFICIENCY MUST BE PRECEDED BY FULL  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATI  DEFICIENCY)			ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 658	supervision after set The physician order "Renvela* Tablet 80t tablet by mouth three (chronic kidney disea Monday, Wednesda  *Renvela® (sevelam the control of serum chronic kidney disea Review of the May 2 administration record Tablet 800 MG; Give times a day for CKD Monday, Wednesday medication was docu administered on 5/16 The comprehensive documented in part, related to: ESRD (er "Interventions" docum medications per phy  It was reported to thi practical nurse) #1, to dialysis on 5/16/18 a was observed return at 11:00 a.m.  An interview was con practical nurse) #1 of asked when Resider #1 stated the resider Wednesday and Fric	up assistance was provided.  dated, 4/12/18 documented, 0 MG (milligrams); Give 2 e times a day for CKD ase), Hold during dialysis y and Friday."  er carbonate) is indicated for phosphorus in patients with se (CKD) on dialysis. (2)  018 MAR (medication d) documented, "Renvela* 2 tablet by mouth three , Hold during dialysis y and Friday." The umented as having been 6/18 at 9:00 a.m.  care plan dated, 4/27/17, "Focus: Renal insufficiencies id stage renal disease)." The mented in part, "Administer	F	658			

NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-FAIR OAKS  TAIS  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 658  C Ontinued From page 149 around 11:00 a.m. LPN #1 was asked to read Resident #105's Renvela order. LPN #1 was then asked to review the MAR for 5/16/18 for the Renvela. When asked if she gave the Renvela on 5/16/18 at 9:00 a.m. LPN #1 stated, "No, I did not give that medication." When informed the medication was signed off as administered, LPN #1 stated, "That's a problem."  The facility policy, "Medication and Treatment Administration Guidelines" documented in part, "Medications and treatments administered are	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
MANORCARE HEALTH SERVICES-FAIR OAKS  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 658  Continued From page 149  around 11:00 a.m. LPN #1 was asked to read Resident #105's Renvela order. LPN #1 stated, "No, I did not give that medication." When informed the medication was signed off as administered, LPN #1 stated, "That's a problem."  The facility policy, "Medication and Treatment Administration Guidelines" documented in part,			495217	B. WNG_	B. WING		-	
F 658  Continued From page 149 around 11:00 a.m. LPN #1 was asked to read Resident #105's Renvela order. LPN #1 was then asked to review the MAR for 5/16/18 for the Renvela. When asked if she gave the Renvela on 5/16/18 at 9:00 a.m. LPN #1 stated, "No, I did not give that medication." When informed the medication was signed off as administered, LPN #1 stated, "That's a problem."  The facility policy, "Medication and Treatment Administration Guidelines" documented in part,	-		S-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHW		03/1/2016	
around 11:00 a.m. LPN #1 was asked to read Resident #105's Renvela order. LPN #1 was then asked to review the MAR for 5/16/18 for the Re nvela. When asked if she gave the Renvela on 5/16/18 at 9:00 a.m. LPN #1 stated, "No, I did not give that medication." When informed the medication was signed off as administered, LPN #1 stated, "That's a problem."  The facility policy, "Medication and Treatment Administration Guidelines" documented in part,	PREFIX	( EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	( (EACH CORREC CROSS-REFEREN	CTIVE ACTION SHDULD BE NCED TO THE APPROPRIATE	COMPLETION	
documented immediately following administration or per state specified standards. The licensed nurse is responsible for validating documentation is completed for any medication administered during the shift."  According to "Fundamentals of Nursing", Seventh Edition, 2009: by Perry and Potter Chapter 35 "Medication Administration" Chapter 35, pg 707 read: "Professional standards, such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration, the six rights of medication administration include the following: 1. The right medication, 2. The right dose, 3. The right client, 4. The right route, 5. The right time, and 6. The right documentation."  The administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant, were	F 658	around 11:00 a.m. L Resident #105's Rer asked to review the Renvela. When aske 5/16/18 at 9:00 a.m. give that medication medication was sign #1 stated, "That's a p The facility policy, "N Administration Guide "Medications and tre documented immedi or per state specified nurse is responsible is completed for any during the shift."  According to "Funda Edition, 2009: by Pe "Medication Administre ad: "Professional s American Nurses As and Standards of Nuto the activity of medication administry ou administer medicerrors can be linked, inconsistency in adh medication administr medication administr The right medication right client, 4. The rig and 6. The right doce The administrative st administrator, ASM #	LPN #1 was asked to read ovela order. LPN #1 was then MAR for 5/16/18 for the ed if she gave the Renvela on LPN #1 stated, "No, I did not "When informed the ed off as administered, LPN problem."  Medication and Treatment elines" documented in part, fatments administered are ately following administration distandards. The licensed for validating documentation medication administered  mentals of Nursing", Seventh for yand Potter Chapter 35 tration" Chapter 35, pg 707 standards, such as the sociation's Nursing: Scope arising Practice (2004) apply dication administration. To errors, follow the six rights ration consistently every time cations. Many medication in some way, to an ering to the six rights of ration. The six rights of ration include the following: 1. , 2. The right dose, 3. The ght route, 5. The right time, umentation."	F	558			

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STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULT. A. BU)LO)N	LTIPLE CONSTRUCTION DING			(X3) OATE SURVEY COMPLETEO		
		495217	B. WING_	B. WING		C 05/17/2018			
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICE	S-FAIR OAKS		STREET AOORESS, CITY, STATE, ZIP COOE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033					
(X4) )O PREF)X TAG	SUMMARY STATEMENT OF DEPICIENCIES )D (EACH OEFICIENCY MUST BE PRECEDED BY FULL PREF). REGULATORY OR LSC (DENT)FY)NG (NFORMAT)ON) TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULO BE E APPROPR) A		)XS) COMPLETION DATE			
F 658	Continued From pag	ge 150	F6	658					
	made aware of the a 5:52 p.m.	above concern on 5/17/18 at							
	No further information was provided prior to exit.								
	Non-Medical Reade Chapman; page 266 (2) This information following website: https://dailymed.nlm	ary of Medical Terms for the er, 5th edition, Rothenberg and 5. was obtained from the n.nih.gov/dailymed/drugInfo.cf ea2e5-4a82-9ca2-7dfef56b63b							
		ailed to clarify two different structions for administration							
	4/9/18 with a readm diagnoses that inclu sepsis (destruction of contamination, infect (paralysis of the low amputation, pressur	dmitted to the facility on dission on 4/24/18 with ded but were not limited to: of tissue by bacterial toxins, ction) (1), paraplegia for limbs) (2), below the knees the ulcer and osteoarthritis ges in the joints) (3).							
	assessment, a Medi with an assessment coded the resident a (brief interview for m she was moderately daily decisions. The requiring extensive a staff members for al	DS (minimum data set) icare 14 day assessment, reference date of 5/6/18, as sconng a 12 on the BIMS mental status) score, indicating rimpaired to make cognitive resident was coded as assistance of one or more Il of her activities of daily living ch she required supervision							

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E (X5) COMPLETION DATE	

		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL1 A, BUILOI	TIPLE CONSTRUCTION NG		(X3) OATE SURVEY COMPLETEO		
		495217	B. WING			C 5/1 <b>7/20</b> 18		
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	S-FAIR OAKS		STREET AOORESS, CITY, STATE, ZI 12475 LEE JACKSON MEMORIAI FAIRFAX, VA 22033	IP COOE	11/2010		
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI TAG		ACTION SHOULO BE TO THE APPROPRIATE	(X5) COMPLETION OATE		
F 658	5/14/18 at 2:07 p.m 5/17/18 at 4:39 p.m An interview was connurse) #13 on 5/18/13 asked to read both th Tylenol orders. When should be given, RN: the resident their pair medications. Both of clarified. They are now hat level of pain."  On 5/18/18 at 8:55 a. conducted with admir (ASM) #2, the directo asked to review the TASM #2 read the orders need to be clathe nurse's scope of pto give unless the phy parameters, ASM #2  ASM #1, the administ of nursing, ASM #3, to consultant, and ASM another facility in the aware of the above fin p.m.  No further information (1) Barron's Dictionary	pain level - 3 ducted with RN (registered 8 at 8:45 a.m. RN #13 was e Tramadol order and the asked which medication #13 stated, "First you ask a level. Then review the these orders need to be of clear as to what to give for m., an interview was histrative staff member of nursing. ASM #2 was ramadol and Tylenol orders. ers and stated, "These riffied." When asked if it is in practice to decide which one visician has specific stated, "You are correct."	F	658				
	Non-Medical Reader, Chapman; page 435.	y of Medical Terms for the 5th edition, Rothenberg and y of Medical Terms for the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WNG_	B. WING		C 05/1 <b>7/20</b> 1 <b>8</b>		
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	00/	1772018	
BEA NODC	ARE HEALTH SERVICES	EVID UVRG	12475 LEE JACKSON MEMORIAL HIGHWAY					
MANORO	RRE HEALTH SERVICES			FA	IRFAX, 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION OATE	
F 658	Continued From page	÷ 153	F6	58				
	Chapman; page 422. (4) This information w following website:	nih.gov/pubmedhealth/P <b>MH</b>						
F 684 SS=D	•	F 684 The statement made on this pla				o and d	0	
	applies to all treatment facility residents. Base assessment of a resident residents receive accordance with professor practice, the compreherance plan, and the resident processor plan, and the resident processor plan, and the resident plan for one of a sample, Resident #37. The facility staff failed 37's metoprolol (1) per the findings include:  Resident # 37 was ad 10/31/16. Resident # 47.	andamental principle that and care provided to sed on the comprehensive dent, the facility must ensure treatment and care in sessional standards of sensive person-centered sidents' choices.  is not met as evidenced  ew, facility document cord review, the facility staff sents received treatment and se with professional and the comprehensive 8 residents in the survey  to administer Resident # or the physician order.  mitted to the facility on 37's diagnoses included but exiety (2), hypertension (3), oral disturbances (4),			alleged dficiencies herein. To recompliance with all Federal and 3 regulations, the center has taken take the actions set forth in the forplan of correction. The following constitutes the center's allegation compliance such that all alleged deficiencies cited have been or work corrected by the date indicated.  It is the practice of the facility sure residents receive treatmes services in accordance with prostandards of practice and complements are plans.	State or will ollowing POC of of vill be to en- ent and ofessio		

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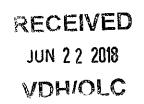
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495217	B. WING_			C 05/17/2018	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033				
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		_
F 684	Resident #37's most set), a significant cha ARD (assessment recoded Resident # 37 interview for mental s - 15, 99 - indicating the cognitive patterns was coded as being a cognition for making 37 was coded as regione staff member for The POS (physician's 2018 and signed by the documented, "Metopic (milligram). Give 0.5 ft day for HTN (hyperte Hold for SBP (systolic pressure is given as 2 represents the pressute heart beats called (less than) 120 and H 60."  The eMARs (electron records) dated March 2018 documented, "Milligram). Give 0.5 ft day for HTN (hyperte Hold for SBP (systolic than) 120 and HR (here Review of the eMAR documented:	s not due to a substance or condition (6).  recent MDS (minimum data nge assessment with an ference date) of 03/23/18 as scoring a 99 on the brief tatus (BIMS) of a score of 0 ne staff assessment for scompleted. Resident # 37 severely impaired of daily decisions. Resident # uiring limited assistance of activities of daily living.  sorder sheet) dated May ne physician on 05/13/18 colol Tablet 25 MG (ablet by mouth one time a nision). 0.5 tablet=12.5 mg. colood pressure [blood 2 numbers. The first number are in your blood vessels as a systolic pressure] (7)) < IR (heart rate) < (less than)  ic medication administration and (2018, April 2018 and May Metopolol Tablet 25 MG (ablet by mouth one time a nision). 0.5 tablet=12.5 mg. colood pressure) < (less than) dated March 2018  and HR 79 coded 5 (five).	Fé	1. Resident #37, order was clarified 2. All residents ha affected. 3. Licensed nurse administer medica 4. DON and/or de random audits of Emedications are acorders. These aux four (4) and then The results of the forwarded to the Cand Assessment Coreview and action The committee will for further audits a 5. Date of compliance.	I.  ave the p es will be ations per esignee v EMAR/E dminister dits will be n monthly se audits Quality As Committe as appro Il determind/or ac	otential to be re-educated to redoctor order. vill complete 5 TAR to ensure red per doctor weekly x two (2). will be ssurance see for opriate. ine need tion.	

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ C 495217 B. WING 0**5**/1**7/2**01**8** NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY MANORCARE HEALTH SERVICES-FAIR OAKS FAIRFAX, VA 22033 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY F 684 Continued From page 155 F 684 03/14/18 - SBP 118 and HR 83 coded 5. 03/19/18 - SBP 106 and HR 84 coded 5. 03/21/18 - SBP 119 and HR 72 coded 5. 03/28/18 - SBP 103 and HR 61 coded 5. Further review of the eMAR dated March 2018 documented, "Chart Codes. 5=Hold." Review of the eMAR dated April 2018 documented: 04/13/18 - SBP 115 and HR 88 coded 5. 04/22/18 - SBP 111 and HR 70 coded 5. 04/23/18 - SBP 118 and HR 73 coded 5. Review of the eMAR dated May 2018 documented: 05/06/18 - SBP 117 and HR 77 coded 5. 05/16/18 - SBP 115 and HR 80 coded 5. The care plan for Resident # 37 with a target date of 07/21/2018 documented, "Focus, Cardiac disease related to Hyperlipidemia, Hypertension." Under "Interventions" it documented, "Administer medication per physician orders. Date initiated: 11/01/2016," On 05/17/18 at 8:56 a.m., an interview was conducted with LPN (licensed practical nurse) # 1. LPN # 1 was asked to review the eMARs for resident # 37 dated March and April and May 2018. When asked about the parameters of Hold for SBP (systolic blood pressure) < (less than) 120 and HR (heart rate) < (less than) 60" for the medication metoprolol, LPN # 1 stated that both parameters needed to be met to hold the

medication. When asked if it was correct to hold the medication when only one parameter was met LPN # 1 stated "No." After reviewing the eMARs dated 03/05/18, 03/09/18, 03/14/18, 03/19/18,

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		495217	B. WNG			C 05/17/2018	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW. FAIRFAX, VA 22033		03/11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHDULI		HDULD BE	(X5) COMPLETION DATE			
F 684	03/21/18, 03/28/18, 0 05/06/18 and 05/16/1 medication should ha asked if the physician # 1 stated, "No."  On 05/17/18 at 3:50 p conducted with ASM member) # 2, director procedure for followin ASM # 2 was asked t resident # 37 dated M 2018. When asked a for SBP (systolic blood 120 and HR (heart ra medication metoprolod parameters needed to medication. When as the medication when met, ASM # 2 stated eMARs dated 03/05/203/19/18, 03/21/18, 0 04/23/18, 05/06/18 ar "The medication shou asked if the physician 2 stated, "No."  The facility document TREATMENT ADMIN documented, "Medica accordance with stan specific and federal g  On 05/17/18 at appro (administrative staff in administrator and ASI were made aware of	4/13/18, 04/22/18, 04/23/18, 8, LPN # 1 stated, "The ve been given." When it's order was followed, LPN  b.m., an interview was (administrative staff of nursing regarding the get the physician's orders. The oreview the eMARs for farch and April and May bout the parameters of Hold depressure) < (less than) to the less than of the	F6	84			

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Event ID: OJ2611

Facility ID: VAD153

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STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		IOENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) OATE SURVEY COMPLETEO	
		495217	B. WING _				C / <b>17/2</b> 0 <b>18</b>	
	ROVIOER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET AOORESS, CITY, STATE, ZIP COOE 12475 LEE JACKSON MEMORIAL HIGHW FAIRFAX, VA 22033		1 50/	172010	
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F 684	medications to treat used to prevent ang improve survival after also is used in combined medications to treat a class of medication works by relaxing ble heart rate to improve blood pressure. This from the website: https://medlineplus.gtml  (2) Fear. This information website: https://medlineplus.gtml  (2) Fear. This information website: https://www.nlm.nih#summary.  (3) High blood press obtained from the website: https://www.nlm.nihessure.html.  (4) Psychological sy abnormalities are concharacteristics of desymptoms such as opsychosis, agitation, and sleep disturbance 90% of patients with behavioral disorders interactions between psychological symptoms.	combination with other high blood pressure. It also is ina (chest pain) and to er a heart attack. Metoprolol bination with other heart failure. Metoprolol is in a called beta blockers. It bood vessels and slowing a blood flow and decrease information was obtained aps: gov/druginfo/meds/a682864.h anation was obtained from the gov/medlineplus/anxiety.html  sure. This information was ebsite: gov/medlineplus/highbloodpr  mptoms and behavioral mmon and prominent mentia. They include depression, anxiety aggression, disinhibition, aggression, disinhibition, aggression, disinhibition, aggression, disinhibition, aggression, disinhibition, aggression, disinhibition, aggression, disinhibition, aggression, disinhibition, aggression, disinhibition, aggression, disinhibition, aggression, disinhibition, aggression, auxiety aggression, disinhibition, aggression, disinhibition, aggression, disinhibition, aggression, disinhibition, aggression, auxiety aggression, disinhibition, aggression, disinhibition, aggression, auxiety aggression, disinhibition, aggression, disinhibition, aggression, auxiety aggression, disinhibition, aggression, auxiety aggression, disinhibition, aggression, auxiety aggression, disinhibition, aggression, auxiety aggression, disinhibition,	F	584				
	from the website:	n.nih.gov/pmc/articles/PMC31						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>. 0938-03</u> 91
	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) OATE SURVEY COMPLETEO	
		495217	B. WING			05/	7/2018
NAME OF P	ROVIOER OR SUPPLIER		· [	SI	TREET AOORESS, CITY, STATE, ZIP COOE		
MANORC	ARE HEALTH SERVICES	-FAIR OAKS	i		2475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFII TAG	Κ	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION DATE
	the esophagus and in was obtained from the https://www.nlm.nih.g  (6) Severe mental dis thinking and perceptiolose touch with reality are delusions and hal false beliefs, such as plotting against you o secret messages. Hal perceptions, such as something that is not obtained from the well https://medlineplus.go	to leak back, or reflux, into ritate it. This information website: ov/medlineplus/gerd.html.  orders that cause abnormal ons. People with psychoses. Two of the main symptoms lucinations. Delusions are thinking that someone is reflect that the TV is sending you lucinations are false hearing, seeing, or feeling there. This information was osite: ov/psychoticdisorders.html.		684			
F 686 SS=D	CFR(s): 483.25(b)(1)(1)(1)(1)(2)(4)(3)(4)(1)(1)(2)(4)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	rity re ulcers. hensive assessment of a nust ensure that- care, consistent with s of practice, to prevent oes not develop pressure vidual's clinical condition ry were unavoidable; and ssure ulcers receives and services, consistent dards of practice, to rent infection and prevent	F	586	The statement made of this plan correction are not an admission not constitute an agreement with alleged deficiencies herein. To rin compliance with all Federal ar regulations, the center has taker will take the actions set forth in thing plan of correction. The follow POC constitutes the center's alle of compliance such that all alleged deficiencies cited have been or worrected by the date indicated.	to and d the emain of State or he following egation ed	

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Evem 10: 0J2611

Facility IO: VAD153

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED	
		495217	B. WING				C 17/2018
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE  12475 LEE JACKSON MEMORIAL HIGHWA 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	was determined that treatment and service infection and promote for two of 48 resident Resident #57 and #1	d clinical record review it facility staff failed to provide es in a manner to prevent e healing of a pressure ulcer s in the survey sample,	F	686	It is the practice of the facility vide treatment and services i to prevent infection and promof a pressure ulcer.	n a man	: I
	Resident #57's dress scissors removed from and used them to cut directly into Resident staff also used gloves uniform pocket to per 2. The facility staff faremoving Resident #dressing, prior to don perform wound care.	iled to wash hands after 101's pressure wound ning new gloves, worn to The facility staff also used tored in the uniform pocket					
	12/9/09 and readmitte that included but were dementia, high choles pressure. Resident #3 (minimum data set) a assessment with an A date) of 4/8/18. Resi- severely impaired for Staff Interview for Me #57 was coded as re- from two staff member transfers and toileting	57's most recent MDS ssessment was an annual ARD (assessment reference dent #57 was coded as cognitive function, on the ntal Status exam. Resident quiring extensive assistance					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495217	B. WING _			l '	47/2049
NAME OF PR	ROVIDER OR SUPPLIER	450217		STREET ADDRESS, CITY, STAT  12475 LEE JACKSON MEMOI		1 05/	17/2018
MANORCA	ARE HEALTH SERVICES	-FAIR OAKS		FAIRFAX, VA 22033	NAL HIGHWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PR <b>E</b> FIX TAG	(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPRDPRIA FICIENCY)		(X5) COMPLETION OATE
F 686	hygiene; and total de dressing and bathing section M (Skin Condunhealed stage three measuring 4.4 x 3.6 x Review of Resident # summary) dated 5/1/order: "SKIN every dasacrum wound with Napply zinc ointment to	pendence on staff with  Resident #57 was coded in  litions) as having an or four pressure ulcer (1) c 1.0 cm (centimeters).  57's POS (physician order 18, revealed the following ay shift for wound care clean IS (normal saline), pat dry, o surrounding tissue pack Ilginate (2) and cover with	F6	1. Resident #5 identified risk of during wound it written. Resident #101 infection practification wound care. No 2. All resident tential to be aff 3. Licensed no correct infection before, during, reusable supplession of the during in the du	urses will be re- on control praction and after wour lies and not stol	riea w orders utified of ent was written. are have educate ces (hai nd care, ring any	poor receiving the po- ed on ndwashing cleaning of
	dated 6/8/2012 and redocumented the following incontinent of the being incontinent of the ulcer to sacrum. Goal from erythema, break bruising until next revianding while transfesskin condition with AE care daily; report abnoredistributing device of skin audit, administer and supplements per Encourage and assist reposition; use assist On 5/16/18 at 9:06 a. was conducted with Linurse) #6 and LPN (lill LPN #6 was observed.	wing: "At risk for alteration in to fragile skin and resident bowl and bladder, Pressure it: Skin will remain intact, free adown, excoriation or iew. Interventions: Gentle erring/repositioning, Observe DL (activities of daily living) ormalities, pressure on bed and chair, weekly treatments per order, diet		4. DON and/o 2 nurses durir control practice weekly x four ( The results of warded to the Assessment C action as appre will determine actions.	d care in pocker designee will was designee will was designee will was. These audits will Quality Assurantonmittee for recopriate. The conneed audits and appliance will be	visually for properts will be onthly x to the for- nice and eview an ommittee door	er infection e done two (2). d
	gloves and placed the	PN #6 took a handful of em into her scrub pocket. own the resident's beside					

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) OATE SURVEY COMPLETEO	
						(	c
		495217	B. WNG			05/	17/2018
NAME OF P	ROVIOER OR SUPPLIER	, ,			STREET AOORESS, CITY, STATE, ZIP COOE	·	
				1	12475 LEE JACKSON MEMORIAL HIGHWAY		
MANORCA	ARE HEALTH SERVICES	-FAIR OAKS		,	FAIRFAX, VA 22033		
(X4) IO	SUMMARY ST	ATEMENT OF OEFICIENCIES	10	1	PROVIDER'S PLAN OF CORRECTION		Λε\
PREFIX TAG	(EACH OEFICIENC)	Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRI, OEFICIENCY)	_	(X5) COMPLETION DATE
F 686	Continued From page	÷ 161	F	686			
	table with an antisept	ic wipe. LPN #6 placed a					
		d set her supplies down.					
		pair of gloves that were					
		ub pocket. LPN #6 was not					
	observed washing he	r hands prior to Resident					
	#57's dressing change	e. LPN #6 stated that she					
		ssors. LPN #6 placed her					
	hand into LPN #3's po	ocket, and grabbed a pair of					
	scissors. LPN #6 ther	used the scissors to cut					
		LPN #6 did not sanitize the					
	scissors prior to use.						
		on the drape. LPN #6					
		f her pocket and signed the					
		oam dressing was then					
		ape. LPN#6 then removed					
		d a new pair of gloves from					
		N#6 stated, "My pockets are					
		6 then assisted LPN #3 with					
		LPN #6 placed a blue					
		#57 and began removing					
	_	r sacrum. Resident #57					
		ressure ulcer. LPN #6					
		ind then donned a new pair				İ	
		ub pocket. LPN #6 took a the wound and then used					
		the wound. LPN #6 then					
	grabbed the calcium a	d bed. LPN #6 applied the					
	•	d Resident #57's wound;					
	skin prepped the area	·					
		and LPN #6 then used the					
		e used for the dressing					
	change to place Resid	<del>_</del>					
		ent for repositioning. The					
		o used to apply Resident					
	_	I #6 then threw away the					
	trash, washed her har						
		used bleach wipes to wipe					
	down the scissors.	. Lat at white					

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	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILOI		NSTRUCTION	(X3) OATE COMP	SURVEY LETEO
		495217	B. WING			05/	0 17/2018
	ROVIOER OR SUPPLIER	-FAIR OAKS	•	1247	ET AOORESS, CITY, STATE, ZIP COOE 5 LEE JACKSON MEMORIAL HIGHWAY RFAX, VA 22033		
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI TAG	×	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION DATE
F 686	conducted with LPN would wash her hand LPN #6 stated that if wound, she would wadressing change and dressing. LPN #6 state wounds, she would weach wound dressing would just change he dirty to clean. When transport supplies su change, LPN #6 state in her scrub pocket. You pocket with the glove dressing change on I'll don't recall what we current time, LPN #6 and cell phone in her she washed her unife scrub top was clean pen and cell phone will "Everything I put in it if she knew if LPN #3 she used the scissors she us stated, "We always canything that went in LPN #6 was informed on 5/16/18, LPN #6 casked what was in LI scissors that were us #6 stated that did not above observations will assert the scissors that were us #6 stated that did not above observations will assert the scissors that were us #6 stated that did not above observations will scissors that were us #6 stated that did not above observations will scissors that were us #6 stated that did not above observations will scissors that were us #6 stated that did not above observations will scissors that were us #6 stated that did not above observations will scissors that were us #6 stated that did not above observations will scissors that were us #6 stated that did not above observations will scissors that were us #6 stated that did not above observations will scissors that were us #6 stated that did not above observations will scissors that were us #6 stated that did not above observations will scissors that were us #6 stated that did not scissors that were us #6 stated that did not scissors that were us #6 stated that did not scissors that were us #6 stated that did not scissors that were us #6 stated that did not scissors that were us #6 stated that did not scissors that were us #6 stated that did not scissors that were us #6 stated that did not scissors that were us #6 stated that scissors that were us #6 stated that scissors that were us #6 stated that scissors that were us #6 stated that scissors that were us #6 stated that scissors that were us #6 s	m., an interview was #6. When asked when she is during a dressing change, a resident only has one ash her hands prior to the after completion of the ted that if a resident had two yash her hands between LPN #6 stated that she or gloves when going from asked how she would ch as gloves for a dressing ed that she would put them When asked what was in her s while she was doing the Resident #57, LPN #6 stated, as in my pocket then." as in her pocket at that stated that she had her pen pocket. LPN #6 stated that form every day and that her that day. When asked if her were clean, LPN #6 stated, is clean, yes." When asked is scrub top was clean when is from her scrub pocket, he wasn't sure. When asked ed were clean, LPN #6 lean the scissors. I didn't cut to the wound bed." When d of the observations made lid not say anything. When PN #3's pocket with the ed to cut the alginate, LPN evere a concern, LPN #6 infection control issue.	F	586			

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Event IO: 0J2611

Facility IO: VAD153

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(2) MULTIPLE CONSTRUCTION  . BUILDING			(X3) DATE SURVEY COMPLETED	
							C	
		495217	B. WING_			05/	1 <b>7/</b> 2 <b>018</b>	
NAME OF PI	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE			
MANOPO	ARE HEALTH SERVICES	EVIB OVK		12475	LEE JACKSON MEMORIAL HIGHWAY			
IIIA NO NO	AIRE HEAEIH SERVICES	AIR OARS		FAIRF	AX, VA 22033			
(X4) ID PREFIX TAG			ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From page	e 163	F	686				
	On 5/17/18 at 6:05 p. staff member) #1, the	m., ASM (administrative administrator and ASM #2, Nursing) were made aware						
	GUIDE" documented, performed using non-unless otherwise order physician. In general considered when performed to principles of infection and dirty, provide bar supplies, appropriate maintain appropriate cleaning of wound be	, the following guidelines are forming treatments: -adhere on control- separate clean rier field for treatment use and changing of gloves, precautions, appropriate d (center of wound to eansing of scissors, hand						
	the skin over a bony p blade, elbow, hip, but from prolonged press from being confined to in elderly and immobiled ulcers may be prevent position, early ambulated skin lubricants and a called bedsores. Preso Dictionary of Medical Reader 2006; Mikel A Charles F. Chapman.	Terms for the Non Medical Rothenberg, M.D. and Page 155.  wound dressing that partly ith wound fluid to form a esult of the exchange of I fluid for calcium ions in the ation was obtained from						

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Facility ID: VA0153

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPART	VIENT OF HEALTH AN	ID HUMAN SERVICES			F	ORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OME	3 NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	CONSTRUCTION		DATE SURVEY COMPLETED
		495217	B. WING			C 05/17/2018
NAME OF PE	ROVIDER OR SUPPLIER	<u>.</u>	s	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	00/11/20/0
MANORCA	ARE HEALTH SERVICES	-FAIR OAKS	1	2475 LEE JACKSDN MEMORIAL HIGHWA AIRFAX, VA 22033	ıΥ	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN DF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	lOULD BE	(X5) COMPLETION DATE
F 686	(3) Stage Four Pressitissue loss with exposisions or eschar may of the wound bed. Off tunneling. Further destage IV pressure ulcolocation. The bridge of malleolus do not have these ulcers can be sextend into muscle ar (e.g., fascia, tendon costeomyelitis possible visible or directly palpobtained from The Na Advisory Panel websithttp://www.npuap.org  2. The facility staff faremoving Resident #* dressing and prior to perform wound care. gloves, which were st to perform wound care.	ure Ulcer- Full thickness sed bone, tendon or muscle. If the present on some parts ten include undermining and scription: The depth of a scription: The depth of a scription: The depth of a scription: The depth of a scription: The depth of a scription: The depth of a scription: The depth of a scription: The depth of a scription: The depth of a scription: The depth of a scription: The subcutaneous tissue and hallow. Stage IV ulcers can addor supporting structures or joint capsule) making scription: Exposed bone/tendon is table. This information was attonal Pressure Ulcer te at tendom and the scription of the donning new gloves, worn to the facility staff also used ored in the uniform pocket e.	F 686			
	diagnoses that includ	ed on 4/1//18 with ed but were not limited to: high blood pressure and				
		(minimum data set), a 14				

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reference date) of 6/1/18 coded the resident as having scored a 15 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions.

Eveni ID: QJ2611

Facility ID: VA0153

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	OF DEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			E CONSTRUCTION	(X3) OATE COMP	SURVEY LETEO
		495217	B. WING			05/	C 17/2018
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS	,	,	STREET AOORESS, CITY, STATE, ZIP COOE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	, ,	
(X4) ID PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO E CROSS-REFERENCEO TO THE APPROPRI OEFICIENCY)		JX6J COMPLETION DATE
F 686	The resident was cod for all activities of dail Review of the resider 4/17/18 documented, pressure ulcer to the mobility. Interventions physician orders."  Review of the May 20 documented, "Cleans normal saline, pat dry cover with foam dress."  Review of the May 20 administration record open area to sacrum apply Xeroform and A wound care observ 5/17/18 at 11:07 a.m. nurse) #6, the wound (registered nurse) #1, and took a pair of glowashed her hands an from the box in the bathe resident over onto the brief. LPN #6 rem pair of gloves out of h LPN #6 did not wash #6 removed the resid dressing. LPN #6 rem another pair of gloves them on without wash cleaned the wound at #6 removed the glove RN #1 picked up a pict threw it in the trashcal	led as requiring assistance by living.  It's care plan initiated on "Focus. Resident has sacrum related to impaired is. Administer treatment per 18 physician's orders be open area to sacrum with an apply Xeroform (1) and sing."  18 medication documented, "Cleanse with normal saline, pat dry, cover with foam dressing."  ation was conducted on with LPN (licensed practical	F	686			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A, BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		<b>4952</b> 17	B. WING				C 1 <b>7/2</b> 01 <b>8</b>	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES			124	REET ADDRESS, CITY, STATE, ZIP CODE 475 LEE JACKSON MEMORIAL HIGHWAY NIRFAX, VA 22033	1 03/	1772016	
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 686	or sanitize her hands, positioned and covered. An interview was comp.m. with ASM (admir the director of nurses should wash their har each patient care, who room." When asked where the that were to be used stated, "They should When asked if uniform #2 stated they were maked when staff was wound care, LPN #6, the asked when staff was wound care, LPN #6 number one. We was different wounds." Whockets were conside "Well I wash my unifor asked what else was that the gloves were that the gloves	The resident was ed.  ducted on 5/17/18 at 1:56 nistrative staff member) #2, . When asked when staff ads, ASM #2 stated, "After en they go into the patient's when staff washed their care, ASM #2 stated, "After et the dirty wound dressing." are gloves should be kept for the wound care, ASM #2 be on the side of the field." an pockets were clean, ASM pot.  ducted pn 5/17/18 at 1:59 awound care nurse. When hed their hands during stated, "Handwashing is hour hands between hen asked if the uniform wered clean, LPN #6 stated, rm every night." When kept in her uniform pocket kept in, LPN #6 did not reply.  ducted pn 5/17/18 at 3:20 an asked when staff should at 1 stated, "After taking er taking off gloves." When preservation made that day N #1 stated, "I thought I did hands after removing her	F	686				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495217	B. WING			C 17/2018
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	_ <del>_</del>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	1772010
				12475 LEE JACKSON MEMORIAL HIGHWAY		
MANORCA	ARE HEALTH SERVICES	-FAIR OAKS				
	·=· ·	17 40 11		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 CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR	BE	(X5) COMPLETION OATE
F 686	Continued From page	e 167	F 68	36		
	ASM #3, the quality a	ssurance consultant were				
	made aware of the fir					
	No further information	n was obtained prior to exit.				
F 689 SS=D	subtribromo-phenolathas an astringent, de effect. Xeroform is us and salves for the treulcers and inflammati information was obtain https://encyclopedia2orm Free of Accident HazaCFR(s): 483.25(d) (1): §483.25(d) Accidents The facility must ensure	edicinal preparation of bismuth blate and bismuth trioxide that desicca-tive, and antiseptic used externally in powders treatment of intertrigoes and of nations of the mucosa. This brained from: ia2.thefreedictionary.com/Xerof  lazards/Supervision/Devices (1)(2)  Ints. Insure that - Iresident environment remains  The statement made on this plan of tion are not an admission to and do stitute an agreement with the allege ficiencies herein. To remain in con with all Federal and State regulatio the center has taken or will take the	do not co eged de- ompliand tions,	e ns		
	§483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on resident in facility document revireview, it was determ failed to ensure adeq services to prevent accord 48 residents in the #427. The facility staff failed	sident receives adequate stance devices to prevent is not met as evidenced terview, staff interview, ew and clinical record ined that the facility staff		The following plan of correction the center's allegation of compliant that all alleged deficiences cited or will be corrected by the date in	constitute ance sucl have bee	s n ⊋n

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	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) OATE COMP	SURVEY LETEO
		495217	B. WING				0 1 <b>7/2</b> 01 <b>8</b>
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		1:	TREET AOORESS, CITY, STATE, ZIP COOE 2475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033	001	7772010
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IÓ PREFI TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BI CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION DATE
F 689	facility smoking without also failed to ensure if were not kept on his pure. The findings include:  Resident #427 was as 5/3/18 with diagnoses.	no was observed outside the ut supervision. The staff Resident #427's cigarettes person.  dmitted to the facility on a that included but were not nee replacement, bipolar	F	689	It is the practice of the facility to sure adequate supervision and sto prevent accidents and hazard.  1. Resident #427, smoking a was completed immediately materials were collected from secured at nurses' station. Features was re-educated on facility secured.	ervices s. assessr and sm n reside Residen	nent oking ent and t #427
	Review of the most reset), an admission as (assessment reference the resident as having (brief interview for me resident was cognitive decisions. The reside assistance from staff sliving.  On 5/15/18 at 11:00 at a list of any residents	ecent MDS (minimum data sessment, with an ARD se date) of 5/10/18 coded a 15 out of 15 on the BIMS ental status) indicating the ely intact to make daily int was coded as requiring for all activities of daily  i.m., a request was made for who smoked. A paper was g, "No known smokers are in		was re-educated on facility smaudit was completed on all resthat there were no more un-ide.  2. Any resident that smokes in potential to be affected.  3. Staff has been re-educated policy on smoking.  4. DON and/or designee will admissions to ensure that their smokers. These audits will be x four (4) and then monthly x in the results of these audits will warded to the Quality Assurar and Assessment Committee for view and action as appropriate Committee will determine nee			s to ensure d smokers. e facility all new no new weekly 
	of Resident #427. The outside the facility und director of nurse's wind smoking a cigarette.  An interview was content p.m. with Resident #4 smoking yesterday out #427 stated, "Yes I was to the gazebo." When	nade on 5/15/18 at 5:05 p.m. e resident was sitting der the administrator's and adows. The resident was ducted on 5/16/18 at 3:06 27. When asked if he was atside the facility, Resident as out there. I usually go out asked if the staff were d, Resident #427 stated,			further audits and/or actions. 5. Date of compliance will b		19, 2018

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STATEMENT DF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILD			DISTRUCTION	(X3) DATE SURVEY COMPLETED		
		495217	B. WING	B. WING			05/17/2018	
NAME OF PI	ROVIDER OR SUPPLIER	· ·			EET ADDRESS, CITY, STATE, ZIP CODE	1 00/	17/2010	
MANORCA	MANORCARE HEALTH SERVICES-FAIR OAKS				RFAX, VA 22033			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<b>.</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION · OATE	
F 689	F 689 Continued From page 169		F	889				
		nme out there." When asked eep his cigarettes and 7 stated he was.					:	
		nt's care plan initiated on ce documentation regarding	i.					
	A review of the 5/3/18 nursing admission assessment documented that the resident was a "non-smoker."  A review of the 5/6/18 physician's history and physical documented, "Tobacco. 1/2 PPD (pack per day)."							
		clinical record did not ion regarding a smoking						
	p.m. with LPN (licenseresident's nurse. Whe followed if a resident "As far as I know we'r somebody is smoking have any cigarettes in the unit manager."							
	a.m. with RN (register manager. When aske a resident smoked, R admission we ask if the non-smoker. This is a							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
	495217 B. WNG				C		
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE  12476 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	<u> </u>	05/17/2018	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From page and getting a nicotine had a smoker that we Resident #427)."  An interview was comp.m. with RN #12, the asked if she was awas smoked, RN #12 stat When asked when the stated, "Probably four here. He told me he him a pack of cigarett not smoke in the roor far away from the fact this is a non-smoking When asked if she paother staff, RN #12 stat known that he smoke strongly of smoke." We completed a smoking stated, "No, I didn't the one should have been yes.  On 5/17/18 at 5:45 p.	e 170  a patch. We just learned we were not aware of (name of ducted on 5/17/18 at 3:46  a nursing supervisor. When are of any resident who ed Resident #427 smoked. At was discovered, RN #12  are or five days after he got had a family member buy less and I told him him could an and that he needed to be lility because by Virginia law facility. I took his lighter."  assed this information on to lated, "Everybody must have do because he smelled very with a safety assessment, RN #12 ink about it." When asked if an completed, RN #12 stated  m. ASM (administrative staff inistrator, ASM #2, the	F 68	DEFICIENCY)	OPRIATE		
	assurance consultant findings.  Review of the facility's GUIDELINES" docume determine if a patient or an At Risk Smoker the privilege to smoke center and to establist that desire to smoke, GUIDELINES: Evaluation	were made aware of the s policy titled, "SMOKING nented, "PURPOSE: To is an independent Smoker before the patient exercises while residing within the h guidelines for all patient as well an non-smokers. ate patients that smoke Evaluation tool either: (a)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495217	B. WNG		C 05/17/2018	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 695 SS=D	unsafe smoking pract current smoker; or, (o smokes has a signific conditionUpon com the interdisciplinary to physician will make a is an Independent or patient is determined Smoker, the patient in assistance at center of Independent Smokers guidelines including, I smoking accessories when not in use and a areas at designated to No further information  1. Bipolar disorder—health condition that of mood, energy, and be often appears in late adulthood, although a time of life. This information (FR(s): 483.25(i))  § 483.25(i) Respirator tracheostomy care are The facility must ensureds respiratory car care and tracheal succare, consistent with practice, the comprehensions.	when a previous takes up smoking: (c) if tices are observed in a b) when a patient that that change in medical tipletion of the evaluation, the team, including the attending decision whether the patient At Risk Smoker if the to be an Independent that smoke without designated times. Is must still follow smoking tout not limited to, keeping in control of center staff smoking only in designated times." In was obtained prior to exit. Bipolar disorder is a mental causes extreme shifts in the chavior. This disorder most adolescence or early tymptoms can begin at any mation was obtained from: w/condition/bipolar-disorder thomy Care and Suctioning	Fé	The statement made on this percentage of constitute an agreeme alleged deficiencies herein. To in compliance with all Federal regulations, the center has tall take the actions ser forth in the plan of correction. The follow correction constitutes the center of compliance such that all all ciencies cited have been or we corrected by the date indicate.	on to and int with the foremain and State ken or will e following ing plan of ter's allegation eged defi- ill be	
ORM CMS-2567(02-99) Previous Versions Obsolete Event ID: OJ2611 Facility IO: VA0153 If continuation sh						

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STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION  (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:  495217		(X2) MULTIPLE CONSTRUCTION  A. BUILOING			(X3) OATE SURVEY COMPLETEO				
		B. WING	B. WING			7/2018			
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS	1	1247	EET AOORESS, CITY, STATE, ZIP COOE 75 LEE JACKSON MEMORIAŁ HIGHWAY RFAX, VA 22033		_		
(X4) IO PREFIX TAG	X (EACH OEFICIENCY MUST BE PRECEOEO BY FULL		(EACH OEFICIENCY MUST BE PRECEOEO BY FULL		IO PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE CO			(X5) COMPLETION OATE
F 695	and 483.65 of this sull This REQUIREMENT by: Based on observation document review and was determined that it provide respiratory can 48 residents in the sull and #71.  1. The facility staff fail Resident #19 at the pathree liters.  2. The facility staff fail respiratory equipment. The findings include:  1. The facility staff fail respiratory equipment. The findings include:  1. The facility staff fail Resident #19 at the pathree liters.  Resident #19 was add 8/26/17. Resident #1 were not limited to he and high blood pression recent MDS (minimum assessment with an Adate) of 3/4/18, coded cognitively intact. Se Resident #19 receive.	is not met as evidenced  n, staff interview, facility clinical record review, it the facility staff failed to are and services for two of rvey sample, Residents #19  led to administer oxygen to hysician prescribed rate of  led to store Resident #71's t in a sanitary manner.  led to administer oxygen to hysician prescribed rate of  mitted to the facility on 9's diagnoses included but art failure, high cholesterol ure. Resident #19's most in data set), a quarterly uRD (assessment reference if the resident as being ction O documented doxygen therapy.  19's clinical record revealed atted 4/24/18 for oxygen at cannula every shift for Resident #19's colan dated 12/5/17	F	695	1. The facility immediately caudit of oxygen order of resident prescribed rate. Resident mask was sanitized and tubin was replaced and stored in a 2. Residents who are receiving care have the potential to be affected.  3. Nursing staff has been restoring of respiratory equipment tary manner and licensed stare-educated on administration prescribed rate.  4. DON and/or designee will receiving respiratory care to is being administered at preequipment stored in a sanital x four and then monthly x two The results of these audits where warded to the Quality Assurance Assessment Committee for reaction as appropriate. The owill determine need for further and/or actions.  5. Date of compliance will be	ompleted dent oxygen ap #71 respond a plastic being respondent in a saff has being of oxygen and the condition of oxygen and the condition of oxygen and the committee are audits	oplied iratory  ag. atory  d on proper sani- en en at the e (5) residents at oxygen ate and r weekly		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495217 B. WING			C 05/17/2018			
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		1	STREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	007	11/2010
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION OATE
F 695	(high blood pressure ordered"  On 5/15/18 at 12:28 Resident #19 was colying in bed with a nather than a nather	cholesterol), Hypertension )Administer oxygen as  p.m., observation of inducted. The resident was asal cannula in her nose, as attached to an oxygen as attached to an oxygen as a sattached to an oxygen as a sattached to an oxygen was administered to the in between three and three ovidenced by the middle of the for flow meter positioned are line and the three and a stime, Resident #19 asked such oxygen was she ade aware of this surveyor's not #19 voiced concern to the was supposed to and two liters. Resident #19 as surveyor would get a nurse.  p.m., an interview was (licensed practical nurse) #8. For the rate of oxygen as oxygen was supposed to see liters. LPN #8 was asked #19's oxygen concentrator. The concentrator and turned the filling it is oxygen asked to the helpow meter should be on when asked if the middle of the liter line, LPN #8 stated was a little above the three	F	695			
		e administrator) and ASM #2 ng) were made aware of the					

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STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) OATE SURVEY COMPLETEO	
			С				
		495217	B. WING			05	/17/2018
	MANORCARE HEALTH SERVICES-FAIR OAKS			1247	ET ADORESS, CITY, STATE, ZIP COOE  LEE JACKSON MEMORIAL HIGHWAY  FAX, VA 22033		
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IDENTIFYING INFORMATION)	IO PREFI TAG	×	PROVIDER'S PLAN OF CO <b>R</b> RECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCEO TO THE APPROF OEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	above concern.  The facility document ADMINISTRATION of "PREPARATION OF oxygen concentrator, on and set flow meter No further information.  2. The facility staff fair respiratory equipment Resident #71 was ad 4/16/18. Resident #7	t titled, "OXYGEN documented, EQUIPMENT3. For plug in power cord, turn unit r to correct flow rate" In was presented prior to exit.  Iled to store Resident #71's t in a sanitary manner.  mitted to the facility on 1'1's diagnoses included but	F	695			
	(1), muscle weakness Resident #71's most set), an admission as (assessment reference the resident as being coded Resident #71 or more staff with bed required extensive as dressing and eating. Resident #71 utilized Review of Resident # a physician's order darespiratory machine.  On 5/15/18 at 12:49 pp.m., the mask attach respiratory machine versident to the resident # 5/16/18 at 10:32 a.m.	e71's clinical record revealed ated 4/16/18 for a ventilatory o.m. and 5/15/18 at 2:48					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		495217	B. WING			С	
NAME OF D	ROVIDER OR SUPPLIER	700211		STREET ADDRESS OFF STATE THE CO	.DE	05/	17/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
MANORC	ARE HEALTH SERVICES	-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIG FAIRFAX, VA 22033	HVVAY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 695	Continued From page	e 175	F 6	95			
	LPN #1 was asked herespiratory equipment stated, "So we have a in the bag and we dat why the mask should stated, "For infection mask should be out of LPN #1 stated, "No. I be in a bag."  Resident #71's compression of the storage of respirations.	dicensed practical nurse) #1.  bw a mask attached to t should be stored. LPN #1 a bag. The mask, you put it te everything." When asked be stored in a bag, LPN #1 control." When asked if the in the table when not in use, if not used, it should always  rehensive care plan dated iment information regarding					
	staff member) #1 (the (the director of nursing above concern.  The facility document ADMINISTRATION" of use, store oxygen tub mask in separate, lab	administrator) and ASM #2 g) were made aware of the titled, "OXYGEN documented, "2. When not in ing and nasal cannula or eled plastic bag"					
	(1) "Amyotrophic later nervous system disea called neurons in you These neurons transm brain and spinal cord the ones you can con legs" This informati website:	ral sclerosis (ALS) is a use that attacks nerve cells represented prior to exit.  ral sclerosis (ALS) is a use that attacks nerve cells represented by the second s					

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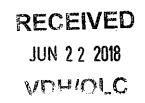
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WNG	B. WING		C 05/17/2018	
NAME OF PROVIDER OR SU	IPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	<u>  U5/</u>	17/2018
				1:	2475 LEE JACKSON MEMORIAL HIGHWAY		
MANORCARE HEALTH SERVICES-FAIR OAKS				F	AIRFAX, VA 22033		
PREFIX (EAC	SUMMARY STATEMENT DF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
sclerosis  (2) "Positivuses a mad the airway windpipe of delivered by pressure) put that block the sleep apne Your healther PAP maching Continuous provides a your airway Autotitrating (APAP) chat based on your air	e airway p chine to pu of the lung oen during y CPAP (c revents ep ne breathin a and othe care prov ne that tar positive a gentle and to keep it g (adjustat anges pres our breath tive airway or pressure ure when was obtai lineplus.gc gement 3.25(k)  Pain Mana must ensu residents with profes hensive po idents' goa IREMENT	ressure (PAP) treatment mp air under pressure into s. This helps keep the sleep. The forced air ontinuous positive airway bisodes of airway collapse in people with obstructive or breathing problems ider will prescribe the type of gets your problem: inway pressure (CPAP) steady pressure of air in open. ble) positive airway pressure sure throughout the night, ing patterns. If pressure (BiPAP or BIPAP) is when you breathe in and you breathe put" This ned from the website: by/ency/article/001916.htm		695	The statement made on this plan correction are not an admission to not constitute an agreement with alleged deficiencies herein. To rin compliance with all Federal and regulations, the center has taken take the actions set forth in the formulation of correction. The following constitutes the center's allegation pliance such that all alleged deficited have been or will be correct the date indicated.	o and d the emain d State or will bllowing POC n of com ciencies	<b> -</b>

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Facility ID: VA0153

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING	_		C		
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	I	STREET ADORESS, CITY, STATE, ZIP CODE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033					
(X4) ID PREFIX TAG	(EACH OEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IOENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION OATE	
F 697	program and services the survey sample, R	sive pain management s for one of 48 residents in esident #5. I to administer Resident #5's	F	697	It is the practice of the facility to a comprehensive pain manager program and services.			
	Resident #5 was admitted to the facility on 7/16/16. Resident #5's diagnoses included but were not limited to diabetes, muscle weakness and osteoarthritis. Resident #5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/10/18, coded the resident's cognition as moderately impaired. Section J documented Resident #5 reported no pain during the last five days.				1. The facility immediately com assessment on resident #5 and of missed dose. No new order doctor.  2. Residents who have pain mescribed have the potential to be 3. Licensed nurses have been redoctor's orders and administer.	notified was obta edication affected e-education	doctor ained by pre- d. ted to follow	
	Review of Resident #5's clinical record revealed a physician's order dated 4/12/18 for Capsagel Gel (Capsaicin) (1) 0.025%- to be applied to the resident's bilateral knees one time a day for pain. Resident #5's May 2018 eMAR (electronic medication administration record) documented, "Capsagel Gel 0.025% (Capsaicin) Apply to bilat (bilateral) knees topically one time a day for pain." On 5/9/18, the eMAR documented a nurse's initials and the code "5" that indicated, "Hold/See Nurse Notes." The May 2018 eMAR location of administration report documented Capsagel was topically applied to both of Resident #5's knees every day in May 2018 except for 5/9/18. The eMAR documented a pain evaluation was completed on 5/9/18 but failed to document any further information regarding the evaluation. A nurse's note dated 5/9/18 documented, "Capsagel Gel 0.025% Apply to bilat knees				scribed.  4. DON and/or designee will consults of five (5) residents EMA that pain medications are being as prescribed. These audits will weekly x four (4) and monthly x The results of these audits will be to the Quality Assurance and A Committee for review and action priate. The committee will deter for further audits and/or actions 5. Date of compliance will be J	R/ETAR adminis l be dor two (2). be forwassessmen as apprinte no	to ensure stered e arded ent pro- eed	

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) OATE SURVEY COMPLETEO		
		405045	D W410	D WHIO		С	
		495217	B. WING			05/	17/2018
NAME OF P	ROVIOER OR SUPPLIER			!	STREET AODRESS, CITY, STATE, ZIP CODE		
MANOPO	ARE HEALTH SERVICES	EVID UVKS			12475 LEE JACKSON MEMORIAL HIGHWAY		
MANORO	MANUAL HEALIT SERVICES   AIR SARC				FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IO PROVIOER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULO TAG CROSS-REFERENCED TO THE APPROPR OEFICIENCY)			(X5) COMPLETION OATE
F 697	7 Continued From page 178		F	697	,		<u>-</u>
	topically one time a dorder placed."	ay for pain Pharmacy aware					
	7/16/16 documented,	hensive care plan dated "Generalized medication per physician					
		ent #5. The resident stated t she gets a pill and cream					
	· ·	e for signing the above as no longer employed at					
	On 5/17/18 at 8:36 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what the code "5" on the eMAR meant. LPN #1 stated, "Hold. See nurses note." LPN #1 was shown the code "5" for the Capsagel on Resident 5's eMAR for 5/9/18. LPN #1 was asked if the code meant the medication was not given. LPN #1 stated, "It could be." LPN #1 was asked to read the nurse's note dated 5/9/18. LPN #1 stated, "Sometimes if we do click and it says it's on order and you call the pharmacy and they say they will bring it on the next run then notify the MD (medical doctor)." LPN #1 was asked the process to ensure nurses did not run out of physician ordered medicated gels. LPN #1 stated, "When you are giving and see that it's running low, you send for a refill."						
	staff member) #1 (the	m., ASM (administrative administrator) and ASM #2 g) were made aware of the					

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		I IOENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) OATE SURVEY COMPLETEO	
		495217	B. WING			C 05/17/2018	
-	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS	•	STREET ADORESS, CITY, STATE, ZIP COOE 12475 LEE JACKSON MEMORIAL HIGHWA FAIRFAX, VA 22033			
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)		IQ PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 697		titled, "PAIN PRACTICE	F6	97			
F 755 SS=D	GUIDE" documented treat musculoskeletal The facility document TREATMENT ADMIN documented, "Medica accordance with stan specific and federal government of the facility may be accordance with stan specific and federal government of the facility in the facility in the facility must provide and biologicals them under an agree §483.70(g). The facility personnel to administ permits, but only under a licensed nurse.  §483.45(a) Procedure pharmaceutical service that assure the accurdispensing, and administiologicals) to meet the §483.45(b) Service C	"Topical agents are used to and neuropathic pain."  Ititled, "MEDICATION AND ISTRATION GUIDELINES" ations are administered in dards of practice and state uidelines."  In was provided prior to exit.  In to treat osteoarthritis, a nots become swollen and stiff. obtained from the website: cation.s3.amazonaws.com/tis-pain_consumer.pdf bedures/Pharmacist/Records (1)-(3)  Pervices ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed	F7	55			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED
						С
		495217	B. WING _		05	/17/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				12475 LEE JACKSON MEMORIAL HIGHWA	AY	
MANORCA	ARE HEALTH SERVICES	-FAIR OAKS		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 CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 755	Continued From page	÷ 180	F 7	<b>'</b> 55		
	pharmacist who-					
	the facility.	on of pharmacy services in		The statement made on t correction are not an adm do not constitute an agrealleged deficiencies herein compliance with all Fed	nission to and ement with th in. To remair deral and	e 1
1	§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and			State regulations, the cer		1
				or will take the actions se		
				following plan of correction ing POC constitutes the constitut	enter's allega	ation
	order and that an acc is maintained and per	ines that drug records are in ount of all controlled drugs iodically reconciled. is not met as evidenced		of compliance such that a ficiencies cited have been corrected by the date ind	n or will be	
	Based on resident in facility document revier review, it was determined to ensure physic were available for administration.	terview, staff interview, ew and clinical record ined that the facility staff cian prescribed medications ministration for two of 48 y sample, Resident #5 and		It is the practice of the fac physician prescribed med available.		
	pain medication gel fr	iled to acquire Resident #5's rom the pharmacy in a timely n missed dose on 5/9/18.				
	Aubagio (1) was avail	led to ensure Resident #69 lable for administration as dian. Resident #69 missed edication.	;			
	The findings include:					
	7/16/16. Resident #5 were not limited to dia	dmitted to the facility on 's diagnoses included but abetes, muscle weakness esident #5's most recent				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IOENTICIOATIONALI MADED.		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETEO  C 05/17/2018	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	S-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP COOE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH OEFICIENC	ATEMENT OF DEFICIENCIES  YMUST BE PRECEOEO BY FULL  LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 755	with an ARD (assess 5/10/18, coded the remoderately impaired. Resident #5 reported days.  Review of Resident # physician's order dat (Capsaicin) (1) 0.025 resident's bilateral kn Resident #5's May 20 medication administr "Capsagel Gel 0.025 (bilateral) knees topic On 5/9/18, the eMAR initials and the code Nurse Notes." The Nadministration report topically applied to be every day in May 20 nurse's note dated 5 "Capsagel Gel 0.025 topically one time a corder placed."  Resident #5's comproved to the composition of the code of the c	set), a quarterly assessment ment reference date) of esident's cognition as . Section J documented I no pain during the last five . S's clinical record revealed a sed 4/12/18 for Capsagel Gel . So to be applied to the sees one time a day for pain D18 eMAR (electronic ation record) documented, . (Capsaicin) Apply to bilat cally one time a day for pain It documented a nurse's . That indicated, "Hold/See . May 2018 eMAR location of documented Capsagel was both of Resident #5's knees . 18 except for 5/9/18. A . 19/18 documented, . May a documented, . May a documented Generalized Generalized Generalized	F7	1. Resident #5 pain gel i the facility. Resident #6 available in the facility. 2. All residents have the affected. 3. Licensed nurses will be process of obtaining med doctor when medications further orders as needed 4. DON and/or designee audits of five (5) resident sure that medications are administered per doctor audits will be done weekl and monthly x two (2). The results of these audit forwarded to the Quality and Assessment Commit view and action as approacommittee will determine further audits and/or actions. Date of compliance will determine the sum of the compliance will determine further audits and sum of the compliance will dete	potential to the re-educations are unavaill complement of the re-educations are unavaill complement of the re-education of the	on is now to be ated on the add notifying allable for lete random AR to enand ese )	

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		IOENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) OATE SURVEY COMPLETEO	
		495217	B. WNG _		_	05/17	7/2018
	ROVIOER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS		STREET ADORESS, CITY, ST 12475 LEE JACKSON MEN FAIRFAX, VA 22033		1 00/11	,2010
(X4) IO P <b>R</b> EFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFII TAG	( (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CCTIVE ACTION SHOULO B NCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION DATE
F 755	LPN #1 was asked wieMAR meant. LPN # note." LPN #1 was sit Capsagel on Resident #1 was asked if the cowas not given. LPN # #1 was asked to read 5/9/18. LPN #1 state and it says it's on order pharmacy and they say next run then notify the LPN #1 was asked the did not run out of phygels. LPN #1 stated, see that it's running to Con 5/17/18 at 1:52 p.: conducted with ASM member) #2 (the direct stated that although Counter medication, the	m., an interview was licensed practical nurse) #1. hat the code "5" on the 1 stated, "Hold. See nurses nown the code "5" for the t 5's eMAR for 5/9/18. LPN ode meant the medication #1 stated, "It could be." LPN the nurse's note dated d, "Sometimes if we do click er and you call the ay they will bring it on the le MD (medical doctor)." e process to ensure nurses sician ordered medicated "When you are giving and low, you send for a refill."  m., an interview was (administrative staff ctor of nursing). ASM #2 capsagel can be an over the ne facility staff obtains the sharmacy. ASM #2 stated ed in the facility STAT	F	755	OEFICIENCY)		
	medications that can medication is not ava On 5/17/18 at 5:09 p. administrator) and AS nursing) were made a The facility/pharmacy Delivery and Receipt	be accessed if a resident's ilable). m., ASM #1 (the iM #2 (the director of invare of the above findings.					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C		
		495217	B. WING		05/17/2018			
	ROVIDER OR SUPPLIER	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE  12476 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION OATE		
F 755	Continued From pag	e 183	F 75	5				
	TREATMENT ADMIN documented, "Medic	t titled, "MEDICATION AND NISTRATION GUIDELINES" ations are administered in indards of practice and state guidelines."						
	No further informatio	n was provided prior to exit.						
	condition in which joi This information was https://ahrq-ehc-appl media/pdf/osteoarthr 2. The facility staff fa Aubagio (1) was ava	to treat osteoarthritis, a nts become swollen and stiff. obtained from the website: ication.s3.amazonaws.com/ itis-pain_consumer.pdf  illed to ensure Resident #69 illable for administration as cian. Resident #69 missed edication.						
	7/8/17 and readmitte that included but wer disease, multiple sold disorder. Resident # (minimum data set) a assessment with an adate) of 4/12/18. Rebeing intact in cognit possible 15 on the B	Imitted to the facility on d on 5/1/18 with diagnoses re not limited to Parkinson's erosis (2), and bipolar 169's most recent MDS assessment was a quarterly ARD (assessment reference sident #69 was coded as ive function scoring 15 out of IMS (Brief Interview for						
	as requiring extensive more staff members and toileting, extension member with locomorpersonal hygiene and with bathing.	Resident #69 was coded e assistance from two or with bed mobility, transfers, ve assistance from one staff tion, dressing, eating, and d total dependence on staff  #69's most recent POS						

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

Eveni ID: OJ2611

Facility ID: VA0153

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JUN 2 2 2018 VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495217	B. WING _			C 05/17/2018	
	RDVIDER OR SUPPLIER	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP COD 12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033	DE .	56, 17, 2015	
(X <b>4</b> ) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1D PREFIX TAG	``   . `	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 755	mouth one time a da This order was order 5/2/18.  Review of the May 2 Administration Reco revealed that Reside daily dose of Aubagi	(milligram) Give 14 mg by y for MS (multiple sclerosis)." red on 5/1/18 and initiated on 018 MAR (Medication rd) for Resident #69's ent #69 did not receive her to on 5/2/18, 5/3/18 and the of Aubagio was not	F7	755			
	following: "Daughter daughter regarding r medication is sent di house. She is made medication to give a	did visit today; I did speak to medication Abagio (sic). The rectly to the daughters aware that we have no this time. Per the daughter it she "will call" for the					
	evidence any prior a Aubagio. There was attempts to obtain the pharmacy. There was	e nursing notes failed to ttempts to receive the no documented evidence of is medication from the as no evidence in the nursing cian was made aware of the					
	conducted with LPN Resident #69's nursi the process staff foll due to be administer medication cart. LP leave the eMAR blan	.m., an interview was (licensed practical nurse) #3, e. LPN #3 was asked about bws if a medication that was ed is missing from the N #3 stated that she would hk for that particular he STAT (immediate) box for					

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILOING			(X3) OATE SURVEY COMPLETEO	
		495217	B. WING				C <b>17/2</b> 01 <b>8</b>	
	ROVIOER OR SUPPLIER	S-FAIR OAKS		12475	ET AOORESS, CITY, STATE, ZIP COOE LEE JACKSON MEMORIAL HIGHWAY FAX, VA 22033			
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES BY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI TAG	×	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO E CROSS-REFERENCEO TO THE APPROPRI OEFICIENCY)		(X5) COMPLETION DATE	
F 755	were not in the STAT physician and family, would also notify pha medication as soon a why Resident #69's / 5/5/18 when it was o stated that Resident Aubagio from a spectated that the medic daughter rather the finow the medication i facility. LPN #3 state facility pharmacy doe When LPN #3 was a daughter that they di 5/2/18, LPN #3 state When asked if the pharmacy does the work of the pharmacy does not a marmacy does the pharmacy does not a marmacy doe	on, and if the medication box, she would notify the LPN #3 stated that she	F	755				

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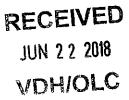
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) OATE SURVEY COMPLETED	
		495217	B. WING_	B. WNG		C 0 <b>5/17/2</b> 018		
NAME OF PI	ROVIDER OR SUPPLIER			\$TRE	ET ADORESS, CITY, STATE, ZIP CODE	1 00,	1772010	
******	DE LIEATTH SERVICES	END ONES		12478	LEE JACKSON MEMORIAL HIGHWAY			
MANORU	ARE HEALTH SERVICES	-FAIR OAKS		FAIR	FAX, 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 DF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 755	Continued From page	÷ 186	F	755				
	On 5/17/18 at 2:13 p. conducted with OSM pharmacy technician. pharmacy carried the #5 stated that the phamedication but that the requested that the phamedication from a spestated that they had redication, but that the medication, but that the medication.  On 5/17/18 at 6:05 p. staff member) #1, the the DON (Director of of the above concerns	m., an interview was (other staff member) #5, the When asked if the medication Aubagio, OSM armacy did not carry the e facility could have armacist order the ecialty pharmacy. OSM #5 eceived the order for the here was no hard script for as required to fill the m., ASM (administrative administrator and ASM #2, Nursing) were made aware s.						
	in part, the following: are to be initiated by scheduled routine do:	tion Guidelines" documents "New medications orders the time of the next					:	
	immunomodulatory armultiple sclerosis. The from The National Institutes://pubchem.ncbi.unomide#section=Top  (2) Multiple sclerosis disease that affects y damages the myeling surrounds and protect damage slows down between your brain a	nlm.nih.gov/compound/Teriflob.  (MS) is a nervous system our brain and spinal cord. It sheath, the material that ts your nerve cells. This						

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

Evenl ID: 0J2611

Facility ID: VA0153

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING			1	C 17/2 <b>018</b>	
NAME OF P	ROVIDER OR SUPPLIER		1	ş	TREET ADDRESS, CITY, STATE, ZIP CODE	,		
MANORC	ARE HEALTH SERVICES	-FAIR OAKS			2475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IOENTIFYING INFORMATION)	ID PR <b>E</b> FI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION OATE	
F <b>7</b> 55	Continued From page	± 187	F	755				
	from The National Ins https://medlineplus.go	titutes of Health at ov/multiplesclerosis.html.						
F 758 SS=D	Free from Unnec Psy- CFR(s): 483.45(c)(3)(	chotropic Meds/PRN Use e)(1)-(5)	F	758				
	affects brain activities processes and behav but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a compreheresident, the facility manual compreheresident, the facility manual compreheresident.	notropic drug is any drug that associated with mental ior. These drugs include, drugs in the following						
	unless the medication	e not given these drugs n is necessary to treat a diagnosed and documented						
	drugs receive gradual behavioral interventio	nts who use psychotropic I dose reductions, and ns, unless clinically effort to discontinue these						
	unless that medication	ursuant to a PRN order n is necessary to treat a indition that is documented						
	§483.45(e)(4) PRN or	ders for psychotropic drugs						

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

Event ID: OJ2611

Facility ID: VA0153

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STATEMENT DF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		495217	B. WING _		C 05/17/2018
	ROVIDER OR SUPPLIER	S-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 758	are limited to 14 day §483.45(e)(5), if the prescribing practition appropriate for the F beyond 14 days, he rationale in the resic indicate the duration §483.45(e)(5) PRN of drugs are limited to renewed unless the prescribing practition the appropriateness This REQUIREMEN by:  Based on staff inter and clinical record rethe facility staff failed free of unnecessary one of 48 residents Resident #420.  The facility staff failed order to give Seroque medication, on an action of the findings include Resident #420 was 5/11/18 with diagnostic staff and the staff failed order to give Seroque medication, on an action of the findings include Resident #420 was 5/11/18 with diagnostic staff failed from the findings include Resident #420 was 5/11/18 with diagnostic staff failed failed from the findings include Resident #420 was 5/11/18 with diagnostic staff failed failed from the findings include Resident #420 was 5/11/18 with diagnostic failed from the findings included Resident #420 was 5/11/18 with diagnostic failed from the findings included Resident #420 was 5/11/18 with diagnostic failed from the findings included Resident #420 was 5/11/18 with diagnostic failed from the findings included Resident #420 was 5/11/18 with diagnostic failed from the findings included Resident #420 was 5/11/18 with diagnostic failed from the findings included Resident #420 was 5/11/18 with diagnostic failed from the findings included from the findings inclu	attending physician or mer believes that it is PRN order to be extended or she should document their lent's medical record and for the PRN order.  Orders for anti-psychotic 14 days and cannot be attending physician or mer evaluates the resident for of that medication.  T is not met as evidenced view, facility document review eview, it was determined that do to ensure a resident was psychotropic medication for in the survey sample,  and to clarify the physician's seel, an antipsychotic is needed basis.	F 7		Imission to and reement with herein. To remail Federal and enter has taken set forth in the tion. The follow-recenter's allegation all alleged degenor will be adicated.
	(MDS) at the time of Review of the 5/11/1 assessment document	leted minimum data set if the survey.  8 nursing admission ented that the resident could lift understood. The resident			

STATEMENT OF DEFICIENCIES (> ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPI A. BUILOING	LE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
			7 5050		С
		495217	B. WING		05/17/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP COOE	· <u> </u>
REALIONO	ARE HEALTH SERVIC	ES ENID ONES	İ	12475 LEE JACKSON MEMORIAL HIGHWAY	
MANORO	AKE HEALIH SEKVIC	ES-FAIR CARS		FAIRFAX, VA 22033	
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F 758	Review of the care documented, "Focumented, "Focumented to: use of an antipsychotic media effectiveness and spossible decrease/drugs."  Review of the May documented, "SER (milligrams) Give 0 hours as needed for 5/16/18."  Review of the May administration guid Tablet 25 MG (milligmouth every 24 howas documented the given on 5/12/18 at An interview was commented the director of nurs Seroquel was used Seroquel is to be oblipolar schizophrer for dementia with a if Seroquel could be basis, ASM #2 stattalking to the doctoneed to engage a particular and the director of the doctoneed to engage a particular and the director of the doctoneed to engage a particular and the doctoneed to engage a particular and the doctoneed to engage a particular and the doctoneed to engage a particular and the doctoneed to engage a particular and the doctoneed to engage a particular and the doctoneed to engage a particular and the doctoneed to engage a particular and the doctoneed to engage a particular and the doctoneed to engage a particular and the doctoneed to engage a particular and the doctoneed to engage a particular and the doctoneed to engage a particular and the doctoneed to engage a particular and the doctoneed to engage a particular and the doctoneed to engage a particular and the doctoneed to engage a particular and the doctone and the	plan initiated on 5/15/18 us. At risk for adverse effects intidepression (sic) and cations. Interventions. Evaluate cide effects of medications for elimination of psychotropic  2018 physician's orders Oquel (1) Tablet 25 MG .5 tablet by mouth every 24 or agitation. Start Date:  2018 medication e documented, "SEROquel grams) Give 0.5 tablet by urs as needed for agitation." It nat the medication had been e 9:14 p.m.  conducted on 5/17/18 at 1:56 ministrative staff member) #2, ing. When asked what for, ASM #2 stated, "Seroquel ordered for specific disorders, nia and I've seen doctors use it lot of behaviors." When asked e given on an as needed ed, "No. The nurses should be or. At the end of the day we obsych (psychiatric) consult."	F 75		prn anti- dent was of all residents was of all residents was other residents who nedications. anti-psychotic potential to be educated to follow- uing prn anti- appropriate. I complete audit of AGLE Room for ns and clarify orders and then monthly of the pro- ance and review and committee er audits and/
	supervisor. When a	tered nurse) #12, the nursing asked what Seroquel was used "It's used for agitation it's also			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION	C	(X3) DATE SURVEY COMPLETED	
		495217	B. WING			C 05/17/2018	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICE	1	STREET ADDRESS, CITY, STATE, ZIP CODE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033			03/1//2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIAT		
F 758	used for antipsychot prescribing for short what that meant, RN my previous experie took every day." Who of they had an ord RN #12 stated, "I like it needs to be sched is more faster acting medication."  On 5/17/18 at 5:45 p administrator, ASM # ASM #3, the quality made aware of the finance	ic behavior. I've seen a lot of term agitation." When asked #12 stated, "As needed. In nice it was something they en asked what staff should fer for as needed Seroquel, et to suggest to the doctor that fulled or give something that like an anti-anxiety  2.m. ASM #1, the #2, the director of nursing and assurance consultant were indings.  Inducted on 5/18/18 at 8:43 seed practical nurse) #8, the en asked what Seroquel was sted, "It's an antipsychotropic ehavioral psychological tia). It has to be scheduled disais) and there should be on."  I's policy titled, "MEDICATION ADMINISTRATION mented, "GENERAL: ininistered in accordance with e and state specific and	F	758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		1 IDENTIFICATION NUMBER.		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		*****			c ·	
		495217	B. WING		05/17/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET AODRESS, CITY, STATE, ZIP CODE		
MANOPO	ARE HEALTH SERVICES	-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHWAY		
MANORO	AND HERE HIS SERVICES	- AIR GARG		FAIRFAX, VA 22033		
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F 758	Continued From page	÷ 191	F 75	58		
		nih.gov/dailymed/drugInfo.cf c3c-48fe-1a90-79608f78e8a			·	
F 759 \$S≔D	Free of Medication Er	ror Rts 5 Pront or More	F 75	correction are an admission to not constitute an agreement wi	and do th the	
	§483.45(f) Medication The facility must ensu			alleged deficiencies herein. To in compliance with all Federal a regulations, the center has take	and State	
	percent or greater; This REQUIREMENT by: Based on observation document review, and facility staff failed to e a less than 5% (five p rate. Of 30 opportunit	ion error rates are not 5 is not met as evidenced n, staff interview, facility d clinical record review, the nsure the facility was free of ercent) medication error ies for error, 4 medication involving 2 of 5 residents		will take the action set forth in the plan of correction. The following constitutes the center's allegation compliance such that all allege deficiencies have been or will be corrected by the date indicated	ng POC on of d ne	
	resulted in a medicati	is #109 and #423. This on error rate of 13.33%. iled to follow physician's stration of Zoloft and		It is the practice of the facility sure that the facility is free of than 5% (five percent) medica error rate.	a less	
		iled to follow physician's stration of Senokot and a ssident #423.				
	The findings include:					
	4/30/18 with the diagr	s admitted to the facility on noses of but not limited to a displaced avulsion tle. The most recent MDS				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZI 12475 LEE JACKSON MEMORIAL FAIRFAX, VA 22033			
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F 759	coded as being cognically life decisions. requiring total care for and transfers; extensions between the company of bowel and bladde. On 5/16/18 at 9:26 at #1 was observed premedications for Resional Baclofen [1] 10 mg (bubble on the medications for Resional Baclofen [1] 10 mg (bubble on the medications for Resional Baclofen [1] 10 mg (bubble on the medications for Resional Baclofen [1] 10 mg (bubble on the medications for Resional Baclofen [1] 10 mg (bubble on the medications for Resional Baclofen Bac	was an admission ARD (Assessment ARD) (A	F	759			

A BUILDING COMPLETED  C 495217  B. WING OF PROVIDER OR SUPPLIER  ORCARE HEALTH SERVICES-FAIR OAKS  DID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL GEACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)  OR REGULATORY OR LSC IDENTIFYING INFORMATION)  A BUILDING COMPLETED  C 05/17/20  STREET ADDRESS, CITY, STATE, ZIP CDDE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033  DID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE)  COMPLETED  C 05/17/20  STREET ADDRESS, CITY, STATE, ZIP CDDE  12476 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033  DID PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE  COMPLETED  C C 05/17/20  STREET ADDRESS, CITY, STATE, ZIP CDDE  12476 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033  DID PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTION SHOULD BE COMPLETED  COMPLETED  C 05/17/20
ORCARE HEALTH SERVICES-FAIR OAKS  ORCARE HEALTH SERVICES-FAIR OAKS  ID  SUMMARY STATEMENT OF DEFICIENCIES FIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL FIX  REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CDDE  12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033  ID  PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM CROSS-REFERENCED TO THE APPROPRIATE
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DEFICIENCY)
759 Continued From page 193 A review of the clinical record revealed the physician's order sheet (PoS) for May 2018. This review revealed an order dated 5/4/18 for the Baclofen for 15 mg, three times a day; and an order dated 5/8/18 for Zoloft, 25 mg daily for one week, then increase to 50 mg daily. The start date for the 50 mg dose was 5/16/18.  On 5/16/18 at 11:43 a.m., in an interview with RN #1, when asked about the resident getting 75 mg of Zoloft and no Baclofen, RN #1 stated that he did not get the right dose of either medication as ordered.  A review of the care plan revealed one dated 5/2/18 for "At risk for complications due to musculoskeletal problems rt (related to) muscle spasm secondary to MS (multiple sclerosis)." This care plan included an intervention for "Administer medication per physician order." This intervention was dated 5/2/18.  A review of the care plan also revealed one dated 5/15/18 for "At risk for adverse effects related to: use of antidepression medication." This care plan idid not specify to administer medications per order.  On 5/16/18 at 11:58 a.m., RN #2, the unit manager was notified of medication errors and order given to monitize of medication feelots. No side effects. No side effects. No side effects were noted. Resident #109, doctor was notified of medication feelots. No side effects. No side effects. No side effects. No side effects. No side effects were noted. Resident #203, doctor was and order was given to monitor resident for any side effects. No side effects. No side effects. No side effects. No side effects were noted. Resident #203, doctor was notified of medication and order was given to monitor end and order was given to monitor medication and antinistration band in medication and antinistration and order was given to monitor end and order was given to monitor end and order was given to monitor medication. Than and order was given to monitor end and order was given to monitor end and order was given to monitor end and order was given to monitor end and order was
use of antidepression medication." This care plan did not specify to administer medications per order.  On 5/16/18 at 11:58 a.m., RN #2, the unit manager was notified of the concern.  5/16/18 at 3:25 p.m., ASM #2 (administrative staff member, [the Director of Nursing]) stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A, BUILDING			SURVEY LETED
		495217	B. WING		· · · · · · · · · · · · · · · · · · ·	C 05/17/2018	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICE:	S-FAIR OAKS		12	TREET AOORESS, CITY, STATE, ZIP CODE		
					AIRFAX, VA 22033		
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F 759	Treatment Administration documented, "Mer accordance with star specific and federal speci	Continued From page 194  Treatment Administration Guidelines'' documented, "Medications are administered in accordance with standards of practice and state specific and federal guidelinesMedications are					
	"rights" of medication patient, right medical right time, right docu refuse, right clinical is administered accord orders are reported to practitioner and docuincluding the name as	rdance with the following administration: right tion, right dose, right route, mentation, right of patient to indicationMedications not ing to medical practitioner's the attending medical umented in the clinical record and dose of the medication is not administered"			The statement made on this pla		
	and the reason it was not administered"  On 5/16/18 at 3:57 p.m., ASM #1 (the administrator) and ASM #2 were notified of the findings. ASM #2 stated that RN #1 just froze up, that she had done ok on med pass observations conducted by the facility and an independent individual, in order to be checked off on the task as a new nurse.  No further information was provided.				do not constitute an agreement alleged deficiencies herein. To in compliance with Federal and regulations, the center has take will take the actions set forth in following plan of corrections. T following POC constitutes the callegation of compliance such the alleged deficiencies cited have will be corrected by the date incompliance.	with the remain State on or the he enter's hat all been or	ė
	decreases the numb spasms caused by n cord diseases. It also muscle movement. Information obtained	the spinal cord nerves and er and severity of muscle nultiple sclerosis or spinal o relieves pain and improves from ov/druginfo/meds/a682530.h	pinal cord nerves and discoverity of muscle e sclerosis or spinal ves pain and improves			ncated.	
	(sores on the lining of intestine); gastroeso (GERD, a condition i	ion) is used to treat ulcers of the stomach or small phageal reflux disease n which backward flow of the causes heartburn and					

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO		
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	ROVIDER OR SUPPLIER Are Health Service	S-FAIR OAKS		STREET AOORESS, CITY, STATE, ZIP COOE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	,	03/11/2010
(X <b>4</b> ) IO PREFIX TAG	IX (EACH OEFICIENCY MUST BE PRECEOEO BY FULL PREFIX (EACH		PROVIOER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APP OEFICIENCY)	OULO BE	BE COMPLETION	
F 759	mouth and stomach stomach produces to acidOver-the-coursed to prevent and indigestion and sour drinking certain food obtained from https://medlineplus.gml  [3] Zoloft is used to obsessive-compulsith oughts that won't gperform certain actid attacks (sudden, unfear and worry about posttraumatic stress psychological symptomical symptomical symptomical life). It is also symptoms of preme including mood swirth or performation obtained https://medlineplus.gtml  [4] Multivitamin/mine combination of vitant sometimes have otherbs. They are also simply vitamins. Mul recommended amount of the source of the stomach and the	gus [tube that connects the l); and conditions where the conduction where the conduction where the conduction where famotidine (Pepcid) is a treat heartburn due to acid a stomach caused by eating or its or drinks. Information gov/druginfo/meds/a687011.ht treat depression, we disorder (bothersome go away and the need to ons over and over), panic expected attacks of extreme to these attacks), disorder (disturbing coms that develop after a ce), and social anxiety ar of interacting with others att of others that interferes with the used to relieve the instrual dysphoric disorder, ags, irritability, bloating, and diffrom gov/druginfo/meds/a697048.h erall supplements contain a pains and minerals. They are ingredients, such as o called multis, multiples, or this help people get the curts of vitamins and minerals of do not get enough of these	F 75	59		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 759	ons.html  [5] Vitamin D3 help Calcium is one of the bone. A lack of vital diseases such as of the bone of the bone. A lack of vital diseases such as of the bone. A lack of vital diseases such as of the bone. A lack of vital metaes of the bone. The bone of the bone of the bone of the bone. The bone of the	es.gov/definitions/vitaminsdefinitions.gov/definitions/vitaminsdefinitions.gov/definitions/vitaminsdefinit	F 75	9			
	orders for the adm Lidocaine patch to Resident #423 was 5/2/18 with the dia stroke, high choles disease, chronic p most recent MDS admission assessi Reference Date) of coded as cognitive life decisions. The requiring extensive of daily living and a bladder. On 5/16/18 at 9:46 #1 was observed p medications for Re	s admitted to the facility on gnoses of but not limited to sterol, diabetes, Parkinson's ain, and choric embolism. The (Minimum Data Set) was an ment with an ARD (Assessment of 5/9/18. The resident was ly intact in ability to make daily resident was coded as a care for all areas of activities as incontinent of bowel and or a.m., RN (registered nurse) or paring the following					

FORM CMS-2567(D2-99) Previous Versions Obsolete

Eveni ID: OJ2611

Facility ID: VA0153

If continuation sheet Page 197 of 222

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER		) MULTIPLE CONSTRUCTION BUILDING		
		495217	B. WING_				7/2018
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS			TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY		
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F 759	Continued From pag (tablet) Lidocaine [2] patch 5 Plavix [3] 75 mg, one Aspirin [4] 81 mg, or Lantus[5] 20 units, i	5%, applied to left shoulder e tab ue tab	F 7	759			
	2018 Physician's On documented an orde be given twice daily. (Medication Adminis revealed the schedu AM and at 5:00 PM.	dication at 9:54 a.m., almost					
	were orders for the I  An order dated 5/4/1 to left shoulder topic	POS revealed that there idocaine patch as follows:  8 for Lidocaine patch "Apply ally every 12 hours for pain move per schedule."					
		8 for Lidocaine patch "Apply ically at bedtime, for Pain 2 hours."					
		8 for Lidocaine patch "Apply ically one time a day for pain , off for 12 hours."					
	The resident was no shoulder.	t offered a patch for the right					
	#1, she stated that t shoulder, was disco	a.m., in an interview with RN ne patch for the right ntinued. When informed the the right shoulder was still					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	(XS	(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  FAIRFAX, VA 22033				
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F 759	appearing as a currer computer and stated, as a current order. The provided that the order RN #1 did not offer the right shoulder, and RI that it had been applied A review of the care point of	nt order, RN #1 checked the that it was still being listed here was no evidence er had been discontinued. He resident a patch for the N #1 signed off on the MAR ed.  Dlan revealed one dated ain r/t disease process" and tion, "Administer pain cian orders." This ed 5/4/18.  AM, RN #2, the unit manager incern.  M, the ASM #1 (the SM #2 were notified of the ented that RN #1 just froze up, on med pass observations eithy and an independent be checked off on the task in was provided.  In a short-term basis to treat from ov/druginfo/meds/a601112.ht	F	759				

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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F 759	and blood vessels in stroke, heart attack, to used to prevent serio problems with the heapeople who have per circulation in the blood to the legs). Information obtained https://medlineplus.gd tml  [4] Aspirin used to relate the lining of the join caused by breakdown systemic lupus erythe the immune system and causes pain and rheumatologic condition immune system attack. Nonprescription aspirand to relieve mild to headaches, menstruate toothaches, and must attacks in people who the past or who have occurs when the head oxygen)to reduce the who are experiencing experienced a heart a strokes (strokes that blocks the flow of blomini-strokes (strokes blood to the brain is the people who have had mini-stroke in the past Information obtained	ning problems with the heart people who have had a or severe chest painis also us or life-threatening art and blood vessels in ipheral arterial disease (poor divessels that supply blood from ov/druginfo/meds/a601040.h dieve the symptoms of arthritis caused by swelling hts), osteoarthritis (arthritis in of the lining of the joints), ematosus (condition in which attacks the joints and organs swelling) and certain other ions (conditions in which the isks parts of the body). In is used to reduce fever moderate pain from all periods, arthritis, colds, cle achesto prevent heart of have had a heart attack in angina (chest pain that it does not get enough the risk of death in people or who have recently attackto prevent ischemic occur when a blood clot obt to the brain) or that occur when the flow of blocked for a short time) in a this type of stroke or st	F	759				

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		E CONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
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TATAL OF TH	TO VIOLIT ON GOTT EILIN			12475 LEE JACKSON MEMORIAL HIGHWAY		
MANORCA	ARE HEALTH SERVICES	-FAIR OAKS		FAIRFAX, VA 22033		
PREFIX	(EACH OEFICIENC	Y MUST BE PRECEOEO BY FULL	IO PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 759	tml [5] Lantus is used to t	reat diabetes	F 75	9		
F 773 SS=D	Lab Srvcs Physician of CFR(s): 483.50(a)(2) The fact (i) Provide or obtain Is ordered by a physicial practitioner or clinical accordance with State practice laws. (ii) Promptly notify the physician assistant, in nurse specialist of lab outside of clinical refewith facility policies an notification of a practice physician's orders. This REQUIREMENT by:  Based on staff intervand clinical record rethe facility staff failed per nurse practitioner residents in the survey. The facility staff failed PT/INR (prothrombin normalized ratio (1)) I other week per the nurse practice.	cility must- aboratory services only when in; physician assistant; nurse nurse specialist in e law, including scope of e ordering physician, iurse practitioner, or clinical poratory results that fall erence ranges in accordance and procedures for tioner or per the ordering  is not met as evidenced iew, facility document review view, it was determined that to obtain laboratory services 's order for one of 48 by sample, Resident #40.  It to obtain Resident #40.  It to obtain Resident #40's time/international aboratory (lab) tests every urse practitioner's order taff obtained the labs every	F 77	The statement made on this pl correction are not an admission not constitute an agreement walleged deficiencies herein. To in compliance with all Federal regulations, the center has tak take the actions set forth in the plan of correction. The following constitutes the center's allegat compliance such that all allege ficiencies cited have been or water corrected by the date indicated.  It is the practice of the facility obtain laboratory services penurse practitioner's order.	n to and do th the remain and State en or will following ng POC ion of id de- iill be l.	

NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-FAIR OAKS  STREET AGORESS, CITY, STATE, 2P CODE 12476 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, WA 22033  PROVIDER OR JAMMARY STATEMENT OF DEPICIENCIES GEACH DEPTICENCY MUSTS ER PRECEDED BY YOU. REGULATORY OR LISC IDENTIFYING INFORMATION)  F 773  Continued From page 201  F 773  Continued From page 201  F 773  Continued From page 201  F 773  Continued From page 201  F 773  Continued From page 201  F 773  Continued From page 201  F 773  Continued From page 201  F 773  Continued From page 201  F 773  Continued From page 201  F 773  L Resident #40 was admitted to the facility on 10/1/16. Resident #40'S diagnoses included but were not limited to high blood pressure, generalized anxiety disorder and diabetes. Resident #40's most recent MIDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/26/18, coded the resident's cognition as severely impaired. Review of Resident #40's clinical record revealed a physician's order signed by the nurse practitioner on 4/17/18 hat documented, "4. Docrasse the frequency of INR testing to every other Monday. Next one is 4/30/18 Resident #40's clinical record revealed #40/30/18 Resident #40's clinical record revealed #40/18. F 7/18 and 5/4/18 (obtained every week instead of every other week).  Resident #40's comprehensive care plan dated 11/28/17 documented, "Hermatological condition it (related tip) anemia Obtain Lab results as ordered and notify physician or results"  On 5/17/18 at 12:12 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 was asked to review Resident #40's physician order for PTINRs should have been done. RN #5 stated the next PTINRs should have been done on 5/4/18. RN #5 was asked if there was a reason a PTINR was obtained on 5/7/18 and 5/7/18	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	E SURVEY IPLETED
MANORCARE HEALTH SERVICES-FAIR OAKS    Continued From page 201   F773							
MANORCARE HEALTH SERVICES-FAIR OAKS    12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033   PROVIDERS PLAN OF CORRECTION (BASE PRECEDED BY PULL) PREPRIX TAG   PROVIDERS PLAN OF CORRECTION (BASE PRECEDED BY PULL) PREPRIX TAG   PROVIDERS PLAN OF CORRECTION (BASE PRECEDED BY PULL) PREPRIX TAG   PROVIDERS PLAN OF CORRECTION (BASE PREPRICED TO THE APPROPRIATE OFFICIENCY)			495217	B. WING _		05	5/17/2018
FARRAX, va. 2033   CARRED			FAID OAKS				
F773  Continued From page 201  Resident #40 was admitted to the facility on 101/16. Resident #40's diagnoses included but were not limited to high blood pressure, generalized anxiety disorder and diabetes. Resident #40's most recent MDS (minimum data set), a quarferly assessment with an ARD (assessment reference date) of 3/26/18, coded the resident's cognition as severely impaired.  Review of Resident #40's clinical record revealed a physician's order signed by the nurse practitioner on 4/17/18 that documented, "A. Decrease the frequency of INR testing to every other Monday. Next one is 4/30/18 "Resident #40's clinical record revealed madinistration record) documented, "PT/INR labs dated 4/30/18. BTAR (electronic treatment administration record) documented, "PT/INR labs dated 4/30/18. and fall following doctor order and obtain labs (PT/INR) and 5/14/18 (obtained every week instead of every other week).  Resident #40's comprehensive care plan dated 11/28/17 documented, "Hematological condition rt (related to) an ammia Jobtain Lab results as ordered and notify physician or results"  On 5/17/18 at 12:12 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 was asked to review Resident #40's physician order for PT/INRs should have been done on 5/14/18. RN #5 was asked if there was a reason a PT/INR was obtained on 4/30/18 and was asked when the next PT/INR should have been done on 5/14/18. RN #5 was askeded to for 1/4/18. RN #5 was askeded to for 1/4/18. RN #5 was askeded to for 1/4/18. RN #5 was askeded on 1/4/18. RN #5 was askeded on 1/4/18. RN #5 was askeded on 1/4/18. RN #5 was askeded on 1/4/18. RN #6 was askeded on 1/4/18. And there was a reason a PT/INR was obtained on 1/30/18 and was asked when the next PT/INR was obtained on 1/30/18 and was asked when the next PT/INR was obtained on 1/30/18 and was asked when the next PT/INR was obtained on 1/30/18 and was asked when the next PT/INR was obtained on 1/30/18 and was asked when the next PT/INR was obtained on 1/40/18 and was asked whe	MANORO	ARE HEALIH SERVICES	-PAIR OARS		FAIRFAX, VA 22033		
Resident #40 was admitted to the facility on 10/1/16. Resident #40's diagnoses included but were not limited to high blood pressure, generalized anxiety disorder and diabetes. Resident #40's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/26/18, coded the resident's cognition as severely impaired.  Review of Resident #40's clinical record revealed a physician's order signed by the nurse practitioner on 4/17/18 that documented, "4. Decrease the frequency of INR testing to every other Monday. Next one is 4/30/18 "Resident #40's May 2018 e TAR (electronic treatment administration record) documented, "PTINR every other Monday in the morning every 14 day(s)." "Further review of Resident #40's clinical record revealed multiple results of PTINR labs dated 4/30/18, 5/1/18 and 5/14/18 (obtained every week instead of every other week).  Resident #40's comprehensive care plan dated 11/28/17 documented, "Hematological condition rit (related by anemiaObtain Lab results as ordered and notify physician or fersults"  On 5/17/18 at 12:12 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 was asked to review Resident #40's physician order for PTINRs. RN #5 was made aware a PTINR was obtained on 4/30/18, and was asked when the next PTINR should have been done on 5/14/18. RN #5 was asked if there was a reason a PTINR was obtained on 5/7/18 and 4/18 and 5/14/18	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI)	X (EACH CORRECTIVE ACTION SHOUNDS: CROSS-REFERENCED TO THE APPR	LD BE	COMPLETION
stated he needed to check the chart and progress notes,	F 773	Resident #40 was ad 10/1/16. Resident #4 were not limited to his generalized anxiety of Resident #40's most set), a quarterly asse (assessment reference the resident's cognition. Review of Resident # a physician's order signactitioner on 4/17/1 Decrease the frequence of the Monday. Next #40's May 2018 eTAF administration record every other Monday iday(s)." Further revier record revealed multitidated 4/30/18, 5/7/18 every week instead of Resident #40's comp 11/28/17 documented r/t (related to) anemial ordered and notify phonogeneous modern for PT/INRs. Ref. PT/INR was obtained when the next PT/INR RN #5 stated the next done on 5/14/18. RN a reason a PT/INR w stated he needed to complete the resident with the next PT/INR was asked to review order for PT/INRs. Ref. PT/INR was obtained when the next PT/INR RN #5 stated the next pt/INR w stated he needed to complete the resident with the next PT/INR w stated he needed to complete the resident with the next PT/INR w stated he needed to complete the resident with the next PT/INR w stated he needed to complete the resident with the next PT/INR w stated he needed to complete the resident with the next PT/INR w stated he needed to complete the resident with the next PT/INR w stated he needed to complete the resident with the next PT/INR w stated he needed to complete the resident with the next PT/INR w stated he needed to complete the resident with the next PT/INR w stated he needed to complete the resident with the next PT/INR w stated he needed to complete the next PT/INR w stated he needed to complete the next PT/INR w stated he needed to complete the next PT/INR w stated he needed to complete the next PT/INR w stated he needed to complete the next PT/INR w stated he needed to complete the next PT/INR w stated he needed to complete the next PT/INR w stated he needed to complete the next PT/INR w stated he needed to complete the next PT/INR w stated he next PT/INR w stated he next PT/INR w stated he next PT/INR w stated he next PT/INR w stated he next PT/INR w stated h	mitted to the facility on 10's diagnoses included but gh blood pressure, isorder and diabetes. recent MDS (minimum data ssment with an ARD de date) of 3/26/18, coded on as severely impaired.  40's clinical record revealed gned by the nurse 8 that documented, "4. ancy of INR testing to every one is 4/30/18 "Resident R (electronic treatment) documented, "PT/INR in the morning every 14 aw of Resident #40's clinical ple results of PT/INR labs and 5/14/18 (obtained if every other week).  rehensive care plan dated di, "Hematological condition aObtain Lab results as a sysician of results"  b.m., an interview was registered nurse) #5. RN #5 Resident #40's physician with the same and t	F	<ol> <li>Resident #40, lab sche clarified by doctor.</li> <li>All residents who have scheduled have the poten affected.</li> <li>Licensed nurses will be following doctor order and (PT/INR) as ordered.</li> <li>DON and/or designee audits of five (5) resident I that PT/INR labs were ob These audits will be done and then monthly x two (2 The results of these audits warded to the Quality Ass Assessment Committee for action as appropriate. The will determine need for fur and/or actions.</li> </ol>	PT/INR la ial to be re-educa lobtain lal will comple ab orders ained as ce weekly x local review a review a committe ther audits	ted on bs ete random to ensure ordered. four (4) r- d ind ee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495217	B. WING _			C 05/17/2018	
	ROVIDER OR SUPPLIER	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW FAIRFAX, VA 22033		0.5, 11/2015	
(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 CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE	
F 773	staff member) #2 (the stated, "According to an opportunity to upd physician's discretion clarify his statement. physician's order was PT/INR to be obtained saw a weekly trend of through the chart. As a physician's order foo stated the nurses are doctor is addressing a signature written on the confirmed Resident # obtained as ordered a opportunity to improve On 5/17/18 at 2:22 p. conducted with ASM who signed Resident ASM #6 was made at concern. ASM #6 stated the ordered on 5/14/18 were sults and asked the order in the computer On 5/17/18 at 5:09 p. administrator) and AS the above findings.  The facility document TRACKING GUIDELI tests and, or services accordance, with a si	m., an interview was and ASM (administrative director of nursing). RN #5 the policy, there is always ate labs based on the "RN #5 was asked to ASM #2 stated the supposed to read for the devery 14 days and she flabs when she looked SM #2 stated she did not see reweekly PT/INRs. ASM #2 calling the doctor and the he labs as noted by the he lab results. ASM #2 the lab results. ASM #2 was an eithe lab process.  m., an interview was #6 (the nurse practitioner #40's PT/INR lab results). Ware of this surveyor's ated she realized Resident being obtained more than hen she reviewed the lab a unit manager to change the sim #2 were made aware of the sim #2 were made aware of the sim #2 were made aware of sittled, "LABORATORY NES" documented, "Lab	F7	773			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495217	B. WING _			C 0 <b>5/17/2</b> 018	
NAME OF PI	ROVIDER OR SUPPLIER	I.		STREET ADDRESS, CITY, STATE, ZIP CODE			
MANORCA	ARE HEALTH SERVICES	-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHWA FAIRFAX, VA 22033	AY		
(X4) ID PREFIX TAG			,		HOULD BI		(X5) COMPLETION DATE
F 773	laboratory staff; and viservices are provided completion and report routine critical or paniprovision of requisition supplies; when specificattending physician of the No further information (1) "A prothrombin time detect and diagnoses excessive clotting discontralized ratio (INR result and is used to a blood-thinning medical warfarin (Coumadin®	services are provided by the vithin what timeframe those including the draw ting of STAT (immediate), covalue lab results; the ns and, or lab draw fically ordered by the rephysician extender."  In was presented prior to exit.  The (PT) is a test used to help a bleeding disorder or order; the international or is calculated from a PT monitor how well the	F 7	73			
F 812 SS=D	nd-international-norm Food Procurement, Sit CFR(s): 483.60(i)(1)(2) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include form local producers, and local laws or regulii) This provision doe facilities from using p	ore/Prepare/Serve-Sanitary 2)  by requirements.  re food from sources ed satisfactory by federal, les. bod items obtained directly subject to applicable State ulations. Is not prohibit or prevent roduce grown in facility compliance with applicable	F8	112			

PRINTED: 05/30/2018 FORM APPROVED OMB NO. 0938-0391

	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			CONSTRUCTION	(X3) OATE COMP	SURVEY LETEO
		495217	B. WING				C 17/2018
	ROVIOER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS		STREET AOORESS, CITY, STATE, ZIP COOE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033		1 00/	17/2010
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION OATE
F 812	from consuming food §483.60(i)(2) - Store, serve food in accords standards for food se This REQUIREMENT by: Based on observatio document review, it v facility staff failed to p manner in the kitcher The facility staff failed sanitary manner on 5 member) #2 (the coo the floor then used th broccoli from the stea from the tilt skillet.  The facility staff failed sanitary manner on 5 member) #2 (the coo the floor then used th	prepare, distribute and ance with professional rvice safety.  is not met as evidenced in, staff interview and facility was determined that the prepare food in a sanitary in.  It to prepare food in a /15/15. OSM (other staff k) dropped a potholder on e potholder to remove amer and mashed potatoes	F	812	The statement made on this pla correction are not an admission not constitute an agreement wit alleged deficiencies herein. To in compliance with all Federal a regulations, the center has take will take the actions set forth in ing plan of correction. The follo constitutes the center's allegatic compliance such that all alleged ficiencies cited have been or with corrected by the date indicated.  It is the practice of the facility to prepare food in a sanitary mannithe kitchen.	to and h the remain nd State n or the following Poor of de-li be	e pw-
	from the tilt skillet.  On 5/15/18 at 11:33 a food for the lunch me dropped a potholder potholder up and place along with another pothe potholder that he used it to remove a p	a.m., OSM #2 was preparing					

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

Event IO: 0J2611

Facility IO: VA0153

If continuation sheet Page 205 of 222

JUN 2 2 2018
VDH/OLC

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495217	B. WING _				C 1 <b>7/2</b> 01 <b>8</b>
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE  12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X <b>4</b> ) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION OATE
F 812	used the potholder to potatoes from the tilt  On 5/15/18 at 11:45 a conducted with OSM what should be done the floor. OSM #2 stapotholder to the dirty if he remembered drofloor. OSM #2 stated the potholder on the did not want to use the contaminated. At this aware this surveyor opotholder on the floor from the steamer and "Ah. Did I? I'm not s  On 5/17/18 at 5:09 p. staff member) #1 (the director of nursin above concern.  The facility document TO SAFE FOOD HAN The elderly, infants, pregnant women and at risk from contractir serious consequence immature or compron Foods become unsaf abuse, cross-contamin hygiene"	w minutes later, OSM #2 remove a pan of mashed	F 8	312	<ol> <li>OSM #2 was immediately on preparing food in a sanita?</li> <li>All residents have the potaffect.</li> <li>Dietary staff will be re-edipreparing food in a sanitary 4. Food Service Director an will observe food preparation is prepared in sanitary mannand then monthly x two (2). The results of these audits warded to the Quality Assura Assessment Committee for action as appropriate. The cwill determine the need for fraudits and/or actions.</li> <li>Date of compliance will be</li> </ol>	ary manuential to ucated of manner d/or des n to ensi- er week vill be fo ance an review a committe urther	ner.  b be  signee  ure food  kly x four (4  r-  d  nd ee
F 880 SS=E	Infection Prevention & CFR(s): 483.80(a)(1)	& Control	F8	880			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/30/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION NG	(X3	(X3) OATE SURVEY COMPLETEO	
		495217	B. WNG_			C 05/17/2018	
	ROVIOER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS	•	STREET AOORESS, CITY, STATE, ZIP O 12475 LEE JACKSON MEMORIAL H FAIRFAX, VA 22033			
(X4) IO PREFIX TAG	(EACH OEFICIEN	STATEMENT OF OEFICIENCIES ICY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO OEFICIENC	TION SHOULO BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	infection prevention designed to provide comfortable environ development and tradiseases and infection program.  The facility must est and control program a minimum, the following for the providing services using a management based conducted according accepted national stage of the procedures for the procedures for the procedures for the procedures for the procedures in the facility (ii) When and to whice communicable disease reported; (iii) Standard and trate to be followed to present and trate of the procedures of the procedures for the procedures for the procedures for the procedures for the procedures for the procedures for the procedures for the procedures for the procedures for the procedures for the procedure of the proc	control cablish and maintain an and control program a safe, sanitary and ment and to help prevent the cansmission of communicable cons.  In prevention and control cablish an infection prevention of (IPCP) that must include, at owing elements:  Item for preventing, identifying, ing, and controlling infections diseases for all residents, itors, and other individuals onder a contractual upon the facility assessment g to §483.70(e) and following candards;  In standards, policies, and program, which must include, or can spread to other y; one possible incidents of ase or infections should be cansmission-based precautions event spread of infections; collation should be used for a	F	880			

	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		IPLE CONSTRUCTION			OATE SURVEY COMPLETEO	
		495217	B. WING _			05/	7/2 <b>018</b>	
NAME OF P	ROVIOER OR SUPPLIER		<u> </u>	STREET ADORESS, CITY, STATE, ZIP COOR		1 00/	1172010	
				12475 LEE JACKSON MEMORIAL HIGH				
MANORC	ARE HEALTH SERVICES	-FAIR OAKS		FA RFAX, VA 22033				
(X4) IO PREFIX TAG	(EACH OEFICI <b>E</b> NC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	SHOULO BE		[X5] COMPLETION DATE	
F 880	Continued From page	e 207	F8	380				
Γ 0000	(A) The type and dura depending upon the i involved, and (B) A requirement that least restrictive possificircumstances. (v) The circumstance must prohibit employed disease or infected shootnact with residents contact will transmit the (vi)The hand hygiene by staff involved in directive actions take §483.80(a)(4) A system identified under the factorrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual reversions The facility will conduct IPCP and update the This REQUIREMENT by:  Based on observation document review, and was determined that infection control praction the survey sample, #71, and #423.  1. The facility staff fail	ation of the isolation, infectious agent or organism of the isolation should be the pole for the resident under the search with a communicable win lesions from direct or their food, if direct ne disease; and procedures to be followed rect resident contact.  In for recording incidents incility's IPCP and the en by the facility.  It is store, process, and it to prevent the spread of the program, as necessary.  It is not met as evidenced on, staff interview, facility at clinical record review, it facility staff failed to maintain inces for five of 48 residents. Resident #2, #57, #101,	F	The statement made on correction are not an ad not constitute an agreer alleged deficiencies her in compliance with all Fregulations, the center has take the actions ser fort plan of correction. The constitutes the center's compliance such that al ficiencies cited have be corrected by the date in	dmission ment with thein. To ederal a has take the in the followin allegation or windicated.	n to and th the remain and Staten or will following POC on of de-ill be	e I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLI A. BUILDING		LE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495217	B. WING			C (47/2018
NAME OF P	ROVIDER DR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		17/2018
147 (1.0)2 (3) 1 1	NO VIDENDINOUT LIER			12475 LEE JACKSON MEMORIAL F		
MANORCA	ARE HEALTH SERVICE	S-FAIR OAKS		FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 880	2. The facility staff far practices during word.  3. The facility staff far practices during the observation of Resident.  4. The facility staff far respiratory equipme.  5. The facility staff process without cleans obtaining Resident fafter use.  The findings include.  1. Resident #2 was 12/14/11 and readmed diagnoses that includementia, type two or Resident #2's most set) was quarterly as (assessment referent #2 was coded as be cognitive function so on the BIMS (Brief liexam. Resident #2	ailed to follow infection control and care for Resident #57.  ailed to follow infection control 5/17/18 wound care dent #101.  ailed to store Resident #71's int in a sanitary manner.  erformed a blood glucose ing the glucometer before f423 blood sugar reading and itted on 7/25/16 with ded but were not limited to diabetes, and arthritis.  recent MDS (minimum data is essessment with an ARD ince date) of 5/5/18. Resident ing severely impaired in coring three out of possible 15 interview for Mental Status) was coded as requiring	F 88	1. RN #9 was immediassistance to a reside Resident #57 and#10 re-educated on follow during wound care. Fequipment was sanitized manner. RN#1 was resof reusuable equipment after use.  2. All residents have the sanital standard standard proper infection controcare and proper infect of reusuable equipment 4. DON and/or designandom audits to ensidente following infection respiratory equipments anitary manner and being cleaned proper fection control practice be done weekly x founx two (2)  These audits will be for Quality Assurance and Committee for review	nt in a sanitary mand in LPN #3 and #6 wing infection control ced and stored in a reducated on propert before, in between the potential to be a re-educated on fool practices during ion control practice int.  The will complete is a control practice to being stored in glucometers are ly according to ines. These audits with a control practice in the control practice	nner. were of practices ratory sanitary er cleaning en, and affected. oflowing respiratory es of cleaning being s,
	On 5/15/18 at 1:24 p Arcadia dining room RN (registered nurse a male resident. RN then proceeded to the tray. RN #9 did not picking up the food to	orn staff member with meals.  orn., observation of the was conducted. At 1:28 p.m.,  e) #9 was observed talking to I #9 touched his arm and he food cart and picked up a wash her hands prior to ray.		appropriate. The contermine need for furth actions.  5. Date of compliance	nmittee will de- ner audits and/or	

	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) OATE SURVEY COMPLETEO	
		495217	B. WING			l	0 1 <b>7/2</b> 018
	ROVIOER OR SUPPLIER	ES-FAIR OAKS	•	STREET AOORESS, CITY, STATE, ZIP 12475 LEE JACKSON MEMORIAL F FAIRFAX, VA 22033		, , , , , ,	
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F 880	opened her milk car #2's straw with her mouthpiece of the s Resident #2 a sip o then proceeded to f her meal. On 5/17/18 at 2:37	ge 209 In next to Resident #2 and Inton. RN #9 opened Resident pare hands touching the traw. RN #9 then gave If milk using the straw. RN #9 eed Resident #2 the rest of Into p.m., an interview was #9. When asked how to	F	880			
	maintain infection c residents with their would wash her har meal tray and feeding why it is important to feeding a resident, infection control. RN the male resident's #2. RN #9 stated to her hands. RN #9 a hands should not have	meals, RN #9 stated that she had before and after serving a had a resident. When asked to wash hands before and after RN # stated it was to maintain at #9 could not recall touching arm prior to feeding Resident hat she should have washed also stated that her bare ave touched the mouthpiece aw because it was unsanitary.					
	staff member) #1, the the DON (Director of the above concert of the above concert of the facility policy tit documents in part the defined as any action may include either wantiseptic agent, pla antiseptic alcohol be Hand hygiene will be alcohol-based hand visibly soiled or withafter contact with	p.m., ASM (administrative ne administrator and ASM #2, of Nursing) were made aware riss.  led, "Hand Hygiene," ne following: "Hand hygiene is on of hand cleansing which washing hands using an ain soap and water or an ased hand hygiene product. The performed using an antimicrobial soap and water: intact skin. Hand hygiene promed before contact with or					

	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	2) MULTIPLE CONSTRUCTION BUILDING			(X3) OATE SURVEY COMPLETEO	
		495217	B. WING_			C 0 <b>5</b> /17	7/ <b>2</b> 018	
	ROVIOER OR SUPPLIER	CES-FAIR OAKS		STREET AOORESS, CITY, STATE, ZIP 12475 LEE JACKSON MEMORIAL I FAIRFAX, VA 22033				
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F 880	2. The facility staff practices during we resident #57 was 12/9/09 and readn that included but we dementia, high chart included but we dementia, high chart included but we dementia, high chart included but we dementia, high chart included but we dementia, high chart included but we dementia, high chart included but we assessment with a date) of 4/8/18. Review for #57 was coded as from two staff member transfers and toile one staff member hygiene; and total dressing and bath section M (Skin Cunhealed stage that measuring 4.4 x 3 review of Resides summary) dated 5 order: "SKIN even sacrum wound with apply zinc ointmet wound with calciur foam dressing. The 5/11/18.	age 210 ms and beverages."  tion was presented prior to exit.  failed to follow infection control round care for Resident #57.  admitted to the facility on nitted on 6/7/12 with diagnoses were not limited to stroke, olesterol, and high blood at #57's most recent MDS to assessment was an annual an ARD (assessment reference esident #57 was coded as for cognitive function, on the Mental Status exam. Resident arequiring extensive assistance embers with bed mobility, ting; extensive assistance from with eating, and personal dependence on staff with ing. Resident #57 was coded in onditions) as having an ree or four pressure ulcer (1). 6 x 1.0 cm (centimeters).  Int #57's POS (physician order //1/18, revealed the following of day shift for wound care clean the NS (normal saline), pat dry, and to surrounding tissue pack in alginate (2) and cover with his order was initiated on	F	380				

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 17/2018
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		03/	17/20   0
MANODO	ADE HEALTH SERVICES	TAID OAKS		1247	'5 LEE JACKSON MEMORIAL HIGHWAY			
MANORU	ARE HEALTH SERVICES	-rair oaks		FAIF	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE		(X5) COMPLETION OATE
F 880	documented the follo skin integrity related being incontinent of bulcer to sacrum. Goa from erythema, break bruising until next revhandling while transfeskin condition with Alcare daily; report abnredistributing device skin audit, administer and supplements per Encourage and assis reposition; use assist On 5/16/18 at 9:06 a. was conducted with Lnurse) #6 and LPN (ILPN #6 was observe gathering supplies. Lgloves and placed the LPN #6 then wiped dable with an antisept drape on the table an LPN #6 then put on a removed from her sci observed washing he #57's dressing chang could not find her scishand into LPN #3's poscissors. LPN #6 then the calcium alginate. scissors prior to use. calcium alginate back pulled a sharpie out of foam dressing. The for placed back on the diher gloves and donner the science of the science of the differen	wing: "At risk for alteration in to fragile skin and resident to fragile skin and resident to fragile skin and resident to fragile skin and resident to will and bladder, Pressure it. Skin will remain intact, free adown, exceptation or riew. Interventions: Gentle erring/repositioning, Observe DL (activities of daily living) ormalities, pressure on bed and chair, weekly treatments per order, diet physician's orders, as needed to turn and ive devices as needed."  m., wound care observation LPN (licensed practical censed practical nurse) #3. If at the treatment cart is the treatment cart is possible in the resident's beside ic wipe. LPN #6 placed a diet her supplies down. It is pair of gloves that were to pocket. LPN #6 was not in thands prior to Resident e. LPN #6 stated that she is sors. LPN #6 placed her ocket, and grabbed a pair of in used the scissors to cut LPN #6 did not sanitize the	F	880				

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1'''	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
				12475 LEE JACKSON MEMORIAL HIG	GHWAY			
MANORCA	ARE HEALTH SERVIC	ES-FAIR OAKS		FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD B HE APPROPRIA	_	(X5) MPLETION OATE	
F 880	Continued From pa	ge 212 I #6 then assisted LPN #3 with	F 8	080				
	turning Resident #5 drape under Reside the old dressing to had a stage four (3) removed her gloves of gloves from her s saline bottle, cleane gauze to wipe arou grabbed the calciur directly into the wor zinc protectant arou skin prepped the ar dressing over the w same gloves that w change to place Re underneath the resi same gloves were a #57's heel boots. Li trash, washed her h	in the last steed a blue on #57 and began removing the sacrum. Resident #57 and then donned a new pair scrub pocket. LPN #6 took a sed the wound and then used and the wound. LPN #6 then a alginate and placed it and bed. LPN #6 applied the und Resident #57's wound; the and placed the foam round. LPN #6 then used the ere used for the dressing sident #57's pillows dent for repositioning. The also used to apply Resident PN #6 then threw away the hands and washed the en used bleach wipes to wipe						
	conducted with LPN would wash her han LPN #6 stated that wound, she would waressing change ardressing. LPN #6 swounds, she would each wound dressing would just change had dirty to clean. Whe transport supplies schange, LPN #6 stain her scrub pocket pocket with the gloven.	p.m., an interview was I #6. When asked when she ands during a dressing change, if a resident only has one wash her hands prior to the ad after completion of the tated that if a resident had two wash her hands between ag. LPN #6 stated that she are gloves when going from asked how she would uch as gloves for a dressing ated that she would put them When asked what was in her wes while she was doing the Resident #57, LPN #6 stated,						

	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	I * *		CONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
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		495217	B. WING			05/	17/2018
	ROVIOER OR SUPPLIER	EAID OAKS			TREET ADORESS, CITY, STATE, ZIP COOE 2475 LEE JACKSON MEMORIAL HIGHWAY		
MANORC	ARE HEALTH SERVICES	-FAIR OAKS		F.	AIRFAX, VA 22033		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	JO PREFI TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION DATE
F 880	When asked what was current time, LPN #6 and cell phone in her she washed her unifo scrub top was clean to pen and cell phone we "Everything I put in it if she knew if LPN #3 she used the scissors LPN #6 stated that she if the scissors she use stated, "We always cleanything that went into LPN #6 was informed on 5/16/18, LPN #6 dasked what was in LP scissors that were use #6 stated that did not above observations we stated that it was an into Con 5/17/18 at 6:05 p. staff member) #1, the the DON (Director of I of the above concerns The facility document GUIDE" documented, performed using noneunless otherwise order physician. In general, considered when performed using noneunless otherwise order physician, appropriate maintain appropriate maintain appropriate gleaning of wound bed	is in my pocket then." Is in her pocket at that Istated that she had her pen pocket. LPN #6 stated that Im every day and that her hat day. When asked if her ere clean, LPN #6 stated, is clean, yes." When asked Is scrub top was clean when If from her scrub pocket, It wasn't sure. When asked Is de were clean, LPN #6 Is ean the scissors. I didn't cut to the wound bed." When If he observations made id not say anything. When If he observations made id not say anything. When Is with the Is do cut the alginate, LPN Is know. When asked why the It ear a concern, LPN #6 Infection control issue. In ASM (administrative administrator and ASM #2, Nursing) were made aware Is. It titled, "SKIN PRACTICE "Dressing changes are sterile, clean techniques ared by the attending It he following guidelines are orming treatments: -adhere on control- separate clean iter field for treatment use and changing of gloves, orecautions, appropriate	F	880			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		495217	B. WING_				C <b>17/2</b> 0 <b>18</b>
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP C 12475 LEE JACKSON MEMORIAL HI 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 X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD B THE APPROPRIA		(X5) COMPLETION DATE
F 880	the skin over a bony plade, elbow, hip, but from prolonged press from being confined to in elderly and immobil ulcers may be preven position, early ambula skin lubricants and a called bedsores. Pres Dictionary of Medical Reader 2006; Mikel A Charles F. Chapman.  (2) Calcium Alginate-dissolve on contact with hydrophilic gel as a resodium ions in wound dressing. This informathe National Institutes https://www.ncbi.nlm.t. 20733/.  (3) Stage Four Pressut tissue loss with expossional section of the wound bed. Oft tunneling. Further destage IV pressure ulce location. The bridge of malleolus do not have these ulcers can be siextend into muscle and (e.g., fascia, tendon of osteomyelitis possible distance in the second into muscle and (e.g., fascia, tendon of costeomyelitis possible distance in the second into muscle and (e.g., fascia, tendon of costeomyelitis possible distance in the second into muscle and (e.g., fascia, tendon of costeomyelitis possible distance in the second into muscle and (e.g., fascia, tendon of costeomyelitis possible distance in the second into muscle and (e.g., fascia, tendon of costeomyelitis possible distance in the second into muscle and (e.g., fascia, tendon of costeomyelitis possible distance in the second into muscle and (e.g., fascia, tendon of costeomyelitis possible distance in the second into muscle and (e.g., fascia, tendon of costeomyelitis possible distance in the second into muscle and (e.g., fascia, tendon of costeomyelitis possible distance in the second into muscle and (e.g., fascia, tendon of costeomyelitis possible distance in the second into muscle and (e.g., fascia, tendon of costeomyelitis possible distance in the second into muscle and (e.g., fascia, tendon of costeomyelitis possible distance in the second into muscle and (e.g., fascia, tendon of costeomyelitis possible distance in the second into muscle and (e.g., fascia, tendon of costeomyelitis possible distance in the second into muscle and (e.g., fascia, tendon of costeomyelitis possible distance in the second into m	an inflammation or sore on prominence (e.g., shoulder tocks, or heel), resulting ture on the area, usually to bed. Most frequently seen lized persons, decubitus ted by frequently change of ation, cleanliness, and use of water or air mattress. Also sure sores. Barron's Terms for the Non Medical. Rothenberg, M.D. and Page 155.  Wound dressing that partly the wound fluid to form a sult of the exchange of fluid for calcium ions in the ation was obtained from a for Health at hih.gov/pmc/articles/PMC14  The Ulcer- Full thickness to be present on some parts the include undermining and scription: The depth of a ter varies by anatomical fithe nose, ear, occiput and a subcutaneous tissue and mallow. Stage IV ulcers can d/or supporting structures in joint capsule) making. Exposed bone/tendon is able. This information was	F	380			

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		IOENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG	ľ	(X3) OATE SURVEY COMPLETEO	
		495217	B. WING_			C 05/17/2018	
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICES	S-FAIR OAKS		STREET AOORESS, CITY, STATE, Z 12475 LEE JACKSON MEMORIA FAIRFAX, VA 22033			
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F 880	practices during the sobservation of Resident #101 was a 3/22/18 and readmitt diagnoses that include depression, diabetes irregular heart beat.  The most recent MD day assessment, wit reference date) of 6/having scored a 15 cointerview for mental swas cognitively intact The resident was coffor all activities of data Review of the reside 4/17/18 documented pressure ulcer to the mobility. Intervention physician orders."	illed to follow infection control 5/17/18 wound care ent #101.  admitted to the facility on ed on 4/17/18 with ded but were not limited to:  h, high blood pressure and  S (minimum data set), a 14 h an ARD (assessment 1/18 coded the resident as out of 15 on the brief status indicating the resident at to make daily decisions. ded as requiring assistance	F	B80	IENCY)		
	open area to sacrum	•					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTI A. BUILOIN	IPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO			
		495217	B. WING_			C 05/17/2018		
	ROVIOER OR SUPPLIER  ARE HEALTH SERVICE	S-FAIR OAKS		STREET AOORESS, CITY, STATE, ZIP COOE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033				
(X <b>4) IO</b> PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)		IO PREFIX TAG	PROVIOER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCEO TO TI OEFICIENC		(X5) COMPLETION DATE		
F 880	A wound care obser 5/17/18 at 11:07 a.m nurse) #6, the wound (registered nurse) # and took a pair of gl washed her hands a from the box in the latter resident over on the brief. LPN #6 repair of gloves out of LPN #6 did not was #6 removed the resident over on the brief. LPN #6 repair of gloves out of LPN #6 did not was #6 removed the residressing. LPN #6 reanother pair of gloves them on without sar LPN #6 cleaned the dressing. LPN #6 rewashed her hands. trash off the floor, the removed her gloves gloves. RN #1 did not removed her gloves gloves. RN #1 did not resident was possible. The resident was possible to the director of nurse should wash their has each patient care, we room." When asked hands during wound each time you remo When asked where that were to be used stated, "They should When asked if uniformal resident resident uniformal resident resident uniformal resident residen	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Intinued From page 216  wound care observation was conducted on 17/18 at 11:07 a.m. with LPN (licensed practical rse) #6, the wound care nurse and RN registered nurse) #1. LPN #6 washed her hands d took a pair of gloves out of her pocket. RN #1 ashed her hands and put on a pair of gloves on the box in the bathroom. LPN #1 then rolled be resident over onto the right side, opened up to brief. LPN #6 removed her gloves, and took a pair of gloves out of her pocket and put them on. Which washed her hands of the resident's brief and removed the resident was positioned and covered.  In interview was conducted on 5/17/18 at 1:56 m. with ASM (administrative staff member) #2, a director of nurses. When asked when staff washed their and during wound care, ASM #2 stated, "After ch time you remove the dirty wound dressing." The neaked where the gloves should be kept at were to be used for the wound care, ASM #2 stated, "They should be on the side of the field." Then asked where the gloves hould be were clean, ASM stated they were not.		880				
		nducted on 5/17/18 at 1:59 le wound care nurse. When						

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		<b>495217</b> B. WIN				C 05/17/2018		
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-FAIR OAKS				STREET ADDRESS, CITY, STATE, ZIP CODE  12475 LEE JACKSON MEMORIAL HIGHWAY  FAIRFAX, VA 22033		05)   1120   8		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
F 880	asked when staff was wound care, LPN #6 number one. We was different wounds." Will pockets were conside "Well I wash my unifor asked what else was gloves were kept in, I An interview was con p.m. with RN #1. Who wash their hands, RN care of a resident, aft made aware of the old during wound care, R but I didn't (wash her gloves)." When asked RN #1 stated, "Infection of 5/17/18 at 5:45 p. administrator, ASM # ASM #3, the quality a made aware of the fir No further information.  1. Xeroform — a medi subtribromo-phenolatic has an astringent, deeffect. Xeroform is us and salves for the tre ulcers and inflammati information was obtain https://encyclopedia2.orm  4. The facility staff fair respiratory equipments.	shed their hands during stated, "Handwashing is the our hands between hen asked if the uniform ered clean, LPN #6 stated, orm every night." When kept in her pocket the LPN #6 did not reply.  ducted on 5/17/18 at 3:20 en asked when staff should I #1 stated, "After taking for taking off gloves." When exervation made that day IN #1 stated, "I thought I did hands after removing her did why they wash their hands, on control."  m. ASM #1, the 2, the director of nursing and essurance consultant were endings.  In was obtained prior to exit.  I cinal preparation of bismuth the and bismuth trioxide that sicca-tive, and antiseptic ed externally in powders atment of intertrigoes and of ons of the mucosa. This	F8	80				

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

Event ID: 0J2611

Facility ID: VA0153

If continuation sheet Page 218 of 222

JUN 2 2 2018
VDH/OLC

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/30/2018 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF OFFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY ANO PLAN OF CORRECTION IOENTIFICATION NUMBER: COMPLETEO A. BUILOING \_ C 495217 B. WING 05/17/2018 NAME OF PROVIOER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 12475 LEE JACKSON MEMORIAL HIGHWAY MANORCARE HEALTH SERVICES-FAIR OAKS FAIRFAX, VA 22033 SUMMARY STATEMENT OF OFFICIENCIES (X4) IO ю PROVIOER'S PLAN OF CORRECTION (X5) COMPLETION (EACH OEFICIENCY MUST BE PRECEOED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULO BE PREFIX REGULATORY OR LSC IOENTIFYING INFORMATION) CROSS-REFERENCEO TO THE APPROPRIATE OATE TAG TAG OEFICIENCY) F 880 Continued From page 218 F 880 4/16/18. Resident #71's diagnoses included but were not limited to amyotrophic lateral sclerosis (1), muscle weakness and difficulty swallowing. Resident #71's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/23/18, coded the resident as being cognitively intact. Section G documented Resident #71 was totally dependent on two or more staff with bed mobility/transfers and required extensive assistance of one staff with dressing and eating. Section O documented Resident #71 utilized BIPAP/CPAP (2). Review of Resident #71's clinical record revealed a physician's order dated 4/16/18 for a ventilatory respiratory machine. On 5/15/18 at 12:49 p.m. and 5/15/18 at 2:48 p.m., the mask attached to Resident #71's respiratory machine was observed lying on a table in the resident's room. The mask was not covered. Resident #71 was out of the room. On 5/16/18 at 10:32 a.m., the mask was observed in a plastic bag. Resident #71 was out of the room. On 5/17/18 at 8:36 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked how a mask attached to respiratory equipment should be stored. LPN #1 stated, "So we have a bag. The mask, you put it in the bag and we date everything." When asked why the mask should be stored in a bag, LPN #1 stated, "For infection control." When asked if the mask should be out on the table when not in use, LPN #1 stated, "No. If not used, it should always be in a bag."

Resident #71's comprehensive care plan dated 5/16/18 failed to document information regarding

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		<b>495</b> 21 <b>7</b>	B. WNG			C 05/17/2018		
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-FAIR OAKS				STREET ADDRESS, CITY, STATE, ZIP CODE  12475 LEE JACKSON MEMORIAL HIGHWAY  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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 880	the storage of respiratory equipment.  On 5/17/18 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.  The facility document titled, "OXYGEN ADMINISTRATION" documented, "2. When not in use, store oxygen tubing and nasal cannula or mask in separate, labeled plastic bag"  No further information was presented prior to exit.  (1) "Amyotrophic lateral sclerosis (ALS) is a nervous system disease that attacks nerve cells called neurons in your brain and spinal cord. These neurons transmit messages from your brain and spinal cord to your voluntary muscles - the ones you can control, like in your arms and legs" This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources= medlineplus-bundle&query=amyotrophic+lateral+ sclerosis  (2) "Positive airway pressure (PAP) treatment		F	880				
	uses a machine to put the airway of the lung- windpipe open during delivered by CPAP (co- pressure) prevents ep that block the breathir sleep apnea and othe Your health care provi PAP machine that targ Continuous positive a	mp air under pressure into s. This helps keep the sleep. The forced air ontinuous positive airway isodes of airway collapse in people with obstructive r breathing problems der will prescribe the type of						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING			05/	0 1 <b>7/2</b> 018
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-FAIR OAKS				STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			17/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	(APAP) changes pres based on your breath Bilevel positive airwa has a higher pressure when information was obta https://medlineplus.g  5. The facility staff percheck without cleaning obtaining Resident #after use.  Resident #423 was a 5/2/18 with the diagn stroke, high cholested disease, chronic pairmost recent MDS (Madmission assessmentererence date) of 5/5 coded as cognitively life decisions. The requiring extensive cofficients of daily living and as bladder.  On 5/16/18 at 9:46 a. #1 was observed premedications to Residany medications, RN a blood glucose level 5/16/18 at 9:54 a.m., device from the medithe resident and obta afterwards, returned to the drawer of the meditaling the same stream of the meditaling the resident and obta afterwards, returned to the drawer of the meditaling the resident and obta afterwards, returned to the drawer of the meditaling the resident and obta afterwards, returned to the drawer of the meditaling the resident and obta afterwards, returned to the drawer of the meditaling the resident and obta afterwards, returned to the drawer of the meditaling the resident and obta afterwards, returned to the drawer of the meditaling the resident and obta afterwards, returned to the drawer of the meditaling the resident and obta afterwards.	topen. ble) positive airway pressure secure throughout the night, hing patterns. y pressure (BiPAP or BIPAP) a when you breathe in and you breathe out" This ined from the website: ov/ency/article/001916.htm  arformed a blood glucose and the glucometer before 423 blood sugar reading and dmitted to the facility on oses of but not limited to rol, diabetes, Parkinson's and choric embolism. The inimum Data Set) was an ant with an ARD (assessment before 4718. The resident was intact in ability to make daily esident was coded as are for all areas of activities incontinent of bowel and  m., RN (registered nurse) paring for administration of ent #423. Prior to preparing #1 was observed obtaining from Resident #423 on she obtained the glucometer cation cart drawer, went to	F	80			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

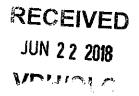
PRINTED: 05/30/2018 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ 495217 B. WING 05/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY MANORCARE HEALTH SERVICES-FAIR OAKS FAIRFAX, VA 22033 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 880 Continued From page 221 F 880 On 5/16/18 at 11:46 a.m., RN #1 stated that the glucometer should be sanitized before and after each use. When asked if she had used it on any other resident prior to Resident #423, RN #1 stated, "yes." When asked if she had sanitized the glucometer after using it on the other resident. prior to using it on Resident #423, RN #1 stated, "no." On 5/16/18 at 11:58 a.m., RN #2, the unit manager was notified of the concern. On 5/16/18 at 3:57 p.m., the ASM #1 (the Administrator) and ASM #2 were notified of the findings. ASM #2 stated that RN #1 just froze up, that she had done ok on med pass observations conducted by the facility and an independent individual, in order to be checked off on the task as a new nurse. A review of the manufacturer's user's guide booklet of the glucometer device, documented, "The EVENCARE G3 Meter should be cleaned and disinfected between each patient." No further information was provided.

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

Event ID: 0J2611

Facility ID: VA0153

If continuation sheet Page 222 of 222



#### RELEASED TO REHAB DUTY

#### Dear Elena Rosales:

Sincerely

We are pleased to advise you that your treating physician has released you to return to work with temporary limitations regarding your work assignment. As you are aware, it is HCR ManorCare's policy to offer rehabilitative duty that will enable you to return to work within those limitations while you recover with the goal of an ultimate return to full duty.

Your physician has released you to return to work with the following restrictions:

- No: lifting/carrying over 5lbs
- No: standing, walking, climbing, sitting for > 1 hour at a time
- Breaks every hour to prevent aggravation of injury, and stiffness

You are to return to work on June 21, 2018 at 7:00am. Your duties will consist of: Transcribing orders, contact family members, contact MDs and/or Pharmacists, lab review, answer phone at nurse's station, organize nurse station area, documentation, chart audits, make patient appointments, med pass, answer call lights, feed residents, which are within your physicians' restrictions. Your hours will be 7:00a.m.-3:30p.m. and your rate of pay will remain the same.

On Wednesday, June 20, 2018, you confirmed that you will be returning to work on June 21, 2018.

Please sign, date and return this letter as acknowledgment of its receipt. We are pleased you will be returning as you have been missed. Should you have any questions, please feel free to contact Briane Accius-Lamy at 703-345-2906.

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Briane Accius-Lamy	
Staffing and Payroll Coordinator	
Elena Rosales	Date

(Original: Personnel File, Copy: To Employee)

(This should be mailed certified and regular mail to the employee with a copy to the Corporate Workers' Compensation Department.)