PRINTED: 07/16/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
	<u> </u>	495038	B. WING _		Of	5/20/2019
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CO 8575 RIXLEW LANE MANASSAS, VA 20109		(Y= 200 12 a L
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E OC	0		
F 000	survey was condu 06/20/2019. The f compliance with 4 Requirement for L	Emergency Preparedness acted 06/18/2019 through acility was in substantial 2 CFR Part 483.73, Long-Term Care Facilities.	F 00	0		=
\$10 (majoriti 1) \$60	survey was condu 06/20/19. Two conduring the survey, compliance with 4	Medicare/Medicaid standard acted 06/18/19 through applaints were investigated. Corrections are required for 2 CFR Part 483 Federal Long ements. The Life Safety Code follow.				
F 622 SS=D	113 at the time of consisted of 39 cu closed record revi Transfer and Disc	harge Requirements	* F 62	2		7/23/19
ADODATO	remain in the facil discharge the resi (A) The transfer or resident's welfare cannot be met in (B) The transfer of because the resid sufficiently so the services provided (C) The safety of endangered due to status of the residues.	sility requirements- st permit each resident to ity, and not transfer or dent from the facility unless- r discharge is necessary for the and the resident's needs the facility; r discharge is appropriate ent's health has improved resident no longer needs the by the facility; Individuals in the facility is o the clinical or behavioral ent;				
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
Electron	ically Signed					07/07/2019

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

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		TE SURVEY
20		495038	B. WING_			C /20/2019
	PROVIDER OR SUPPLIER SAS HEALTH AND RI			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		20/2019
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F 622	(D) The health of in otherwise be enda (E) The resident heappropriate notice, under Medicare or Nonpayment applications appropriate notice, under Medicare or Nonpayment applications appropriate notice, under Medicare or Medicare or Medicare or Medicare or Medicare or Medicare or Medicare in Me	ndividuals in the facility would negered; as failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility, es if the resident does not ary paperwork for third party he third party, including aid, denies the claim and the pay for his or her stay. For a mes eligible for Medicaid after lity, the facility may charge a able charges under Medicaid; ses to operate. not transfer or discharge the appeal is pending, pursuant to hapter, when a resident r right to appeal a transfer or om the facility pursuant to § is chapter, unless the failure to er would endanger the health ident or other individuals in the must document the danger fer or discharge would pose. Immentation. ansfers or discharges a of the circumstances specified (i)(i)(A) through (F) of this must ensure that the transfer umented in the resident's appropriate information is ne receiving health care	F 62	22		

PRINTED: 07/16/2019 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495038	B. WING		06	/20/2019
	PROVIDER OR SUPPLIER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE MANASSAS, VA 20109	1 00	20/2019
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	survey was conduct of 20/20/2019. The factor of 20/2019. The factor of 20/2019. The factor of 20/20/2019. Two conducting the survey.	Medicare/Medicaid standard cted 06/18/19 through applaints were investigated Corrections are required for	F 000	- W		
F 622 SS=D	Term Care require survey/report will for the census in this 113 at the time of the consisted of 39 curelosed record reviews.	120 certified bed facility was he survey. The survey sample rrent Resident reviews and 5 ews.	F 622	€¥.		7/23/19
	§483.15(c) Transfe §483.15(c)(1) Faci (i) The facility must remain in the facilit discharge the resid (A) The transfer or resident's welfare a cannot be met in the (B) The transfer or because the reside sufficiently so the reservices provided to (C) The safety of intendangered due to status of the reside	er and discharge- lity requirements- t permit each resident to ty, and not transfer or dent from the facility unless- discharge is necessary for the and the resident's needs ne facility; discharge is appropriate ent's health has improved resident no longer needs the by the facility; ndividuals in the facility is o the clinical or behavioral ent;				
ABORATORY	OIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					07/07/2019

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

07/07/2019

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495038	B. WING			l	C
	PROVIDER OR SUPPLIER			857	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109	06/	20/2019
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	(D) The health of ir otherwise be endar (E) The resident has appropriate notice, under Medicare or Nonpayment applies submit the necessary payment or after the Medicare or Against or a facility cast (ii) The facility may resident while the as \$431.230 of this of exercises his or he discharge notice from 431.220(a)(3) of this discharge or transfor safety of the resident under any in paragraphs (c)(1) Documentation, the facility or discharge is documedical record and communicated to the institution or providical in Documentation in must include:	ndividuals in the facility would negered; as failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility, as if the resident does not ary paperwork for third party the third party, including aid, denies the claim and the pay for his or her stay. For a mes eligible for Medicaid after lity, the facility may charge a able charges under Medicaid; ses to operate. Internation to appeal a transfer or om the facility pursuant to appeal is pending, pursuant to thapter, when a resident rright to appeal a transfer or om the facility pursuant to \$ is chapter, unless the failure to er would endanger the health ident or other individuals in the must document the danger fer or discharge would pose. Jumentation. Lansfers or discharges a of the circumstances specified (i)(i)(A) through (F) of this must ensure that the transfer umented in the resident's lappropriate information is the receiving health care	F	622			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495038		100000	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 06/20/2019		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, 2 8575 RIXLEW LANE MANASSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 622	section, the speci- be met, facility att needs, and the se facility to meet the (ii) The document (2)(i) of this section (A) The resident's discharge is nece (A) or (B) of this s (B) A physician where the necessary under the section. (iii) Information promust include a mi (A) Contact information (B) Resident representate information (C) Advance Direct (D) All special insongoing care, as a (E) Comprehension (F) All other neces copy of the reside consistent with §4 any other docume a safe and effection This REQUIREMI by: Based on staff in and facility docume that the facility staphysician docume that the required to provided to the re transfers for three	paragraph (c)(1)(i)(A) of this fic resident need(s) that cannot empts to meet the resident revice available at the receiving eneed(s). ation required by paragraph (c) on must be made byphysician when transfer or ssary under paragraph (c) (1) ection; and nen transfer or discharge is paragraph (c)(1)(i)(C) or (D) of covided to the receiving provider nimum of the following: neation of the practitioner escare of the resident.	F 622	1) The facility failed to evidence comprehensive care plan goals with resident #12, failed to evid the required transfer requirement provided to the receiving facility resident #53, and failed to retain the transfer checklist for resident upon facility initiated transfer. N	were sent ence that nt was for n a copy of nt #94	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495038	B. WING			1	C 20/2019
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54 A NI A CO	04021E41TH 4515 SE		1		3575 RIXLEW LANE		
CANAM	SAS HEALTH AND RE	HAB CENTER			MANASSAS, VA 20109		
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F 622	Continued From pa	age 3	F€	522			
	required transfer do the receiving facility the hospital on 2/23. 2. The facility staff comprehensive car Resident #12 to the 3. The facility staff frequired transfer do	failed to evidence that the re plan goals were sent with e hospital on 04/05/2019. failed to evidence what, if any, ocumentations was provided to y when Resident #94 was			clinical outcome has been identified Resident #12, #53, or #94. 2) Any resident transferred to the hospital has the potential to be affer facility staff fail to follow transfer and discharge requirements for any fact and/or resident initiated transfer. Residents transferred in the last 72 will be reviewed and variances add 3) Director of Nursing (DON) or designee will educate licensed staff provide required transfer document for facility and/or resident initiated transfers. 4) The DON or designee will revise.	ected if nd cility 2 hours dressed. If to tation	
	The findings include: 1. The facility staff failed to evidence that the required transfer documentation was provided to the receiving facility for Resident #53's transfer to the hospital on 2/23/19.				charts of residents transferred to the hospital for evidence that required to documentation was provided weeks weeks, then monthly x 2 months. Toon or designee will report finding QAPI committee for further recommendation.	ne transfer ly x 4 The	
	7/18/17 with the dia pleural effusion, pul pressure, chronic ki diabetes, peripheral disorder, and above recent MDS (Minim assessment with an Reference Date) of coded as being cog daily life decisions. A review of the clinic note dated 2/23/19	admitted to the facility on agnoses of but not limited to ilmonary embolism, high blood sidney disease, heart failure, at vascular disease, anxiety e knee amputation. The most num Data Set) was a quarterly in ARD (Assessment 5/19/19. The resident was gnitively intact in ability to make ical record revealed a nurse's that documented, "Resident is admitted with diagnoses of		The state of the s			

DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495038 B. WING 06/20/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS HEALTH AND REHAB CENTER MANASSAS, VA 20109 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 622 Continued From page 4 F 622 (hyperlipidemia) & (and) CAD (coronary artery disease). She is alert and oriented x 3 (alert and oriented to person, place, time), verbally responsive. Currently on ABT (antibiotic therapy) PO (by mouth), Augmentin (1) for UTI (urinary tract infection) & Levaquin (2) tab for PNA (pneumonia). VS (vital signs) 124/80 (blood pressure) 86 (pulse rate) 18 (respirations) 97.9 (temperature) 95% (oxygen saturation) on 2L (two liters) oxygen via NC (nasal cannula). Complained of pleuritic pain radiating to the right flank area at the start of shift, no tenderness or fever noted on assessment, PRN (as needed) Tylenol (3) administered. Approximately 19:30 (7:30 PM) paramedics were seen entering patient's room, she had apparently called 911 and insisted on being taken to the ER (emergency room), unable to reach first emergency contact (name), 2nd emergency contact (name) & MD (medical doctor) notified. Patient transported to (name of hospital) Emergency Room." This note did not document what, if any, required documentation was provided to the hospital upon transfer. Further review of the clinical record revealed a "Nursing Home to Hospital Transfer Form" (E-Interact form) dated 2/23/19 which included information of Resident #53's demographics. code status, emergency contact information. physician contact information, facility contact information, reason for transfer, vital signs, allergies, mental status, usual functional status. devices and treatments, allergies, risk alerts, and impairments. This form did not document that the medication

list and comprehensive care plan goals were

PRINTED: 07/16/2019

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495038	B. WING			C / 20/2019
	PROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP C 8575 RIXLEW LANE MANASSAS, VA 20109	ODE	120/2013
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F 622	provided to the rechospital transfer. A review of the faci revealed that a resisheet, Advanced Dist, most recent His Recent/Relevant La Comprehensive Cadocuments, were to The facility did not upon completion for hospital transfer. Tany of the required the receiving facility transfer. On 6/20/19 at 2:33 #3 (Registered Nurpaperwork that is seresidents' includes face sheet, medical stated there was a completed and that and send it. She st checklist is not kept nurse's document in #3 was asked how information sent to not keep a copy of document a note in RN #3 stated that the not in a note. She semedical services) dipaperwork in an emalready in the folder	lity "Transfer Checklist" dent's E-Interact form, Face birectives, current medication story and Physical, abs [laboratory tests], and are Plan Goals, among other be provided to the hospital. retain a copy of this checklist r Resident #53's 2/23/19 fhere was no evidence that documents were provided to r for the 2/23/19 hospital PM, in an interview with RN se) she stated that the ent to the hospital for the care plan, bed hold notice, tion list, all the orders. RN #3 folder with checklist that is staff check off on the folder ated that a copy of the t. RN #3 stated that the n a note what was sent. RN the facility evidences the the hospital if the facility does checklist and does not cluding the information sent. here wouldn't be any if it was stated that EMS (emergency oesn't wait for a lot of hergency; that most of it is	F 6	22		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		
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F 622	she stated that the for what to send is checklist. On 6/20/19 at appendix Administrator (ASMember) and the #2) reviewed the did not reflect evithospital upon the A review of the fad Discharge" did not documentation is the hospital.	ctical Nurse) the unit manager, the facility goes by the checklist out doesn't keep a copy of the proximately 4:15 PM, the SM #1 - Administrative Staff DON (Director of Nursing, ASM clinical record and stated that it dence of what was sent to the 2/23/19 hospital transfer. Cility policy, "Notification of ot specify what, if any, required to be sent with the resident to mation was provided by the end	F 622			
	Information obtain https://medlineplutml (2) Levaquin is an Information obtain https://medlineplutml (3) Tylenol is use 2. The facility state comprehensive of Resident #12 to the Resident #12 was 01/16/2017. Here	ned from us.gov/druginfo/meds/a685024.h				

NAME OF PROVIDER OR SUPPLIER MANASSAS HEALTH AND REHAB CENTER MANASSAS HEALTH AND REHAB CENTER MANASSAS, VA 20109 STREET ADDRESS, CITY, STATE, ZIP CODE 8576 RIXLEW LANE MANASSAS, VA 20109 SUMMARY STATEMENT OF DEFICIENCIES FREDULATORY OR LISC IDENTIFYING INFORMATION) FREDULATORY OR LISC IDENTIFYING INFORMATION) F 622 Continued From page 7 Hypertension (high blood pressure), and Anemia (low level of red blood cells). Resident #12 s most was an Annual Assessment was an Annual Assessment with an Assessment was an Annual Assessment with an Assessment Reference Date (ARD) of 03252019. The Brief Interview for Mental Status (BIMS) scored Resident #12 at 15, indicating not impairment. Review of the clinical record revealed that Resident #12 was transferred to the hospital on 04/05/2019. Pra a Progress Note dated 04/05/2019. Pra progress Note dated 04/05/2019. Pra progress Note dated on 04/05/2019. Pra practice, Resident eart with discharge paperwork: current med [medication] list, by Paramedics, Resident sent with the resident to the hospital. The progress note did not include documentation that resident's comprehensive care plan goals were sent with the resident to the hospital. On 06/20/2019 at 2-45p.m., an interview was conducted with Licensed Practical Nurse (LPN) #9 regarding transfer of residents to the hospital. PN #9 was asked if the facility retained a copy of the Transfer Checklist as documentation of what is sent with the resident that have very and were included on the Transfer Checklist When asked if the facility retained a copy of the Transfer Checklist is kept.		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		TE SURVEY MPLETED
MANASSAS HEALTH AND REHAB CENTER (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (ECOLOROPY OR 1.50 IDENTIFYING INFORMATION) FEGULATORY OR 1.50 IDENTIFYING INFORMATION) F 622 Continued From page 7 Hypertension (high blood pressure), and Anemia (low level of red blood cells). Resident #12's most recent Minimum Data Set (MDS) assessment was an Annual Assessment with an Assessment Reference Date (ARD) of 032/52/019. The Brief Interview for Mental Status (BIMS) scored Resident #12 to 15; indicating no impairment. Review of the clinical record revealed that Resident #12 to 15; indicating no impairment. Review of the clinical record revealed that Resident #12 to 15; indicating no impairment. Review of the clinical record revealed that Resident #12 to 15; indicating no impairment. Review of the clinical record revealed that Resident #12 to 15; indicating no impairment. Review of the clinical record revealed that Resident #12 to 15; indicating no impairment. Review of the clinical record revealed that Resident #12 to 15; indicating no impairment. Review of the clinical record revealed that Resident #12 to 15; indicating no impairment. Review of the clinical record revealed that Resident with the mentional cycle with heavy bleeding. Pt (patient) was taken out at 1105 (11:05a.m.) by Paramedics, Resident sent with discharge paperwork: current med [medication] list, bed hold policy, transfer form, no advanced directives, face sheet." The progress note did not include documentation that resident's comprehensive care plan goals were sent with the resident to the hospital. LPN #9 was asked if comprehensive care plan goals were sent with the resident to the nospital. LPN #9 was asked if comprehensive care plan goals were sent with the resident to the nospital to the hospital to the hosp		ШПа		B. WING	i		1	
FREEN TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 622 Continued From page 7 Hypertension (high blood pressure), and Anemia (low level of red blood cells). Resident #12's most recent Minimum Data Set (MDS) assessment was an Annual Assessment of Herence Date (ARD) of 0372/2019. The Brief Interview for Mental Status (BIMS) scored Resident #12 at 15, indicating no impairment. Review of the clinical record revealed that Resident #12 was transferred to the hospital on 04/05/2019. Per a Progress Note dated 04/05/2019. Per a Progress Note dated of 40/05/2019. Per a Progress Note dated resident sent to ER (emergency room) via 911 for possible seizure activity with pain in lower abdominal pain associated with menstrual cycle with heavy bleeding. Pt (patient) was taken out at 1105 (11:05a.m.) by Paramedics, Resident sent with discharge paperwork: current med imedication] list, bed hold policy, transfer form, no advanced directives, face sheet.* The progress note did not include documentation that resident's comprehensive care plan goals were sent with the resident to the hospital. On 06/20/2019 at 2:45p.m., an interview was conducted with Licensed Practical Nurse (LPN) #9 regarding transfer of residents to the hospital. LPN #9 was asked if comprehensive care plan goals were sent with the resident on transfer to the hospital. LPN #9 stated that they were, and were included on the Transfer Checklist. When asked if the facility retained a copy of the Transfer Checklist as documentation of what is sent with the resident, LPN #9 stated that no copy of the					8575	5 RIXLEW LANE		20/2019
Hypertension (high blood pressure), and Anemia (low level of red blood cells). Resident #12's most recent Minimum Data Set (MDS) assessment was an Annual Assessment with an Assessment Reference Date (ARD) of 03/25/2019. The Brief Interview for Mental Status (BIMS) scored Resident #12 at 15, indicating no impairment. Review of the clinical record revealed that Resident #12 was transferred to the hospital on 04/05/2019. Per a Progress Note dated 04/05/2019 at 10:59a.m., which documented in part the following: "MD (medical doctor) ordered resident sent to ER (emergency room) via 911 for possible seizure activity with pain in lower abdominal pain associated with menstrual cycle with heavy bleeding. Pt (patient) was taken out at 1105 (11:05a.m.) by Paramedics, Resident sent with discharge paperwork: current med (medication) list, bed hold policy, transfer form, no advanced directives, face sheet.* The progress note did not include documentation that resident's comprehensive care plan goals were sent with the resident to the hospital. On 06/20/2019 at 2:45p.m., an interview was conducted with Licensed Practical Nurse (LPN) #9 regarding transfer of residents to the hospital. LPN #9 stated that they were, and were included on the Transfer Checklist. When asked if the facility retained a copy of the Transfer Checklist as documentation of what is sent with the resident, LPN #9 stated that no copy of the	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETION
Administrative Staff Member (ASM) #1, the		Hypertension (high (low level of red blo recent Minimum Da was an Annual Asse Reference Date (AF Interview for Mental Resident #12 at 15, Review of the clinic Resident #12 was to 04/05/2019. Per a F 04/05/2019 at 10:59 part the following: ". resident sent to ER possible seizure act abdominal pain asse with heavy bleeding 1105 (11:05a.m.) by with discharge pape [medication] list, becadvanced directives. The progress note of that resident's computer sent with the resident with the nospital. LPN #9 was asked if goals were sent with the hospital. LPN #9 were included on the asked if the facility rechecklist as document the resident, LPN #9 checklist is kept.	blood pressure), and Anemia blood cells). Resident #12's most at Set (MDS) assessment essment with an Assessment RD) of 03/25/2019. The Brief all Status (BIMS) scored, indicating no impairment. cal record revealed that transferred to the hospital on Progress Note dated 9a.m., which documented inMD (medical doctor) ordered (emergency room) via 911 for tivity with pain in lower sociated with menstrual cycle g. Pt (patient) was taken out at y Paramedics, Resident sent erwork: current med and hold policy, transfer form, no s, face sheet." did not include documentation prehensive care plan goals resident to the hospital. :45p.m., an interview was ensed Practical Nurse (LPN) er of residents to the hospital. if comprehensive care plan h the resident on transfer to 9 stated that they were, and the Transfer Checklist. When retained a copy of the Transfer rentation of what is sent with 9 stated that no copy of the		522			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G	(X3) DATE SURVEY COMPLETED			
		495038	B. WING _	<u></u>	_	C 20/2019
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 622	Administrator, and Nursing, were info of day meeting on documentation was a school of the causes both a (psychosis) and mania) https://medlineplustration. The facility staff required transfer of receiving facility w transferred to the legical of the street of the cause of th	ASM #2, the Director of rmed of the findings at the end 06/20/2019. No further s provided. disorder is a mental condition loss of contact with reality ood problems (depression or s.gov/ency/article/000930.htm	F 62			
	5/23/16 with the di unspecified demer disturbance, type 2 renal disease (1), and peripheral vas MDS (Minimum Dassessment, with date) of 6/2/19, co 15 out of 15 on the Mental Status) soon cognitive impair A review of the clir note dated 2/18/19 in part, "Res (residual to the companion of the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the companion of the clir note dated 2/18/19 in part, "Res (residual to the companion of the comp	agnoses of but not limited to notia with behavioral 2 diabetes mellitus, end stage dependence on renal dialysis, icular disease. The most recent ata Set), a quarterly an ARD (Assessment reference ded the resident as scoring a e BIMS (Brief Interview for ore, indicating the Resident had rement for daily decision making. Inical record revealed a nurse's 10, at 9:30 AM, that documented lent) has temp (temperature) of 12 change of shiftPer NP 13 resident to be sent out 14 transported to hospital via				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495038	B. WING			I	C
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY 8575 RIXLEW LANE MANASSAS, VA 201		1 06/	<u>/20/2019</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CCTIVE ACTION SHOULD NCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	stretcher with EMT Technician)." A review of the clir physician's note dipart, "Pt (patien lethargic, malaise tremulous through chills/fever/night st (Primary Care Phyand gave order for A review of the "Tr E-Interact Transfe Condition Form, S Appearance, and I Sheet, Current Me Physical), Advance Care Plan Goals, I Bed Hold Policy, (e Transfer Order, (e) Progress Note, and With Resident is to However, the facili form for Resident 2/18/19 and theref the required docum. On 6/20/19 at 4:07 member) #1, the A Director of Risk Ma Assurance & Performade aware of the No further informatithe survey. (1) End Stage Ren	nical record revealed a ated 2/18/19, documented in t) is c/o (complaining of) felling w/ (with) feeling hot and out. He said he has weats and mumblingPCP-NP vsician) immediately notified reR (Emergency Room)" ansfer Checklist" revealed that reorm, E-Interact Change in BAR (Situation, Background, Review and Notify), Face edication List, H&P (History and led Directive, Comprehensive Nursing Home Capabilities List, electronic health record) dectronic health record) dectronic health record) dependent on this form. It is did not retain a copy of this #94's hospital transfer on ore had no evidence that any of mentation was sent. TPM, ASM (administrative staff dministrator and ASM #3, the anagement and Quality ormance Improvement were	F	522			

	OF CORRECTION	IDENTIFICATION NUMBER;	1.70	PLE CONSTRUCTION	COM	E SURVEY IPLETED	
		495038	B. WING			C 20/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 623 SS=D	functioning on a per need for a regular a kidney transplan information was ob- website: https://www.cms.g enefits-and-Recov d-Recovery-Overv ESRD/ESRD.html Notice Requirement	ermanent basis leading to the course of long-term dialysis or to maintain life. This otained from the following ov/Medicare/Coordination-of-Bery/Coordination-of-Benefits-an iew/End-Stage-Renal-Disease-ints Before Transfer/Discharge	F 622	н		7/23/19	
	resident, the facilit (i) Notify the resider representative(s) of the reasons for the language and man facility must send a representative of the Long-Term Care Composed in the reaction of t	ensfers or discharges a y must- ent and the resident's of the transfer or discharge and e move in writing and in a ener they understand. The a copy of the notice to a he Office of the State embudsman. Sons for the transfer or esident's medical record in aragraph (c)(2) of this section;					
	(c)(8) of this section discharge required made by the facilit resident is transfer (ii) Notice must be before transfer or the section of the	fied in paragraphs (c)(4)(ii) and on, the notice of transfer or I under this section must be y at least 30 days before the red or discharged. made as soon as practicable					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495038	B. WING	à		C 06/20/2019	
	PROVIDER OR SUPPLIER SAS HEALTH AND RE			STREET ADDRESS, CITY, STATE, ZIP CO 8575 RIXLEW LANE MANASSAS, VA 20109		00/20/2013	
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F 623	be endangered und this section; (B) The health of in be endangered, und this section; (C) The resident's hallow a more immedunder paragraph (c) (D) An immediate the required by the resident has not days. §483.15(c)(5) Contentice specified in paragraph (c) (i) The reason for the foliation of the form the foliation of the form the foliation of the form the foliation of the folia	der paragraph (c)(1)(i)(C) of adividuals in the facility would der paragraph (c)(1)(i)(D) of a dividuals in the facility would der paragraph (c)(1)(i)(D) of a diate transfer or discharge, e)(1)(i)(B) of this section; ransfer or discharge is ident's urgent medical needs, e)(1)(i)(A) of this section; or not resided in the facility for 30 dents of the notice. The written paragraph (c)(3) of this section allowing: transfer or discharge; the of transfer or discharge; which the resident is harged; the resident's appeal rights, address (mailing and email), aber of the entity which ests; and information on how form and assistance in and submitting the appeal ess (mailing and email) and of the Office of the State	F	623			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495038		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 06/20/2019		
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD 18575 RIXLEW LANE MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	and Bill of Rights codified at 42 U.S (vii) For nursing far disorder or related email address and agency responsible advocacy of indivices tablished under for Mentally III Individual for Mentally III Individual for Men	Act of 2000 (Pub. L. 106-402, a.C. 15001 et seq.); and acility residents with a mental disabilities, the mailing and disabilities, the protection and Advocacy ividuals with a mental disorder the Protection and Advocacy ividuals Act. In anges to the notice. In the notice changes prior to ster or discharge, the facility ecipients of the notice as soon the the updated information et. In advance of facility closure in the facility must provide a prior to the impending closure by Agency, the Office of the Care Ombudsman, residents of the resident representatives, as for the transfer and adequate esidents, as required at § ENT is not met as evidenced therview, clinical record review, then the resident rentative, was provided written the pospital transfer for four of 44 stampled of provide a copy of the notice of abudsman for one of 44 sampled	F 623	1) The facility failed to provide notice to Resident #12, #43, #8 or the residents. Responsible Representatives of facility and initiated transfers to the hospit failed to provide a copy of the transfer to the Ombudsman for #21. No negative clinical outco been identified for Resident #1 or #94 as a result.	or resident or resident al, and notice of resident me has	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495038	B. WING	B. WING			C 20/2019
	PROVIDER OR SUPPLIER SAS HEALTH AND RE	HAB CENTER		85	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE IANASSAS, VA 20109	1 001	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 623	1. The facility staff Resident #53 or the provided with writte hospital transfer on 2. The facility staff f Resident #12 or the written notice for the hospital on 04/05/20 3. The facility staff f #94's representative notification of why thospital on 2/18/19. 4. The facility staff f #43's representative notification of why thospital on 4/10/19. 5. The facility staff ombudsman of a facility staff ombudsman of a facility staff ombudsman of a facility staff on 04/11/19 and 04/16/11/19 and 04/1	failed to evidence that resident representative were notification of the residents 2/23/19. failed to evidence that the responsible party were given residents transfer to the 019. ailed to provide Resident with the required written he resident was sent to the ailed to provide Resident with the required written he resident was sent to the failed to notify the cility-initiated transfer on 1/19 for Resident #21.	F 6	23	2) Any resident transferred to the hospital has the potential to be affer facility staff fail to provide written not a resident, resident representative Ombudsman. Medical records of residents transferred to the hospital last 72 hours will be reviewed to en Resident or Responsible Represent and the Ombudsman has been not Any variance will be addressed. 3) Director of Nursing (DON) or designee will educate licensed nursistaff of the requirement to provide a notice to the resident and/or reside representative. The Director of Nur (DON) will provide education to Soc Services regarding the requirement provide notification to the Ombudsmany facility and/or resident initiated transfers. 4) The DON or designee will reviet charts of residents transferred to the hospital for evidence that the Resident/Responsible Representat the Ombudsman was provided writt notice of facility and/or resident initiatransfer weekly x 4 weeks, then mode a months. Findings will be reported QAPI committee for further recommendation.	ected if otice of sfer to or the all in the sure a stative sified. sing written nt sing cial to man of ewe ive and ten sated onthly x	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		495038	B. WING _	OUVER IND	06	C /20/2019	
	AN OF CORRECTION IDENTIFICATION NUMBER: 495038 OF PROVIDER OR SUPPLIER ASSAS HEALTH AND REHAB CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 623	assessment with a Reference Date) of	n ARD (Assessment 5/19/19. The resident was	F 62:	3			
	daily life decisions. A review of the clin note dated 2/23/19 following, "Compla to the right flank ar tenderness or feve (as needed) Tylenc Approximately 19:3 seen entering patic called 911 and insic (emergency room) emergency contact (name) & Patient transported	ical record revealed a nurse's that documented in part the ined of pleuritic pain radiating ea at the start of shift, no r noted on assessment, PRN of (3) administered. (3) (7:30 PM) paramedics were ent's room, she had apparently sted on being taken to the ER unable to reach first (name), 2nd emergency MD (medical doctor) notified.		7			
	notification was pro- resident represental A review of the fact revealed that, amo "Transfer & Treatm hospital transfer pa a copy of this check Resident #53's 2/2 On 6/20/19 at 4:12 conducted with the	ovided to the resident and/or ative. lity "Transfer Checklist" ng other documents, a sent Form" is included in the acket. The facility did not retain klist upon completion for 3/19 hospital transfer. PM, an interview was Administrator (ASM #1 -					
	Administrative Stat Nursing (ASM #2). describe how the representative are a transfer. ASM #	f Member) and the Director of ASM #1 was asked to esident and the resident's provided written notification of I stated, "If we are sending					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495038	B. WING			1	C
	PROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, Z 8575 RIXLEW LANE MANASSAS, VA 20109	IP CODE	<u> 06/</u>	20/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
	to the hospital and packet with all the clincluded in that packet as the reason for the clinical record (the progress notes resident representat transfer. We use the notification to the representative. The responsible for ensidence of this notifical record and sevidence of the facilical record and sevidence in the facilical record and sevidence of the facilical record and sevidence of the facilical record and sevidence in the facilical record and sevidence of the facilical record and sevidence of the facilical record and sevidence in the facilical record and sevidence of the facilical record	em verbally why they are going we complete the transfer documentation listed on it. Exet is the transfer note that transfer. It is documented in electronic health record) under that that they (resident and tive) were informed of the he transfer note as the written esident and resident ender the Director of Nursing is uring the process is followed." Discipately 4:15 PM, ASM #1 rector of nursing, reviewed the stated that it did not reflect iffication being completed and ity policy, "Notification of inted, "Discharge notices arges will be provided to the ve as soon as possible, provide the the paperwork that attent to the hospital. If not notice to a responsible as soon as practicable all transfer and document in"	F6	23			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 8575 RIXLEW LANE MANASSAS, VA 20109		20/2013	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 623	Continued From p	age 16	F 623	3		8	
	(2) Levaquin is an Information obtain https://medlineplut tml			<			
	Information obtain https://medlineplustml 2. The facility staff Resident #12 or th	s.gov/druginfo/meds/a681004.h failed to evidence that the re responsible party were given ne residents transfer to the		e ×			
	01/16/2017. Her d Schizoaffective Di Hypertension (high (low level of red bl recent Minimum D was an Annual Ass Reference Date (A Interview for Ment	admitted to the facility on iagnoses included Dementia, sorder (1), Epilepsy, and Anemia ood cells). Resident #12's most rata Set (MDS) assessment sessment with an Assessment ARD) of 03/25/2019. The Brief al Status (BIMS) scored 5, indicating no impairment.	oč.				
	Resident #12 was 04/05/2019. Per a 04/05/2019 at 10:5 part the following: resident sent to El possible seizure a abdominal pain as with heavy bleedin 1105 (11:05a.m.) It with discharge par	cal record revealed that transferred to the hospital on Progress Note dated 59a.m., which documented in "MD (medical doctor) ordered R (emergency room) via 911 for ctivity with pain in lower sociated with menstrual cycle g. Pt (patient) was taken out at by Paramedics, Resident sent perwork: current med ed hold policy, transfer form, no es, face sheet."					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING		(X3) DAT	E SURVEY MPLETED	
		495038	B WING	B. WING			С	
	PROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE, ZIP (8575 RIXLEW LANE MANASSAS, VA 20109	CODE	06/	20/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	N SHOULD E	3E	(X5) COMPLETION DATE	
F 623	Continued From pa	age 17	F6	623				
	The progress note that a written notific or sent to the RP (r	did not include documentation cation was given to the resident esponsible party).						
	conducted with ASI member) # 1, admidirector of nursing. describe how the representative are a transfer. ASM # them to the hospital communicate to the to the hospital and packet with all the clinical record (and the progress notes resident representative. The representative.	2 p.m., an interview was M (administrative staff nistrator and ASM # 2, the ASM #1 was asked to esident and the resident's provided written notification of 1 stated, "if we are sending I and if the resident is alert we em verbally why they are going we complete the transfrer documentation listed on it. Eket is the transfer note that transfer. It is documented in electronic health record) under that that they (resident and tive) were informed of the e transfer note as the written esident and resident edirector of nursing is uring the process is followed."						
value y C	Administrative Staff Administrator, and A Nursing, were inform	Member (ASM) #1, the ASM #2, the Director of med of the findings at the end 16/20/2019. No further						
	that causes both a I (psychosis) and mo mania) https://medlineplus.	isorder is a mental condition oss of contact with reality od problems (depression or gov/ency/article/000930.htm ailed to provide Resident	St			i		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		TE SURVEY MPLETED
	8-1	495038	B. WING		06	/20/2019
	PROVIDER OR SUPPLIER		857	REET ADDRESS, CITY, STATE, ZIP CO 75 RIXLEW LANE NASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 623	· · · · · · · · · · · · · · · · ·	page 18 ve with the required written	F 623			
1	hospital on 2/18/1 Resident #94 was 5/23/16 with the d	admitted to the facility on iagnoses of but not limited to				
	disturbance, type renal disease (1), and peripheral vas MDS (Minimum D assessment, with	ntia with behavioral 2 diabetes mellitus, end stage dependence on renal dialysis, scular disease. The most recent ata Set), a quarterly an ARD (Assessment reference ded the resident as scoring a				
Y V	15 out of 15 on the Mental Status) sco no cognitive impai	e BIMS (Brief Interview for ore, indicating the Resident had irment for daily decision making.		15		
	note dated 2/18/19 in part, "Res (resid 101.1 (degrees) a (Nurse Practitione Resident said he feel well.' Residen	nical record revealed a nurse's 9, at 9:30 AM, that documented dent) has temp (temperature) of t change of shiftPer NP r) resident to be sent out e is not nauseous but 'does not transported to hospital via I (Emergency Medical				A
	physician's note d documented in pa (complaining of) for feeling hot and tre has chills/fever/nig PCP-NP (Prima	nical record revealed a ated 2/18/19, at 9:30 AM, rt, "Pt (patient) is c/o elling lethargic, malaise w/ (with) mulous throughout. He said he ght sweats and mumbling ry Care Physician) immediately order for ER (Emergency				
		dence that the resident				

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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	PROVIDER OR SUPPLIER			STRE 8575	ET ADDRESS, CITY, STATE, ZIP CODE RIXLEW LANE NASSAS, VA 20109	<u> 06</u>	/20/2019	
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	written notification the hospital on 2/18 On 6/20/19 at 4:12 conducted with ASI member) # 1, admidirector of nursing, describe how the representative are a transfer. ASM # them to the hospital and packet with all the communicate to the to the hospital and packet with all the clinical record (the progress notes resident representative. The representative. The responsible for ens On 6/20/19 at 4:07 Administrator and A Management and C Performance Improthe findings. No further informatithe survey (1) End Stage Rena condition in which a functioning on a per need for a regular ca kidney transplant.	p.m., an interview was M (administrative staff inistrator and ASM # 2, the ASM #1 was asked to esident and the resident's provided written notification of 1 stated, "If we are sending all and if the resident is alert we sem verbally why they are going we complete the transfer documentation listed on it. Exet is the transfer note that transfer. It is documented in electronic health record) under that that they (resident and ative) were informed of the e transfer note as the written esident and resident edirector of nursing is uring the process is followed." PM, ASM #1, the ASM #3, the Director of Risk	F	623				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IG	(X3) DATE SURVEY COMPLETED			
			495038	B. WING _		06	C /20/2019
		PROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		120,2010
	(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	F 623	enefits-and-Recove	age 20 ov/Medicare/Coordination-of-B ery/Coordination-of-Benefits-an ew/End-Stage-Renal-Disease-	F 62	3		
		#43's representativ	failed to provide Resident re with the required written the resident was sent to the				
		11/19/18 with the d unspecified demen disturbance, periph diabetes mellitus, r anxiety. The most Set), a 14-day sche ARD (Assessment coded the resident the BIMS (Brief Inte- score, indicating th	admitted to the facility on iagnoses of but not limited to take the iagnoses of the ia				
		note dated 4/10/19 part, "Called Dr. (D (follow up) with doc to (name of) hospit IV (intravenous) flu to infection to foot i suggestion to ser (Emergency Room	ical record revealed a nurse's, at 3:00 PM, documented in octor) (name of) office to F/U ctor about possible direct admit al due to fevers, poor appetite, ids, and ABT (antibiotics) due needing amputation at to (name of) hospital ER) for admissionNP (Nurse Primary Care Physician) made as orders."		8	git	
		Further review of the	ne clinical record revealed a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495038	B. WING				C (20/2010
	PROVIDER OR SUPPLIER SAS HEALTH AND RE			STREET ADDRESS, CITY, STATE, ZIP 8575 RIXLEW LANE MANASSAS, VA 20109	CODE	UO/	/20/2019
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	nurse's note dated and spoke with dau (name), updated or conversations and sDaughter is ok witDoes not want a broost." There was no evide representative was written notification of the hospital on 4/10 On 6/20/19 at 4:12 conducted with ASM member) # 1, admir director of nursing. describe how the representative are patransfer. ASM # 1 them to the hospital communicate to the to the hospital and we packet with all the dincluded in that packet with all the dincluded in that packet with all the clinical record (ethe progress notes the resident representative. The responsible for ensuring the clinication to the responsible for ensuring the construction of the resp	4/10/19, at 3:10 PM, "Called aghter/RP (Responsible Party) in all information from today's sending her dad to the hospital ath this and approved transfer bed hold at this time due to ence that the resident provided with the required of why the resident was sent to 0/19. p.m., an interview was M (administrative staff inistrator and ASM # 2, the ASM #1 was asked to esident and the resident's provided written notification of a stated, "if we are sending and if the resident is alert we are verbally why they are going we complete the transfer documentation listed on it. ket is the transfer note that ransfer. It is documented in electronic health record) under that that they (resident and tive) were informed of the e transfer note as the written is ident and resident		523			

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495038		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			TE SURVEY MPLETED
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F 623	No further informathe survey. 5. The facility state ombudsman of a 04/11/19, for Resident # 21 was 12/24/18 and a rediagnoses that inchronic respirator infarction (2), and most recent MDS assessment with date) of 04/09/19, scoring a 15 on the status (BIMS) of a cognitively intact of the facility's "Producted 04/11/2019 following, "13:15 (received to send the Hospital) ER (emergency service Company) called awaiting for arrivation of Hospital) ER at and made him away on 06/20/2019 at conducted with Osocial worker regard ombudsman of a stated, "I send fax and fax and fax and fax as the survey of the service of the s	ation was provided by the end of ff failed to notify the facility-initiated transfer on dent # 21. s admitted to the facility on -admission on 04/18/19 with cluded but were not limited to: y failure (1), old myocardial anxiety (3). Resident # 21's (minimum data set), a quarterly an ARD (assessment reference coded Resident # 21 as the brief interview for mental a score of 0 - 15, 15 - being for making daily decisions. gress Notes" for Resident # 21 documented in part the 1:15 p.m.) New order the resident to (Name of the regency room) for further stomy with constipation with non tes. (Name of Transportation at 13:20 (1:20 p.m.) and I and call placed to the (Name 13:25 (1:35 p.m.). RP notified	F 62	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I .	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	×	495038	B. WING		O.F.	C 5/20/2019
	PROVIDER OR SUPPLIER	EHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP C 8575 RIXLEW LANE MANASSAS, VA 20109	XODE	12012019
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	When asked about to the hospital, OS resident is transfer the ombudsman if go to the hospital anotify the ombudsr that she was not a required to be notiful of whether they are On 06/20/19 at application of whether they are ASM # 3, director of were made aware. No further information obtained from the white process (1) When not enouglings into your blood obtained from the white process. (2) Heart attack. When the hospital information was a blood clot that arteries. The coron oxygen to the heart is starved the	se that went to the hospital." It residents who are transferred M # 10 stated, "When the red to the hospital I only notify the resident is admitted, if they and return the same day I don't man." OSM # 10 further stated ware that the ombudsman was fied of all transfers regardless admitted or not. Proximately 2:15 p.m., ASM # 1 ff member), administrator, and of risk management and QAPI, of the findings. Ition was provided prior to exit. Ingh oxygen passes from your od. This information was website: In.gov/medlineplus/respiratoryfa I lost heart attacks are caused blocks one of the coronary lary arteries bring blood and the lift the blood flow is blocked, if of oxygen and heart cells die as obtained from the website: I gov/ency/article/000195.htm. I mation was obtained from the m.gov/medlineplus/anxiety.html	F6	23		
F 625	Notice of Bed Hold	Policy Before/Upon Trnsfr	F 62	25		7/23/19

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495038 NAME OF PROVIDER OR SUPPLIER MANASSAS HEALTH AND REHAB CENTER		(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION NG	COI	C
			8	STREET ADDRESS, CITY, STATE, ZIP COI 8575 RIXLEW LANE MANASSAS, VA 20109		6/20/2019
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F 625 SS=D	CFR(s): 483.15(d) §483.15(d) Notice §483.15(d)(1) No nursing facility tra the resident goes nursing facility mu the resident or re- specifies- (i) The duration or any, during which return and resum facility; (ii) The reserve be plan, under § 447 (iii) The nursing fa bed-hold periods, paragraph (e)(1) resident to return (iv) The information fof this section. §483.15(d)(2) Bet the time of transfe hospitalization or facility must provi resident represen specifies the dura described in para This REQUIREM by: Based on observ record review, an was determined to that a written bed	e of bed-hold policy and return- tice before transfer. Before a Insfers a resident to a hospital or on therapeutic leave, the lest provide written information to sident representative that If the state bed-hold policy, if the resident is permitted to the residence in the nursing and the decimal policy in the state that the state bed-hold policy in the state that the policies regarding which must be consistent with the finis section, permitting a that and the section permitting a the finis section transfer. At the of a resident for the resident for the repeutic leave, a nursing de to the resident and the that written notice which that of the bed-hold policy graph (d)(1) of this section. ENT is not met as evidenced attion, staff interview, clinical defacility document review, it the facility staff failed to evidence hold notice was provided to the	F 62	The facility failed to provious notification of bed hold policy transfer to the hospital for Res No negative clinical outcome.	upon sident #94.	
	one of 44 residen	entative for a hospital transfer for ts in the survey sample; e facility staff failed to provide		identified for Resident #94. 2) Any resident transferred to hospital has the potential to be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER MANASSAS HEALTH AND REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CO 8575 RIXLEW LANE MANASSAS, VA 20109		12012019	
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Resident #94's representat of the bed hold policy when transferred to the hospital of the bed hold policy when transferred to the hospital of the bed hold policy when transferred to the hospital of the bed hold policy when transferred to the hospital of the bed hold policy when transferred to the hospital of the bed hold policy when transferred to the hospital of 5/23/16 with the diagnoses unspecified dementia with the disturbance, type 2 diabeted renal disease (1), depended and peripheral vascular disease (MDS (Minimum Data Set), assessment, with an ARD (date) of 6/2/19, coded the response to 15 out of 15 on the BIMS (EMENTAL MENTAL MENT	I to the facility on of but not limited to behavioral semilitus, end stage note on renal dialysis, ease. The most recent a quarterly Assessment reference esident as scoring a Brief Interview for ating the Resident had daily decision making. Indicate the company of the company of the revealed a nurse's AM, that documented temp (temperature) of of shiftPer NP at to be sent out auseous but 'does not red to hospital via ency Medical Indicate the revealed a language of the company of the company of the said he and mumbling hysician) immediately	F 62	facility staff fail to provide write bed hold policy upon transfer hospital. Residents transferre hospital in the last 72 hours be reviewed to ensure Reside Responsible Representative very provided written notification of upon transfer. 3) Director of Nursing (DON designee will educate licenses staff of the requirement to pronotice of bed hold policy upon the hospital. 4) The DON or designee will audit for residents transferred hospital for evidence that Resident/Responsible Represented written notificate hold upon transfer weekly x 4 monthly x 2 months. Findings reported to the QAPI Committed further recommendation.	to the d to the charts will ent or were f bed hold) or d nursing vide written transfer to conduct an to the entative ion of bed weeks, then will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION		TE SURVEY MPLETED	
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F 625	E-Interact Transfe Condition Form, S Appearance, and Sheet, Current M Physical), Advance Care Plan Goals, Bed Hold Policy, Transfer Order, (Progress Note, at With Resident is However, the fact form for Resident 2/18/19 and there the required docu On 6/20/19 at 4:3 (Registered Nurswas asked about resident goes to the send the care plad doctor's order. The atransfer check resident." RN #3 evidence the bed the information is the list is not retain the required to the A review of the fare Policy," document is responsible for BEFORE the resident.	ransfer Checklist" revealed that er Form, E-Interact Change in SBAR (Situation, Background, Review and Notify), Face edication List, H&P (History and ted Directive, Comprehensive Nursing Home Capabilities List, (electronic health record) and Personal Belongings Sent to be documented on this form. lity did not retain a copy of this #94's hospital transfer on after had no evidence that any of mentation was sent. 4 PM, an interview with RN e) #3 was conducted. RN #3 the process staff follows when a he hospital. RN #3 stated, "We n, bed hold policy, face sheet, here is a list in the transfer folder list. The packet goes with the was asked if the facility cannot hold notification was provided if not documented and a copy of ned. RN #3 stated, "I guess so." dence that the resident is provided written notification of y when the resident was hospital on 2/18/19. cility's policy "Notice of Bed Hold ted in part,"Nursing Services2.Showing Policy to resident dent goes to the hospital3. d form (or witnessed mark) to	F 625			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER SAS HEALTH AND RE	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		<u>/20/2019</u>
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F 625	Social Services Dep Services/AdmissionFollowing up to see form to resident and Notifying responsible person, documenting form is notified by person, documenting the survey of form if seed on 6/20/19 at 4:07 Member) #1, the Add Director of Risk Marksurance & Performade aware of the survey. (1) End Stage Rena condition in which a functioning on a per need for a regular or a kidney transplant information was obtwebsite: https://www.cms.gorenefits-and-Recove	partmentSocial as are responsible for the that nursing has shown of that resident signed2. the party by phone, or in the generation on Notice thone, having responsible ther in person or by Mail. (Keep that in the mail)" PM, ASM (Administrative Staff diministrator and ASM #3, the that the staff of the staff of the staff that the staff of the staff of the staff that the staff of the staff of the staff that the staff of the staff of the staff that the staff of the staff of the staff that the staff of the staff of the staff that the staff of the staff of the staff that the staff of the staff of the staff that the staff of the staff of the staff that the staff of the staff of the staff that the staff of t	F 6.	25		
F 641 SS=D	resident's status.		F 64	11		7/23/19

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION		E SURVEY PLETED	
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F 641	Based on staff into review, it was dete failed to maintain a (minimum data set residents in the su. The facility staff fai Resident # 107's documented that Fand was discharge on 06/19/19 at 3:5 conducted with LP 7, MDS coordinato Resident # 107's "I Anticipated" MDS awas correctly code check and get bac	erview and clinical record brained that the facility staff a complete and accurate MDS t) assessment for one of 44 arvey sample, Resident # 107. illed to accurately code discharge status to the discharge assessment MDS t) with an ARD (assessment 04/18/19. Instead, the ge was coded as 'Acute de: as admitted to the facility on moses that included but were cle weakness, difficulty walking essure. Resident # 107's MDS t), a discharge assessment with ent reference date) of 04/18/19, 107 as "03 (three) - Acute ection "A2100 Discharge press Notes" dated 04/18/2019, Resident \$ 107 left with her soned home. 55 p.m., an interview was N (licensed practical nurse) # or. LPN #7 was asked if Discharge Return Not assessment dated 04/18/2019 ed. LPN # 7 stated she would	F 641	1) Center staff failed to accurate Resident #107 s discharge statu discharge assessment MDS date 04/18/2019. Resident #107 s, M dated 04/18/2019 was modified to discharge status to community. 2) Any resident whose discharge is not accurately coded in the MD the potential to be affected. A reverse to conducted to ensure accurate conducted to ensure accurate conducted to ensure accurate coding the MDS. 3) The interdisciplinary team restor coding the MDS will be educate regarding accurate coding of the 4) MDS coordinators or designed conduct an audit of 5 completed discharge assessments weekly x weeks, then monthly x 2 months accurate coding of discharge states Findings will be reported to the Q Committee for further recomments.	is on the id DS oreflect e status is has iew of will be ding of sponsible ted MDS. e(s) will 4 for us. API		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER SAS HEALTH AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		120/2019
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SS=D	and the discharge proded incorrectly. On 06/20/19 at 8:08 staff member) 3 1, a surveyor with copy of corrected discharge 04/18/19. Under "si Status" Resident # Community (private assisted living, ground on 06/19/19 at appropriate (administrative staff ASM # 3, director of (quality assurance a improvement), were no further information Develop/Implement CFR(s): 483.21(b) (1) The faimplement a compressident rights set for §483.21(b) (1) The faimplement are identical, nursing, an needs that are ident assessment. The condescribe the following (i) The services that or maintain the reside physical, mental, and	ident # 107's progress notes plan of care that the MDS was provided this possible that \$483.10(c)(2) and processed the comprehensive care plan must properly care plan must properly care plan must provided in the comprehensive care plan must properly care plan must provided in the comprehensive care plan must properly care plan must provided in the comprehensive care plan must plan to the care plan to	F 64			7/23/19

	OF CORRECTION	IDENTIFICATION NUMBER:	175, 607		ATE SURVEY OMPLETED	
۔ ریاد		495038	B. WING		C 6/20/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	30/20/2019	
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F 656	(ii) Any services the under §483.24, §44 provided due to the under §483.10, incommender §483.10, incommender §483.10, incommender §483.10, incommender §483.10, incommender §483 are sufficiently as a result recommendations. Findings of the PAS rationale in the result in the resident's represer (A) The resident's desired outcomes. (B) The resident's future discharge. Find the resident's future discharge plander in the result in the sum plander in th	at would otherwise be required 83.25 or §483.40 but are not a resident's exercise of rights luding the right to refuse 183.10(c)(6). If services or specialized ces the nursing facility will of PASARR of a facility disagrees with the SARR, it must indicate its ident's medical record, with the resident and the ntative(s)-goals for admission and preference and potential for facilities must document and the sessed and any referrals to cies and/or other appropriate	F 656	1) Resident #83 s care plan was reviewed and revised to reflect the use of non-pharmacological interventions prict to administration of as needed pain medication. Residents # 92 and # 43 s care plans were reviewed and revised to reflect the use of side rails. 2) Any resident who resides in the facility has the potential to be affected by this issue. A review of the current residents with as needed pain medication will be conducted to ensure that the Care Plan	r	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
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MANAGE	CAC DEALTH AND DE			8575 RIXLEW LANE	3002	
MANAS	SAS HEALTH AND RE	.HAB CENTER		MANASSAS, VA 20109		
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F 656	Continued From pa	age 31	F 65	56		
	2. The facility staff for comprehensive care for Resident #92.	failed to develop a re plan for the use of side rails		includes the use of non-pha interventions prior to admin needed pain medication an side rails.	nistration of as	
	comprehensive care for Resident #43.	failed to develop the re plan for the use of bed rails		 The interdisciplinary tea for care planning will be ed- regarding accurate care planning. RAI manual. 	lucated anning per the	
	The findings include			4) MDS coordinators or de conduct an audit of 8 care p	plans weekly x	
	The facility staff failed to implement Resident #83's comprehensive care plan for the use of non-pharmacological interventions prior to the administration of as needed pain medication.			4 weeks, then monthly x 2 in Findings will be reported to Committee for further recor	months. the QAPI	
	12/05/2018 with diag	admitted to the facility on agnoses that included but were natoid arthritis (1), depressive nemia (3).				
	set), a significant ch ARD (assessment re coded Resident # 83 assessment for mer	st recent MDS (minimum data hange assessment with an reference date) of 05/28/19, 33 as scoring a 15 on the staff ental status (BIMS) of a score cognitively intact for making				
	conducted with Resi staff assess her pair needed (prn) pain m stated, "Sometimes pain level is from on staff try to alleviate h	administering the pain				
	The "Physician's Ord	der Sheet" dated		10		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	CON	E SURVEY MPLETED	
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MANASSAS HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 8575 RIXLEW LANE MANASSAS, VA 20109		
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F 656	(milligram) (Aceta by mouth every 6 Order Date: 12/14 The eMAR (electrecord) dated "Apabove physician's eMAR revealed Ton 04/02/19 at 9:15 pod/09/19 at 5:49 at 11:23 p.m., and a pain level of foudated "Apr (April) dated 04/02/19 the evidence docume interventions atte of Tylenol.	umented, "Tylenol Tablet 325MG aminophen) Give 1 (one) tablet (six) hours as needed for pain. 4/2018. Start Date: 12/14/2018." ronic medication administration or (April) 2019" documented the corder for Tylenol. Review of the tylenol 325mg was administered 26 p.m., with a pain level of two, o.m., with a pain level of two, o.m., with a pain level of two, a.m., with a pain level of two and d on 04/21/19 at 8:58 p.m., with a pain level of two and d on 04/21/19 failed to entation of non-pharmacological mpted prior to the administration	F 65			
	record) dated "Ma physician's order eMAR revealed T on 05/19/19 at 6:56 three and at 6:56 Further review of and the eMAR no evidence docume interventions atte of Tylenol.	ronic medication administration ay 2019" documented the above for Tylenol. Review of the ylenol 325mg was administered 30 a.m., with a pain level of p.m. with a pain level of three. the eMAR dated "May 2019" tes dated 05/19/19 failed to entation of non-pharmacological mpted prior to the administration ronic medication administration				
1 to 1	record) dated "Ju physician's order revealed Tylenol 3 06/02/19 at 7:32 a	ne 2019"documented the above for Tylenol. Review of the eMAR 325mg was administered on a.m., with a pain level of three at 8:27 p.m. with a pain level of	Ž3			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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NAME OF PROVIDER OR SUPPLIER MANASSAS HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP 8575 RIXLEW LANE MANASSAS, VA 20109		120/2019
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F 656	three. Further revision of the administration of the administratio	ew of the eMAR dated "June R notes dated 06/02/19 and vidence documentation of cal interventions attempted diration of Tylenol. e care plan for Resident # 83 documented, "Focus. potential for pain, has H/O es and has [sic] contractors Initiated 12/05/2018. 2019." Under "it documented, "Assess pain and PRN (as needed) and as needed. Date Initiated: 22 a.m., an interview was (registered nurse) # 2, unit as asked to describe the dministration of prn pain estated, "Ask them if they have cord for the resident's prn pain and the location of the er for which pain medication is much, administer the liment it in the eMAR. Follow an hour to determine the medication." When asked on-pharmacological	F 6	56		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		
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F 656	attempted. Wher of a care plan, RN take care of the p Resident #83's complemented/follor non-pharmacolog "No." On 06/20/19 at ap (administrative stands and administrative stands and a saffect of the joints and saffect other organ obtained from the https://medlineplut. (2) Depression m blue, unhappy, middling from the https://medlineplut. (2) Depression m blue, unhappy, middling from the https://medlineplut. (3) Low iron. This information. This the website:	time documented ical interventions were not asked to describe the purpose I # 2 stated, "It tells us how to atient." When asked if the emprehensive care plan was ewed for the use of ical interventions RN #2 stated, proximately 2:15 p.m., ASM # 1 aff member), administrator, and of risk management and QAPI experiormance improvement), of the findings. Action was provided prior to exit. It can also use the information was expected as feeling sad, is erable, or down in the dumps. It was a way at one time or another for nical depression is a mood feelings of sadness, loss, anger, fere with everyday life for weeks ormation was obtained from the information was obtained from the information was obtained from the information was obtained from		6		
	nttps://www.nim.n -	ih.gov/medlineplus/anemia.html		A		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE	3		ST 85	FREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE ANASSAS, VA 20109	<u> 06/</u>	/20/2019
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	comprehensive ca for Resident #92. Resident #92 was 5/18/19 with the d high blood pressu diabetes, epilepsy retinopathy, diabe blindness, conges peripheral vascula disease, amputation recent MDS (Mininal admission/5-day and (Assessment Referesident was code ability to make dai was coded as requibathing, hygiene, to transfers; and was Observations made	failed to develop a are plan for the use of side rails admitted to the facility on agnoses of but not limited to re, chronic kidney disease, renal dialysis, diabetic tic neuropathy, depression, tive heart failure, stroke, ar disease, end stage renal on of right toes. The most num Data Set) was an assessment with an ARD erence Date) of 5/25/19. The das being cognitively intact in ly life decisions. The resident ultring extensive care for oileting, dressing, and a independent for eating.	F	556			
	revealed Resident up on both sides. A review of the clir readmission from "Nursing Admissio (and) Interim POC four)" form was co a section identified Mobility/Safety." T for "Side rails." Ne for marking "Yes" cyes:1. Left, line in the above se	#92 in bed, with half side rails itical record revealed that on the hospital on 5/5/19, a n/Readmission Assessment & (plan of care) - V4 (version mpleted. This form contained I as "Section K. his section contained an area ext to "Side Rails" was a circle or "No." Under that, was "a. if _2. Right,3. Both." (Each entence represented a circle on selecting which answer					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495038		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COI	(X3) DATE SURVEY COMPLETED		
	PROVIDER OR SUPPLIE	B value of the second of the s		STREET ADDRESS, CITY, STATE, ZIP 3575 RIXLEW LANE MANASSAS, VA 20109		06/20/2019 E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL I LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	2. Full" (Each represented a circ selecting which a was, "c. Are side independence wit No." (Each line i represented a circ selecting which a #92, this docume half-length side rapromote independent further review of reveal any evident entrapment for the	hat, was "b. If yes:1. Half, line in the above sentence cle on the document, for inswer applied). Under that, rails used to promote h bed mobility1 Yes,2. In the above sentence cle on the document, for inswer applied). For Resident intidentified she was to use alls on both sides of the bed to dence with bed mobility. The clinical record failed to ce an assessment for risk of e use of side rails with Resident.	F 656				
	risk and benefits discussed with the evidence of an interest the side rails for FA review of the correvealed one date the need for ADL assistance." This	omprehensive care plan ed 5/18/19 for "Demonstrates (activities of daily living) care plan did not include any he use of side rails that the					
	On 6/20/19 at 2:4 conducted with LI Nurse) the unit m resident uses her that the resident "seizures so side rasked if the side LPN #9 stated the can initiate or cha	7 PM, an interview was PN #9 (Licensed Practical anager. She stated that the side rails to turn and reposition, is blind, has anxiety, and has ails are appropriate." When rails should be care planned, by should be. When asked who ange a care plan, LPN #9 stated dmitting nurse and supervisor					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIER		F. S.	STREET ADDRESS, CITY, STATE, ZIP (8575 RIXLEW LANE MANASSAS, VA 20109	CODE	0012012013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATI	COMPLETION DATE
F 656	does, but that any A review of the factore Planning Promust develop a coeach resident that objectives and time medical, nursing, a needs that are ideassessment. An inteam shall develop and care plan for eoutcomes of assess resident, family an members. The teatoverseeing resider comprehensive caseven (7) days of comprehensive as the care plan is a freviewed and updatamily or represent (interdisciplinary) to additional intervent addressed" On 06/20/19 at 4:0 #1 - administrative aware of the findin provided by the en	cility policy, "Comprehensive ocess" documented, "The facility omprehensive care plan for includes measurable tetables to meet a resident's and mental and psychosocial entified in the comprehensive interdisciplinary assessment of a comprehensive assessment each resident based on saments and input from the indinterdisciplinary team am serves as the authority for inticare servicesA are plan is developed within completion of the initial assessment (MDS)Additionally, fluid document and shall be atted at any time the resident, tative or member of the ID team determines a need for attions or care areas to be	F 65	56		
	11/19/18 with the d	admitted to the facility on diagnoses of but not limited to not without behavioral		.0		

(X3) DATE SURVEY COMPLETED C 06/20/2019			
		J BE RIATE	(X5) COMPLETION DATE
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 656	physician attends the stated, "No." We reads the care plant. On 6/20/19 at 4:07 Administrator and Administrator and Administrator and Administrator and Compensation of the findings. No further information the survey.	ne care plan meetings, ASM hen asked if the physician ASM #1 stated, "No." PM, ASM #1, the ASM #3, the Director of Risk Quality Assurance & evement were made aware of on was provided by the end of	F 656			
SS=D	S483.25(e)(1) The stresident who is con admission receives maintain continence condition is or beconot possible to main \$483.25(e)(2) For a incontinence, based comprehensive assensure that— (i) A resident who e indwelling catheter is catheterization was (ii) A resident who e indwelling catheter is assessed for rem	ence. acility must ensure that tinent of bladder and bowel on services and assistance to e unless his or her clinical mes such that continence is ntain. resident with urinary d on the resident's essment, the facility must nters the facility without an is not catheterized unless the endition demonstrates that	F 690			7/23/19
	demonstrates that cand	atheterization is necessary; s incontinent of bladder				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	СОМІ	E SURVEY PLETED C 20/2019
	PROVIDER OR SUPPLIER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE IANASSAS, VA 20109		114
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 690	prevent urinary tracontinence to the §483.25(e)(3) For incontinence, bas comprehensive as ensure that a resireceives appropriates as much repossible. This REQUIREMS by: Based on observing record review, it was failed to provide a suprapubic cathet of 44 residents in 56. The facility states 56's catheter collection. The findings inclusing the facility and a rediagnoses that incretention of urine, disorder (2), and a Resident # 56's manual resident # 56's	ate treatment and services to act infections and to restore extent possible. The a resident with fecal ed on the resident's essessment, the facility must dent who is incontinent of bowel atte treatment and services to normal bowel function as ENT is not met as evidenced eation, staff interview and clinical was determined that facility staff are and services for a ter to prevent infections for one the survey sample, Residents # aff failed to prevent Resident # ection bag from resting on the	F 690	1) Facility staff failed to provide a services for an indwelling catheter prevent infections by failing to precatheter collection bag from resting floor for Resident #56. Educational coaching was provided to staff and catheter collection bag was remove the floor. No negative clinical outdowns identified. 2) Any resident with an indwelling catheter has the potential to be affacility staff fail to prevent catheter collection bags from resting on the Residents with indwelling catheter observed to ensure collection bags secured to prevent infections. 3) Center staff will be educated to prevent catheter collection bags from resting on the floor.	r to vent ng on the al d ved from come g urinary fected if r e floor. rs will be is are	
	ARD (assessmen coded Resident # the brief interview score of 0 - 15, 7 impaired of cognit Resident # 56 was	t reference date) of 05/16/19, 56 as scoring a 7 (seven) on for mental status (BIMS) of a (seven) - being severely tion for making daily decisions. s coded as being totally staff member for activities of		4) A random observational audit residents with indwelling urinary c will be conducted daily (M-F) x 5 c weekly x 3 weeks and monthly x 2 to verify catheter collection bags a resting on the floor. Findings will be reported to the QAPI Committee f	atheters days, 2 months are not be	,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109			20/2019
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 690	Resident # 56 was catheter (including nephrostomy tuber On 06/18/19 at 4:: Resident # 56 revelying in her bed was of the bed revealed it was attained resting on the The POS (physicia 56 dated "June 19 pubic catheter 20 centimeters) ballo Change PRS (as a Order Date: 09/11 The comprehensive dated 06/08/2015 resident has an In Neurogenic bladde (urinary tract infection 08/19/2016." On 06/19/19 at 11 conduct with CNA When asked to deresident's catheter "The collection bas and low so it drain to avoid infection."	on H "Bladder and Bowel" so coded as "A. Indwelling group suprapubic catheter and a)." 21 p.m., an observation of ealed she was in her room, atching television. Observation and it was low to the ground and the catheter collection bag tached to the side of the bed afloor. an's order sheet) for Resident # 9, 2019" documented, "Supra F (French) with 20cc (cubic confor neurogenic bladder. Indeeded) for facility protocol. //17." // e care plan for Resident # 56 documented, "Focus: The dwelling (Suprapubic) Catheter: er. At risk for chronic UTIs tions) date Initiated: // 232 a.m., an interview was (certified nursing assistant) # 7. scribe the placement of a collection bag, CNA # 7 stated, g is put on the side of the bed s. It should not be on the floor	F 690	further recommendations.		
	When asked to de	scribe the placement of a collection bag, LPN # 4 stated,				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495038	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	СОМ	E SURVEY PLETED 20/2019
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CO 3575 RIXLEW LANE MANASSAS, VA 20109		20/2019
(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 S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 690	should not be on contamination." The facility's polic "PROCEDURE: H	ng is put on the side of the bed it the floor to avoid infection or by "Catheter Care" documented, Id. Collection container is below	F 690		1 — _iei	
	On 06/19/19 at ag (administrative standard ASM # 3, director (quality assurance improvement), we no further information and the standard from the obtained from the			£	- 12 - 12	
	essure.html. (2) Depression m blue, unhappy, m Most of us feel th short periods. Cli disorder in which or frustration interor more. This infewebsite:	ay be described as feeling sad, iserable, or down in the dumps. is way at one time or another for nical depression is a mood feelings of sadness, loss, anger, fere with everyday life for weeks ormation was obtained from the is.gov/ency/article/003213.htm.				
	brain and spinal of sheath, the mater your nerve cells. blocks messages body, leading to t	tem disease that affects your cord. It damages the myelin rial that surrounds and protects This damage slows down or between your brain and your he symptoms of MS. They can turbances, muscle weakness.	a			21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	06/20/2019
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MANASS	SAS HEALTH AND RE	HAB CENTER			
				MANASSAS, VA 20109	
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F 690	Continued From pa	ge 43	F6	90	
	trouble with coordin such as numbness, needles" and thinki This information wa https://medlineplus.	ation and balance, sensations prickling, or "pins and ing and memory problems. is obtained from the website: gov/multiplesclerosis.html.			
F 695 SS=D		ostomy Care and Suctioning	F 6	95	7/23/19
	GFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that facility staff failed to provide care and services for a tracheostomy consistent with professional standards of practice, the comprehensive person-centered care plan for one of 44 residents in the survey sample, Residents # 21. The facility staff failed to wash her hands and change her gloves while providing Resident #			1) Facility staff failed to provide ca services for a tracheostomy consists with professional standards of pract and the comprehensive person-cent care plan for Resident #21 by failing wash hands and change gloves whi providing tracheostomy care. Educa coaching was provided to the staff member who completed tracheostomy care. No negative clinical outcome videntified.	ent ice tered j to le ational my was
	change her gloves v 21's tracheostomy c	ed to wash her hands and while providing Resident # eare.		 2) Any resident requiring tracheost care has the potential to be affected facility staff fail to wash their hands a change their gloves while providing tracheostomy care. 3) Licensed staff will be educated regarding professional standards of 	l if and/or
	riesidelii # 21 was a	admitted to the facility on		practice for providing tracheostomy	care.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE A. BUILDING	LE CONSTRUCTION	СОМ	PLETED
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	PROVIDER OR SUPPLIE		8	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE MANASSAS, VA 20109	COMPL C 06/20 S, CITY, STATE, ZIP CODE ANE A 20109 IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY) Trector of Nursing (DON) or fill observe tracheostomy care of x 5, weekly x 3 and monthly x stency with professional of practice. Findings will be the QAPI Committee for	8 3
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 695	12/24/18 and a rediagnoses that indichronic respirator infarction (2), and Resident # 21's met), a quarterly a (assessment refe Resident # 21 as interview for mention 15, 15 - being codecisions. Under Procedures and Ecoded as "D. Succare." On 06/19/19 at 10 conducted of trace 21 performed by 6. LPN #6 entere up packaged trace clean barrier. LP and put on a clean barrier. LP and put on a clean sterile "Suction Kingloves, opened at the kit. LPN #6 the sterile suction tub from the suction machine in LPN #6 then place the sterile tubing Resident #21's trace Upon completing suction machine, removed the glove then donned a pasterile "Tracheostitems and placed"	-admission on 04/18/19 with cluded but were not limited to: y failure (1), old myocardial	F 695	4) The Director of Nursing (DO designee will observe tracheosto daily (M-F) x 5, weekly x 3 and n 4 for consistency with professior standards of practice. Findings were ported to the QAPI Committee further recommendations.	omy care nonthly x nal vill be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 8575 RIXLEW LANE MANASSAS, VA 20109	ZIP CODE	06/20/2019
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F 695	wearing the regular removed the cannuplaced it in the tray and peroxide, place cleaned it using the wearing the same ganother bottle of sacleaned the area at opening. LPN #6 the from the "Tracheos the strap on the rig cuff. She then attated over-the-bed table gloves, went to the the old strap from the wearing to the lef #6 then removed at package and place Resident # 21's trace. The POS (physicial 21 dated "June 19, [tracheostomy] care needed). Order Data The comprehensive dated 01/18/2019 df 21) is at risk for reto chronic condition respiratory failure wacute exacerbation Under "Intervention" Provide Trach Care 02/08/2019." On 06/19/19 at 1:21 conducted with LPN regarding the traches.	r plastic gloves LPN # 6 ala from Resident # 21's trach, , opened the bottle of saline ed the cannula in the tray and e enclosed brush. While gloves LPN # 6 opened aline and using a cotton swab round Resident #21's trach ben removed a clean strap stomy Care Tray" and removed the side of Resident #21's trach ched the new strap, moved the while wearing the same left side of the bed, removed the trach cuff and attached the t side of the trach cuff. LPN new cannula, opened the d a new, clean cannula into ch cuff. n's order sheet) for Resident # 2019" documented, "Trach e q (every) shift and PRN (as	F	695		

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
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F 695	procedure for using sanitize or wash in LPN #6 was then observations of not hands between clitems while wearing Resident # 21's treshould have only sterilized field. I to same gloved hand on with." When a her hands between trach care for Resident # 21's policity of the facility's policity of the facility of	ing gloves, LPN # 6 stated, "I my hands between glove use." informed of the above of changing gloves, washing her nanging gloves and touching ing gloves when providing ach care. LPN # 6 stated, "I stouched the items in the outhed the suction tubing with d I turned the suction machine sked if she washed or sanitized on changing gloves during the sident LPN stated, "No." "y "Tracheostomy Care" OCEDURE: A. 2. Wash your edure as aseptic as possible)."." proximately 5:30 p.m., ASM # 1 aff member), administrator, and of risk management and QAPI or and performance or made aware of the findings. Aution was provided prior to exit.	F 695		
	arteries. The cord oxygen to the hea the heart is starve	onary arteries bring blood and ort. If the blood flow is blocked, ed of oxygen and heart cells die. was obtained from the website:			11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER SAS HEALTH AND RE	EHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	00/20/2019	
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F 695	(3) Fear. This info website: https://www.nlm.nil #summary.	.gov/ency/article/000195.htm. rmation was obtained from the n.gov/medlineplus/anxiety.html	F 695			
	provided to resident consistent with protent the comprehensive and the residents' of This REQUIREMENT Based on resident clinical record reviet facility staff failed to one of 44 residents Resident # 83. The facility staff fail non-pharmacologic administration of as Resident #83. The findings include Resident # 83 was 12/05/2018 with dianot limited to rheun disorder (2), and ar Resident # 83s moset), a significant of	anagement. Insure that pain management is ofts who require such services, fessional standards of practice, person-centered care plan, goals and preferences. In it is not met as evidenced interview, staff interview and ew, it was determined that to provide pain management for in the survey sample, all interventions prior to the sal interv	F 697	1) Facility staff failed to implement non-pharmacological interventions at the administration of as needed pair medication to Resident #83. Educat coaching was provided to the nurse implement non-pharmacological interventions prior to administration. negative clinical outcome was identical as needed pain medication has the potential to be affected if center staft to implement non-pharmacological interventions prior to administering medication. 3) Licensed staff will be educated implement non-pharmacological interventions prior to the administration as needed pain medication. 4) The Director of Nursing (DON) of designee will conduct an audit of 10 residents with physician orders for a	orior to n tional to No ified. ers for ff fail to	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
Section 1		495038	B. WING			20/2019		
	PROVIDER OR SUPPLIER	HAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 8575 RIXLEW LANE MANASSAS, VA 20109					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 697	assessment for me of 0 - 15, 15- being daily decisions. Re requiring extensive member for all ADI On 06/19/19 at 8:4 conducted with Re staff assess her paneeded pain medic "Sometimes they vis from one to ten." alleviate her pain via dministering the patted, "No." The "Physician's Co"06/19/2019" docu (milligram) (Acetar by mouth every 6 (Order Date: 12/14/ The eMAR (electrorecord) dated "Aprabove physician's eMAR revealed Tyon 04/02/19 at 9:20 04/08/19 at 9:15 p. 04/09/19 at 5:48 a. at 11:23 p.m., and a pain level of four dated "Apr (April) 2 dated 04/02/19 threevidence documents."	33 as scoring a 15 on the staff ental status (BIMS) of a score a cognitively intact for making esident # 83 was coded as assistance of none staff as (activities of daily living). 1 a.m., an interview was sident # 83. When asked if the ain before giving her an as eation, Resident # 83 stated, will ask me what my pain level. When asked if the staff try to with other techniques prior to be ain medication Resident # 83.	F 697	needed pain medication weekly weeks, then monthly x 2 month evidence of non-pharmacologic intervention prior to pain medicadministration.	ns for cal			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495038	B. WING			1	C
	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CIT 8575 RIXLEW LANE MANASSAS, VA 20		<u> 06.</u>	<u>/20/2019</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRI	'S PLAN OF CORRECTIO ECTIVE ACTION SHOULD ENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	The eMAR (electrorecord) dated "May physician's order for eMAR revealed Tylon 05/19/19 at 6:30 three and at 6:56 p Further review of the and the eMAR not evidence document interventions attern of Tylenol. The eMAR (electrorecord) dated "June physician's order for revealed Tylenol 32 06/02/19 at 7:32 a. and on 06/15/19 at three. Further review 2019" and the eMA 06/15/19 failed to enon-pharmacologic prior to the administ The comprehensive dated 01/15/2019 of (Resident # 83 has (history of) migraine from arthritis. Date Revision on: 01/15/"Interventions/tasks level q (every) shift apply interventions 12/05/2018." On 06/20/19 at 10:0	onic medication administration of 2019" documented the above or Tylenol. Review of the lenol 325mg was administered of a.m., with a pain level of three are eMAR dated "May 2019" as dated 05/19/19 failed to tation of non-pharmacological opted prior to the administration are 2019" documented the above or Tylenol. Review of the eMAR 25mg was administered on m., with a pain level of three 8:27 p.m. with a pain level of ew of the eMAR dated "June R notes dated 06/02/19 and vidence documentation of all interventions attempted tration of Tylenol. The care plan for Resident # 83 documented, "Focus. potential for pain, has H/O es and has [sic] contractors Initiated 12/05/2018. 2019." Under "it documented, "Assess pain and PRN (as needed) and as needed. Date Initiated:	F	597			
	manager. RN #2 w	(registered nurse) # 2, unit as asked to describe the dministration of prn pain					

F 697 Continued From predication. RN # pain. Check the redication based the highest level of pain, check the orprescribe and how mediation and docup with the reside effectiveness of the about attempting interventions, RN non-pharmacolog attempted prior to When asked when non-pharmacolog # 2 stated, "It is do review of the eMA May and June 201 above dates and ton-pharmacolog attempted. The facility's policy	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495038	B. WING		06	C /20/2019
				STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		120/2013
PRÉFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 697	medication. RN # pain. Check the medication based the highest level of pain, check the or prescribe and how mediation and do up with the reside effectiveness of the about attempting interventions, RN non-pharmacolog attempted prior to When asked when non-pharmacolog # 2 stated, "It is do review of the eMAM and June 20 above dates and non-pharmacolog above dates and non-pharmacolog # 2 stated above dates and non-pharmacolog # 2 stated above dates and non-pharmacolog	2 stated, "Ask them if they have record for the resident's prn pain I on scale zero to ten, ten being of pain, and the location of the refer for which pain medication is w much, administer the cument it in the eMAR. Followent an hour to determine the medication." When asked non-pharmacological #2 stated, "The lical interventions should be administering the medication." re the staff document the lical interventions attempted, RN ocumented in the eMAR." After AR for Resident #83 dated April, 19, RN #2 agreed that for the	F 69	7		
	Long Term Care S Document preser the resident for the alternative treatme and cold application On 06/20/19 at application	by "Pain Management In The Setting" it documented, "3. In and past treatments utilized by the treatment of pain, include: b. In the ents such as positioning, heat ons." Deproximately 2:15 p.m., ASM # 1 aff member), administrator, and the of risk management and QAPI				
	improvement), we	e and performance ere made aware of the findings. ation was provided prior to exit.				
		sease. It leads to inflammation				

STATEMEN' AND PLAN	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495038	B. WING		0.	C 2/20/2010	
	PROVIDER OR SUPPLIER SAS HEALTH AND RE	HAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 697	of the joints and sur affect other organs. obtained from the w https://medlineplus. (2) Depression may blue, unhappy, mise Most of us feel this short periods. Clini disorder in which fe or frustration interfe or more. This information website: https://medlineplus. (3) Low iron. This in the website: https://www.nlm.nih	rrounding tissues. It can also This information was	F6				
F 700 SS=E	CFR(s): 483.25(n)(1) §483.25(n) Bed Rai The facility must attral alternatives prior to a bed or side rail is correct installation, rails, including but nelements. §483.25(n)(1) Assess entrapment from be §483.25(n)(2) Revie bed rails with the resi	Is. empt to use appropriate installing a side or bed rail. If used, the facility must ensure use, and maintenance of bed not limited to the following ess the resident for risk of d rails prior to installation.	F 70	20		7/23/19	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	GCON	E SURVEY MPLETED	
	TRANSPORTED OF OURSELEE	495038	B. WING		20/2019	
0 =	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	- = 1 \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 700	standard and a standard and maintaining the standard and standard an	sure that the bed's dimensions or the resident's size and weight. low the manufacturers' or and specifications for installing	F 70			
	staff failure to ass review the risks a siderails and obta use of bed rails. The findings inclu 1. The facility staft benefits and obta use of bed rails for Resident # 56 wa 07/29/14 and a rediagnoses that incretention of urine, disorder (2), and Resident # 56's m set), a significant ARD (assessment coded Resident # the brief interview	5 and #40, as evidenced facility less for the risk of entrapment, and benefits for the use of in informed consent prior to the de: If failed to review risks and in informed consent prior to the or Resident # 56. Is admitted to the facility on eadmission on 11/30/18 with cluded but were not limited to: hypertension (1), depressive multiple sclerosis (3). Inost recent MDS (minimum data change assessment with an treference date) of 05/16/19, 56 as scoring a 7 (seven) on for mental status (BIMS) of a (seven) - being severely		#43, #105 and #40. Resident #21, #207 and #92 discharged from facility. Bed rail use was discontinued for resident #52, #66 and #69. Resident #56, #58, #5, #83, #88, #26, #19, #14, #38, #90, #75, #32, #53, #94, #43 and #105 were assessed for entrapment, risks and benefits were reviewed and informed consents were signed for continued use. 2) Any resident with bed rails in use has the potential to be affected if center staff fail to assess the resident for risk of entrapment, obtain a physician order, review risks and benefits and obtain informed consent prior to the use of bed rails. Residents with bed rails in use will be audited to identify a physician order, assessment for entrapment, risks and benefits review and informed consent. Any variances will be addressed. 3) Licensed staff will be educated for the requirement to obtain a physician order, assess the resident for risk of entrapment, review risks and benefits and obtain		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495038	B. WING _		C 06/20	
	PROVIDER OR SUPPLIER SAS HEALTH AND RE	EHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	1 00/21	0/2019
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 700	impaired of cognition Resident # 56 was dependent of one stailly living. Review of Resident evidence document for the use of side Resident #56 (or than failed to reveal consent. The comprehensive with a revision on 1 "Interventions/Task with bed mobility. If the comprehensive with a revision on 1 "Interventions/Task with bed mobility. If the comprehensive with a revision on 1 "Interventions/Task with bed mobility. If the comprehensive with a revision on 1 and the comprehensive with a revision on the up were in the raised processed on the up were in the raised processed with ASM member) #1, admir When asked to probenefits of bed rail provided to the residence of the use of	on for making daily decisions. It coded as being totally staff member for activities of the #56's clinical record failed to attation that risks and benefits rail were reviewed with the resident's representative), I documentation of informed to act a care plan for Resident #56 12/27/2018 documented, as: ½ (half) side rails to assist Date initiated: 03/16/2015." 6 a.m., Resident #56 was Bilateral quarter rails were oper portion of the bed and position. When asked if the accussed the risk and benefits of #56 stated, "No." 3 a.m., an interview was M (administrative staff inistrator regarding bed rails, evide evidence that the risk and use were discussed or idents or the resident's SM # 1 stated, "They are asked if there are physician's of the resident's bed rails, ASM they are care planned as a n." When asked about outine maintenance of the ASM # 1 stated, "It's done on	F 700	consent prior to the use of bed rails 4) The Director of Nursing (DON) designee will conduct a medical re audit of newly admitted resident bed rails daily (M-F) x 5, weekly x 3 monthly x 2 for evidence that an assessment for the risk of entrapm was completed, a physician order a informed consent were obtained pr the use of bed rails and that risks a benefits were reviewed with the res or resident representative. Findings reported to the QAPI Committee for further recommendation.	or cord using 3 and nent and rior to and sident s will be	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	W.Y.	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	- W-1	495038	B. WING_		C 06/20/2019	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION	
F 700	beds in April 2019 bed rail inspection When asked to pro was obtained for th #56, ASM # 1 state consent for the use The facility's policy documented, "Reg rails should be man you would many [s Education resident adverse outcomes On 06/20/19 at app (administrative stat ASM # 3, director of (quality performance made aware of the	a bed inspection of all facility that included documentation of as part of the bed inspection. Wide evidence that a consent include evidence that a consent include evidence that a consent included that they did not obtain any expected of the reason for use, and any restraint: [sic] I want the strain of the reason for use, and the strain of the strain of the reason for use, and the strain of the reason for use, and the strain of the strain	F 70			
	References: (1) High blood presobtained from the whttps://www.nlm.nihessure.html. (2) Depression mablue, unhappy, mis Most of us feel this short periods. Clindisorder in which feor frustration interfor more. This inforwebsite:	sure. This information was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495038	B. WING			C 6/20/2010	
	PROVIDER OR SUPPLIER SAS HEALTH AND RE	HAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 700	(3) A nervous syste brain and spinal consheath, the material your nerve cells. The blocks messages be body, leading to the include visual disturt trouble with coording such as numbness, needles and thinks. This information was https://medlineplus. 2. The facility staff of benefits and obtain use of bed rails for Resident # 21 was a 12/24/18 and a readiagnoses that inclusion crespiratory of infarction (2), and a most recent MDS (rassessment with an date) of 04/09/19, cooring a 15 on the status (BIMS) of a scognitively intact for Resident # 21 was a dependent of one stadily living. Review of Resident evidence document for the use of side rassident #21 (or the documentation of in	m disease that affects your rd. It damages the myelin I that surrounds and protects its damage slows down or etween your brain and your symptoms of MS. They can chances, muscle weakness, ation and balance, sensations prickling, or "pins and ng and memory problems. s obtained from the website: gov/multiplesclerosis.html. ailed to review risks and informed consent prior to the Resident # 21. admitted to the facility on dmission on 04/18/19 with ided but were not limited to: ailure (1), old myocardial exiety (3). Resident # 21's minimum data set), a quarterly ARD (assessment reference oded Resident # 21 as brief interview for mental core of 0 - 15, 15 - being making daily decisions. Coded as being totally aff member for activities of #21's clinical record failed to ation that risks and benefits ails were reviewed with a resident's representative) or	F7				

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		СО	TE SURVEY MPLETED C		
	PROVIDER OR SUPPLIER	7		STREET ADDRESS, CITY, STATE 8575 RIXLEW LANE MANASSAS, VA 20109		06/20/2019 DE		
(X4) ID PREFIX TAG	(EACH DEFICIENT	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
F 700	with a revision on "Interventions/Tas in bed mobility. D On 6/20/19 at 11:2 observed in bed. observed on the uwere in the raised facility staff had dibed rails, Residen On 06/20/19 at ap (administrative sta ASM # 3, director (quality performan made aware of the No further information obtained from the https://www.nlm.n.ilure.html. (2) Heart attack. Iby a blood clot that arteries. The coro oxygen to the heart is starve This information whttps://medlineplut. (3) Fear. This information:	02/12/2019 documented, ks: ½ (half) side rails to assist ate initiated: 05/09/2019." 23 a.m., Resident # 21 was Bilateral quarter rails were apper portion of the bed and position. When asked if the scussed the risk and benefits of at #21 stated, "No." approximately 2:15 p.m., ASM # 1 aff member), administrator, and of risk management and QAPI are improvement nurse), were a findings. attion was provided prior to exit.	F 7	700				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495038	B. WING				0
	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CO 8575 RIXLEW LANE MANASSAS, VA 20109	DE	06/3	20/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD B		(X5) COMPLETION DATE
F 700	benefits and obtainuse of bed rails for Resident # 58 was 07/14/12 with diagnot limited to: high high cholesterol. If MDS (minimum divith an ARD (asse 05/18/19, coded If the brief interview score of 0 - 15, 15 making daily decis as requiring super activities of daily like Review of Resider evidence docume for the use of side Resident #58 (or the training that is documentation of the comprehension with a revision on "Interventions/Tas in bed mobility and 03/07/2017." On 6/20/19 at 11:2 resident # 58's room to present. Obserbilateral quarter raportion of the bed	f failed to review risks and in informed consent prior to the or Resident # 58. s admitted to the facility on gnoses that included but were in blood pressure, stroke and Resident # 58's most recent ata set), a quarterly assessment reference date) of Resident # 58 as scoring a 15 on for mental status (BIMS) of a 5 - being cognitively intact for sions. Resident # 58 was coded vision of one staff member for	F7	700			
	(administrative sta	of risk management and QAPI,					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	CO	TE SURVEY MPLETED C
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO B575 RIXLEW LANE MANASSAS, VA 20109	06/20/2019 DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE ADDEDICENCY)	SHOULD BE	(X5) COMPLETION DATE
F 700	Were made aware No further informa 4. The facility staff benefits and obtai use of bed rails for Resident # 52 was 11/21/17 with diag not limited to: high failure to thrive. Reference of the brief interview score of 0 - 15, 7 impaired of cognit Resident # 52 was assistance of one daily living.	of the findings. Ition was provided prior to exit. If failed to review risks and informed consent prior to the	F 700			
	evidence docume for the use of side Resident #52 (or t documentation of The comprehension with a revision on "Interventions/Tas 1-2 (one to two) as mobility/positioning On 6/20/19 at 11:1 Resident # 52's ro	ntation that risks and benefits rails were reviewed with he resident's representative) or informed consent. ye care plan for Resident # 52 05/10/2018 documented, ks: ½ (half) side rails x (times			7.5	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(2	X3) DATE SURVEY COMPLETED
		495038	B. WING			C 06/20/2019
	PROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 8575 RIXLEW LANE MANASSAS, VA 20109	ODE	00/20/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD B	E COMPLETION DATE
F 700	ASM # 3, director of (quality performance made aware of the No further informate) 5. The facility staff	f member), administrator, and of risk management and QAPI se improvement nurse), were findings. ion was provided prior to exit. failed to review risks and	F 7	700		
	Resident # 5 was a 09/03/17 with diagram not limited to: low in depressive disorder recent MDS (minimassessment with an date) of 06/14/19, of a 15 on the brief int (BIMS) of a score of intact for making dawas coded as requistaff member for active recent making dawas coded as requistaff member for active with a revision of in The comprehensive with a revision on 0 "Interventions/Tasks assistance with bed needed. Date initial On 6/20/19 at 11:21	e care plan for Resident # 5 3/18/2019 documented, s: ½ (half) side rails for mobility and transfers as				

AND PLAN	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) E	ATE SURVEY OMPLETED C
MANAS	PROVIDER OR SUPPLIE SAS HEALTH AND R	EHAB CENTER	85	REET ADDRESS, CITY, STATE, 2 75 RIXLEW LANE ANASSAS, VA 20109	I C	6/20/2019
(X4) ID PREFIX TAG	(EACH DEFICIENT	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	were in the raised facility staff had dibed rails, Residen On 06/20/19 at ap (administrative states ASM # 3, director (quality performan made aware of the No further informated aware of the N	pper portion of the bed and position. When asked if the scussed the risk and benefits of t #5 stated, "No." proximately 2:15 p.m., ASM # 1 ff member), administrator, and of risk management and QAPI ce improvement nurse), were e findings. tion was provided prior to exit. In that causes unusual shifts in vity levels, and the ability to any tasks. This information was website: Inih.gov/health/topics/bipolar-dis In the described as feeling sad, erable, or down in the dumps. It way at one time or another for ical depression is a mood elings of sadness, loss, anger, are with everyday life for weeks mation was obtained from the agov/ency/article/003213.htm. If alled to review risks and informed consent prior to the Resident # 83.	F 700			
	12/05/2018 with dia not limited to rheun	admitted to the facility on agnoses that included but were natoid arthritis (1), depressive nemia (3). Resident #83s				

	St.		
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	COM	TE SURVEY MPLETED C /20/2019	
	PROVIDER OR SUPPLIER SAS HEALTH AND R		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 700	most recent MDS significant change (assessment refer Resident # 83 as assessment for m of 0 - 15, 15- being daily decisions. Requiring extensive member for all AD Review of Residence document for the use of side Resident #83 (or th	(minimum data set), a assessment with an ARD ence date) of 05/28/19, coded scoring a 15 on the staff ental status (BIMS) of a score g cognitively intact for making esident # 83 was coded as e assistance of none staff Ls (activities of daily living). Int #83's clinical record failed to intation that risks and benefits rails were reviewed with the resident's representative) or informed consent. In each of the content of th	F 700				
	References:	of the findings. Ition was provided prior to exit. Sease. It leads to inflammation				1	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		TIPLE CONSTRUCTION NG		TE SURVEY
		495038	B. WING			C /20/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	1 00/	20/2019
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 700	of the joints and suraffect other organs obtained from the https://medlineplus (2) Depression mablue, unhappy, mis Most of us feel this short periods. Clin disorder in which for frustration interfor more. This inforwebsite: https://medlineplus (3) Low iron. This is the website:	irrounding tissues. It can also This information was	F 70	00		
	benefits and obtain use of bed rails for Resident # 88 was 05/04/18 with diagrant limited to: diffic high cholesterol. Resident # 88's moset), an annual ass (assessment references Resident # 88 as so interview for mental - 15, 15 - being cog decisions. Resider	admitted to the facility on noses that included but were ulty swallowing, low iron and est recent MDS (minimum data essment with an ARD ence date) of 05/14/19, coded coring a 15 on the brief I status (BIMS) of a score of 0 initively intact for making daily at # 88 was coded as requiring see of one staff member for				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		TE SURVEY MPLETED	
		495038	B. WING		ne ne	6/20/2019	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CO 8575 RIXLEW LANE MANASSAS, VA 20109			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 700	evidence docume for the use of side Resident #88 (or documentation of The comprehensi with a revision on "Interventions/Tas with bed mobility 05/22/2014." On 6/20/19 at 11: Resident # 88's ro On 06/20/19 at ap (administrative sta	ant #88's clinical record failed to entation that risks and benefits a rails were reviewed with the resident's representative) or informed consent. Eve care plan for Resident # 88 02/22/2019 documented, sks: ½ (half) side rails to assist and transfers. Date initiated: 29 a.m., an attempt to observe from bed was unsuccessful.	F 700	N			
	(quality performal made aware of the No further informal 8. The facility staff	ation was provided prior to exit.					
	Resident # 93 wa 06/15/17 with diagnot limited to: healoss. Resident # 93's mset), a significant ARD (assessmen coded Resident #	in informed consent prior to the or Resident # 93. Is admitted to the facility on gnoses that included but were art failure, pain, and hearing host recent MDS (minimum data change assessment with an at reference date) of 06/03/19, if 93 as scoring a 12 on the brief tal status (BIMS) of a score of 0					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495038	B. WING		06	C 5/20/2019
	PROVIDER OR SUPPLIER SAS HEALTH AND RE	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP 8575 RIXLEW LANE MANASSAS, VA 20109		12012019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 700	- 15, 12 - being more for making daily decoded as requiring staff member for acceptance of Resident evidence document for the use of side resident #93 (or the documentation of in The comprehensive with a revision on 0 "Interventions/Tasks in bed mobility and 02/23/2017." On 6/20/19 at 11:23 observed in bed. B observed in the raised p facility staff had discobed rails, Resident in Con 06/20/19 at appropriate the facility performance made aware of the facility performance made aware of the facility staff facilit	derately impaired of cognition cisions. Resident # 93 was extensive assistance of one civities of daily living. #93's clinical record failed to cation that risks and benefits ails were reviewed with e resident's representative) or formed consent. care plan for Resident # 93 6/20/2019 documented, s: ½ (half) side rails to assist transfers. Date initiated: a.m., Resident # 93 was illateral quarter rails were per portion of the bed and osition. When asked if the cussed the risk and benefits of #93 stated, "No." roximately 2:15 p.m., ASM # 1 member), administrator, and frisk management and QAPI improvement nurse), were	F 76			

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION IG		TE SURVEY MPLETED C
	PROVIDER OR SUPPLIER		B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	06/20/2019 DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 700	not limited to: sch (2), and muscle w recent MDS (minit the time of survey admission assess 207 was oriented. Review of Reside evidence docume for the use of side Resident #207 (or or documentation. The comprehensitivity a revision on "Interventions/Tas 1-2 (one to two) a mobility/positionin. On 6/20/19 at 11:3 observed in bed. observed on the uwere in the raised facility staff had did bed rails, Resident. On 06/20/19 at ap (administrative states ASM # 3, director (quality performant made aware of the References:	izoaffective disorder (1), bipolar asting. Resident # 207's most mum data set) was not due at a Resident # 207's nursing ment documented Resident # to person, place and time. Int #207's clinical record failed to ntation that risks and benefits a rails were reviewed with the resident's representative) of informed consent. Interpretation of the sident # 207 06/11/2019 documented, ks: ½ (half) side rails x (times) is needed for bed g. Date initiated: 06/19/2019." But a.m., Resident # 207 was Bilateral quarter rails were apper portion of the bed and position. When asked if the scussed the risk and benefits of the #207 stated, "No." Interpretation of the province improvement and QAPI are improvement nurse), were a findings.				
	(1) A mental cond contact with reality	ition that causes both a loss of y [psychosis] and mood sion or mania]. This information n the website:				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	LTIPLE CONSTRUCTION DING	_		E SURVEY
		495038	B. WING				C 20/2019
	PROVIDER OR SUPPLIER SAS HEALTH AND RE	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP C 8575 RIXLEW LANE MANASSAS, VA 20109	ODE		20/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD E	BE	(X5) COMPLETION DATE
F 700	https://www.nlm.nih 000930.htm. (2) A brain disorder mood, energy, activ carry out day-to-day obtained from the whttps://www.nimh.ni order/index.shtml. 10. The facility staff physician order and to the use of bed rail. Resident #14 was a 12/20/18. Resident were not limited to a disorder and high bl most recent MDS (nassessment with an date) of 3/29/19, cocognitive impairment #14 as requiring sup with bed mobility. Review of Resident a Side Rail Assessment with an dated 1/1/19 do 1-2 as needed for befailed to reveal documented.	that causes unusual shifts in ity levels, and the ability to a tasks. This information was be besite: h.gov/health/topics/bipolar-dis failed to obtain consent, a review risk and benefits prior ils for Resident #14. dmitted to the facility on #14's diagnoses included but alcohol abuse, anxiety lood pressure. Resident #14's minimum data set), a quarterly ARD (assessment reference ded Resident #14 with no lot. Section G coded Resident pervision of one staff member #14's clinical record revealed ment dated 1/22/19, which use upper half rails for obility." #14's comprehensive care poumented, "Half side rails, and mobility/positioning." esident #14's clinical record mented consent, a physician tion that risk and benefits Resident #14 (or the	F7	'00			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY APLETED C /20/2019
	PROVIDER OR SUPPLIE		8	STREET ADDRESS, CITY, STATE, ZIP CO 1575 RIXLEW LANE MANASSAS, VA 20109		20/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 700	observed in bed whalf rails were in use. Resident #1 rails at any time. use those things. On 6/20/19 at 7:3 conducted with A	45 a.m., Resident #14 was watching television. Both upper the lowest position and not in 4 was asked if he used the half Resident #14 stated, "I do not "	F 700			
	rails. ASM #1 was the risk and bene discussed or prov resident's represe are discussed bu it was done. Whe orders for use of	administrator) regarding bed is asked to provide evidence that offits of bed rail use were wided to the residents or the centative. ASM #1 stated, They it there is no documentation that is asked if there are physician's the resident's bed rails ASM #1 ney are care planned as a on."				
	maintenance of the stated, "It's done provided docume facility beds in Ap documentation of the bed inspection evidence that corbed rails ASM #1	ut documentation of routine ne resident's bed rails ASM #1 on an annual basis" and ntation of a bed inspection of all ril 2019 that included bed rail inspection as part of n. When asked to provide sent was obtained for the use of stated that they did not obtain ne use of bed rails.				
	Rail Use," docum as an enabler to p mobility and/or tra to independently for the device. R rails should be m	cility policy, "Guidelines for Side ented, "Side rails may function promote independence with bed ansfers when the resident is able use or requires minimal cueing egardless of the reason for use, anaged on a regular basis as the any restraint: *Do not use		10 G		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495038	B. WING		06	C / 20/2019
	PROVIDER OR SUPPLIER SAS HEALTH AND RE	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIF 8575 RIXLEW LANE MANASSAS, VA 20109		120/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 700	periodically for neer *Education resident outcomes; *Monitor outcomes; *Docum potential accident hattempting to get out around the rails), cour be re-assessed and indicate that therapuse of the rail outwinjury. When side readitional intervential isolation resulting vaddressed. The dorecord should ident need to be padded, rails is not for resident mobility and/or transpector on sistent throughout throughout the consistent throughout the consistent throughout the consistent throughout the survey.	assessment; *Re-evaluate d and potential hazard; the family in potential adverse resident for potential adverse ent use. All side rails are azards - if the resident is ut of bed (through, over, or ontinued use of the rails must documentation should eutic benefit from continued eighs the risk of potential ails are padded, there should ention for the padding and ons to address potential social isual limitation should be cumentation of the medical ify specifically why the rails If the purpose for the use of ent independence in bed sfers, the use of the rails may straint. Documentation and use of side rails should be out the clinical record." PM, ASM (administrative staff of the director of risk uality assurance & vernent), and OSM (other staff gional registered dietitian) of the findings. on was provided by the end of failed to obtain consent, a review risk and benefits prior	F 7			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		co	TE SURVEY MPLETED C 6/20/2019				
			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109				
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 700	Resident #19 was 1/24/19. Resident were not limited to osteoarthritis and most recent MDS assessment with date) of 4/7/19, comoderate cognitive Resident #19 as member with bed Review of Resident a Side Rail Assest documented, "Or independent bed independence with the side of the si	s admitted to the facility on the #19's diagnoses included but to Alzheimer's disease, high cholesterol. Resident #19's forminimum data set), a quarterly an ARD (assessment reference oded Resident #19 with the impairment. Section G coded requiring supervision of one staff mobility. In the #19's clinical record revealed is ment dated 5/3/19, which sally use upper half rails for mobility secondary to the positioning."	F 700				
	plan dated 2/5/19 assist in bed mob assist in bed mob failed to reveal do order or documer were reviewed with resident's repression. Bilateral up Resident #19's bette lowest position. On 6/20/19 at 4:0 member) 1, ASM management and	documented, "Half side rails to bility and transfers." Resident #19's clinical record ocumented consent, a physician nation that risk and benefits th Resident #19 (or the entative). 50 a.m., Resident #19 was of her room sitting in the day oper rails were noted on ed. Both upper half rails were in and not in use. 7 PM, ASM (administrative staff #3 (the director of risk I quality assurance &					
		rovement), and OSM (other staff regional registered dietitian) of the findings.					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	TIPLE CONSTRUCTION	(×	(3) DATE SURVEY COMPLETED
		495038	B. WING		EX.	C 06/20/2019
	PROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP C 8575 RIXLEW LANE MANASSAS, VA 20109	CODE	00/20/2019
(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)	N SHOULD BE	
F 700		ige 70 ion was provided by the end of	F 7	00		
	physician order and to the use of bed ra	failed to obtain consent, a I review risk and benefits prior ills for Resident #26.		•		1
	6/20/17. Resident # were not limited to a blood pressure and #26's most recent N quarterly assessme reference date) of 4 with severe cognitive coded Resident #26	admitted to the facility on 26's diagnoses included but diabetes mellitus type 2, high high cholesterol. Resident MDS (minimum data set), a ent with an ARD (assessment 1/15/19, coded Resident #26 re impairment. Section G as requiring extensive taff member with bed mobility.				
	a Side Rail Assessn	#26's clinical record revealed ment dated 1/9/18, which use upper half rails for obility."				
	plan dated 1/9/18 de	#26's comprehensive care ocumented, "Half side rails, ed mobility/positioning."				
	failed to reveal docu order or documenta	esident #26's clinical record amented consent, a physician ation that risk and benefits Resident #26 (or the fative).				
	observed lying in be Bilateral upper rails	a.m., Resident #26 was d with her eyes closed. were noted on Resident #26's f rails were in the lowest				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING B. WING	PLE CONSTRUCTION 3	COI	TE SURVEY MPLETED C
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		/20/2019
MANASS	SAS HEALTH AND R	EHAB CENTER		8575 RIXLEW LANE MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 700	member) 1, ASM is management and performance impromember) #3 (the rwere made aware) No further informathe survey. 13. The facility staphysician order and to the use of bed resident #38 was 3/29/18. Resident were not limited to failure and anxiety recent MDS (minimassessment with a date) of 4/30/19, cmoderate cognitive Resident #38 as reone staff member. Review of Residera Side Rail Assess	use. PM, ASM (administrative staff #3 (the director of risk quality assurance & overnent), and OSM (other staff egional registered dietitian) of the findings. Ition was provided by the end of ff failed to obtain consent, a direview risk and benefits prior ails for Resident #38. admitted to the facility on #38's diagnoses included but Alzheimer's disease, heart disorder. Resident #38's most num data set), a quarterly in ARD (assessment reference oded Resident #38 with a impairment. Section G coded equiring extensive assistance of with bed mobility. It #38's clinical record revealed iment dated 1/26/19, which y use upper half rails for	F 700			
	plan dated 4/11/18	nt #38's comprehensive care documented, "Half side rails, bed mobility/positioning."	5.5	5		
		Resident #38's clinical record				:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	(X3) DATE SURVEY COMPLETED			
		495038	B. WING				2 0/2019
	PROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 8575 RIXLEW LANE MANASSAS, VA 20109	DE		20/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 700	order or documental were reviewed with resident's represent On 6/19/19 at 12:15 observed outside of day room on the Evails were noted on upper half rails were not in use. On 6/20/19 at 4:07 member) 1, ASM # management and operformance impromember) #3 (the rewere made aware of the survey. 14. The facility staff physician order and to the use of bed rather than the survey. 14. The facility staff physician order and to the use of bed rather than the survey. Resident #66 was a 6/23/17. Resident # were not limited to weakness and high #66's most recent that admission assessmenterence date) of 5 with severe cognitive coded Resident #66 assistance of two obed mobility.	Resident #38 (or the tative). 5 p.m., Resident #38 was f his room eating lunch in the vergreen unit. Bilateral upper Resident #38's bed. Both e in the lowest position and PM, ASM (administrative staff 3 (the director of risk quality assurance & vernent), and OSM (other staff gional registered dietitian)	F 7				

	OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	CON	E SURVEY MPLETED
		495038	B. WING_	MW-88 EE.	I .	C /20/2019
	PROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP C 8575 RIXLEW LANE MANASSAS, VA 20109		20/2019
(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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 700	documented, "Only independent bed in mobility and position." Review of Resident plan dated 6/19/19 1-2 as needed for Further review of Failed to reveal docorder or document were reviewed with resident's represent On 6/19/19 at 12:2 observed outside of day room on the Erails were noted or upper half rails we not in use. On 6/20/19 at 4:07 member) 1, ASM # management and performance impromember) #3 (the rewere made aware)	ment dated 6/19/19, which was upper half rails for nobility secondary to promote oning." It #66's comprehensive care documented, "Half side rails, bed mobility/positioning." Resident #66's clinical record sumented consent, a physician ation that risk and benefits a Resident #66 (or the native). Op.m., Resident #66 was of her room eating lunch in the vergreen unit. Bilateral upper a Resident #66's bed. Both re in the lowest position and PM, ASM (administrative staff as (the director of risk quality assurance & overment), and OSM (other staff regional registered dietitian)	F 70			
	physician order an	if failed to obtain consent, a d review risk and benefits prior ails for Resident #69.	W			
	Resident #69 was	admitted to the facility on	.00	o at		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495038	B. WING			C /20/2019	
	PROVIDER OR SUPPLIER SAS HEALTH AND RE	HAB CENTER	85	TREET ADDRESS, CITY, STATE, ZIP CODE 675 RIXLEW LANE ANASSAS, VA 20109	1 00,	120/2019	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 700	3/26/13. Resident # were not limited to osteoarthritis and a #69's most recent I quarterly assessme reference date) of 3 with severe cognitive coded Resident #69 assistance of two obed mobility. Review of Resident a Side Rail Assessme documented, "No see Recommend side resident roprevent raising." Review of Resident plan dated 3/30/17 side rails, 1-2 as not mobility/positioning. Further review of Resident plan dated 3/30/17 side rails, 1-2 as not mobility/positioning. Further review of Resident plan dated 3/30/17 side rails, 1-2 as not mobility/positioning. Further review of Resident plan dated 3/30/17 side rails, 1-2 as not mobility/positioning. Further review of Resident plan dated 3/30/17 side rails, 1-2 as not mobility/positioning. Further review of Resident plan dated 3/30/17 side rails, 1-2 as not mobility/positioning. Further review of Resident plan dated 3/30/17 side rails, 1-2 as not mobility/positioning. Further review of Resident plan dated 3/30/17 side rails, 1-2 as not mobility/positioning. Further review of Resident plan dated 3/30/17 side rails, 1-2 as not mobility/positioning. Further review of Resident plan dated 3/30/17 side rails, 1-2 as not mobility/positioning. Further review of Resident plan dated 3/30/17 side rails, 1-2 as not mobility/positioning. Further review of Resident plan dated 3/30/17 side rails, 1-2 as not mobility/positioning. Further review of Resident plan dated 3/30/17 side rails, 1-2 as not mobility/positioning.	#69's diagnoses included but Alzheimer's disease, inxiety disorder. Resident MDS (minimum data set), a ent with an ARD (assessment 8/22/18, coded Resident #69 ve impairment. Section G 9 as requiring extensive in more staff members with at #69's clinical record revealed ment dated 6/19/19, which ide rails indicated at this time, ails be removed or tied down at #69's comprehensive care documented, "May use half beded for bed " esident #69's clinical record umented consent, a physician ation that risk and benefits Resident #69 (or the	F 700				
	management and q					**************************************	

	PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		ATE SURVEY DMPLETED C			
	PROVIDER OR SUPPLIER	The second secon		STREET ADDRESS, CITY, STATE, ZIP COI B575 RIXLEW LANE MANASSAS, VA 20109		/20/2019
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AR DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 700	were made aware	egional registered dietitian)	F 700			
	physician order and to the use of bed represented the second seco	ff failed to obtain consent, a d review risk and benefits prior ails for Resident #90. admitted to the facility on 90's diagnoses included but Alzheimer's disease, high d depression. Resident #90's (minimum data set), a quarterly in ARD (assessment reference oded Resident #90 with severe ent. Section G coded Resident upervision of one staff member				
	a Side Rail Assess	nt #90's clinical record revealed sment dated 1/26/19, which y use half upper rails for nobility."		92		
	plan dated 1/22/19	nt #90's comprehensive care documented, "Half side rails, bed mobility/positioning."				
	failed to reveal document	Resident #90's clinical record cumented consent, a physician tation that risk and benefits n Resident #90 (or the ntative).				2
	On 6/19/19 at 12:3	37 p.m., Resident #90 was				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		495038	B. WING		00	C 5 /20/2019
	PROVIDER OR SUPPLIER	EHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 8575 RIXLEW LANE MANASSAS, VA 20109	DE	3/20/2019
(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 A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 700	observed outside of day room on the Ex- rails were noted on upper half rails were not in use.	of his room eating lunch in the vergreen unit. Bilateral upper a Resident #90's bed. Both re in the lowest position and	F7	00		
	member) 1, ASM # management and of performance impro member) #3 (the re were made aware of	vement), and OSM (other staff egional registered dietitian) of the findings.				
	the survey.No furth the end of the surve 17. The facility staff for risk of entrapme	ion was provided by the end of er information was provided by ey. If failed to assess Resident #92 ent, review risks and benefits d consent prior to the use of				
	5/18/19 with the dia high blood pressure diabetes, diabetic in blindness, peripherarenal disease, and a most recent MDS (I admission/5-day as (Assessment Refer resident was coded ability to make daily was coded as requibathing, hygiene, to transfers; and was in the side of the side	admitted to the facility on agnoses of but not limited to e, chronic kidney disease, europathy, depression, al vascular disease, end stage amputation of right toes. The Minimum Data Set) was an sessment with an ARD ence Date) of 5/25/19. The las being cognitively intact in a life decisions. The resident tring extensive care for illeting, dressing, and independent for eating.				
		of Resident #92 on 6/18/19 at and on 6/19/19 at 1:44 PM				

	IENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
88		495038	B. WING		06	/20/2019
	OF PROVIDER OR SUPPLI			STREET ADDRESS, CITY, STATE, ZI 8575 RIXLEW LANE MANASSAS, VA 20109		III am iyu
(X4) PREF TAC	IX (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 DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F7	rails up on both some readmission from "Nursing Admiss (and) Interim PO four)" form was a section identified Mobility/Safety." for "Side rails." If for marking "Yes yes:1. Left, line in the above the document, for applied). Under2. Full" (Each represented a circum selecting which a was, "c. Are side independence who." (Each line represented a circum selecting which a selecting w	nt #92 to be in bed, with half side	F 700			
	Further review of	the clinical record failed to n's order for the use of side rails.		9 V		
	reveal any evider entrapment for the use of siderest and familia.	the clinical record failed to nee of an assessment for risk of ne use of side rails with Resident ted. The clinical record failed to entation that the risk and benefits e rails were discussed with the ily or any evidence of an t for the use of the side rails for				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		(X3) DATI	E SURVEY PLETED
		495038	B. WING				0
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 8575 RIXLEW LANE MANASSAS, VA 20109	CODE	06/7	20/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD I IE APPROPR	BE	(X5) COMPLETION DATE
	revealed one date the need for ADL assistance." This interventions for the resident was observed on 06/20/19 at 7:: conducted with the administrative star of bed rails. When that the risk and bediscussed or proversident's represe are discussed but it was done. "When orders for the use # 1 stated, "No but have a stated, and an annual basis" as a bed inspection of the use of bed rails an annual basis" as a bed inspection of the use of bed rails and obtain any conformation of the use of bed rails not obtain any conformation of the use of bed rails and obtain any conformation of the use of bed rails of the use of th	emprehensive care plan ed 5/18/19 for "Demonstrates (activities of daily living) care plan did not include any he use of side rails that the erved to be using. 33 AM, an interview was e Administrator, (ASM #1 - ff member), regarding the use n asked to provide evidence renefits of bed rail use were ided to the residents or the entatives ASM # 1 stated, "They there is no documentation that en asked if there are physician's of the resident's bed rails ASM at they are care planned as a on." When asked about routine maintenance of the s ASM #1 stated, "It's done on and provided documentation of of all facility beds in April 2019 imentation of bed rail inspection inspection. When asked to that a consent was obtained for s ASM # 1 stated that they did insent for the use of bed rails. roximately 4:00 PM, ASM off member) 1, ASM #3 (the nagement and quality ormance improvement), and nember) #3 (the regional b) were made aware of the	F 7	700			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495038	B. WING	The second secon	06/2	20/2019
	PROVIDER OR SUPPLIER		8	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 RIXLEW LANE MANASSAS, VA 20109		ing with
(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 APPRODEFICIENCY)	.O BE	(X5) COMPLETION DATE
F 700		age 79 tion was provided by the end of	F 700		H	
	#75 for risk of entra	off failed to assess Resident apment, review risks and informed consent prior to the				
	5/16/19 with the dia acute cystitis, sacra disease, atrial fibril prostatic hyperplas (Minimum Data Seassessment with a Reference Date) o coded as being mil daily life decisions. requiring total care	admitted to the facility on agnoses of but not limited to al pressure ulcer, Parkinson's lation, cellulitis, and benign sia. The most recent MDS at was an admission/5-day in ARD (Assessment 5/23/19. The resident was ldly impaired in ability to make the resident was coded as for bathing; extensive tene, toileting, dressing, and ervision for eating.	2.			
	#75 was observed both sides. On 6/1 was not in his roon	0 AM and 5:15 PM, Resident in bed with half side rails up on 9/19 at 1:44 PM, the resident n but the side rails were position on his bed.		5)		
	readmission from t "Nursing Admission (and) Interim POC four)" form was con a section identified Mobility/Safety." T for "Side rails." Ne	ical record revealed that upon the hospital on 5/16/19, a n/Readmission Assessment & (plan of care) - V4 (version mpleted. This form contained as "Section K. this section contained an area ext to "Side Rails" was a circle or "No." Under that, was "a. if				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		495038	B. WING		1	C 20/2019
	PROVIDER OR SUPPLIER SAS HEALTH AND RE	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	1 00/	20/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		DBE	(X5) COMPLETION DATE
F 700	yes:1. Left, line in the above se the document, for s applied). Under the2. Full" (Each lir represented a circle selecting which ans was, "c. Are side ra independence with No." (Each line in represented a circle selecting which ans #75, this document half-length side rails promote independe Further review of th "Safe Transition Me which documented, developed with input (responsible party) / attorney)/Interested A review of the com revealed one dated the need for ADL (ac assistance, has UTI (osteoarthritis), Rha Diabetes." This car intervention, dated of rails x 1-2 (one or tw mobility and position intervention was not cannot be stated tha were informed of the and consented to, th Safe Transition Mee	2. Right,3. Both." (Each ntence represented a circle on electing which answer at, was "b. If yes:1. Half, he in the above sentence on the document, for wer applied). Under that, ils used to promote bed mobility1 Yes,2. the above sentence on the document, for wer applied). For Resident identified she was to use on both sides of the bed to nce with bed mobility. e clinical record revealed a eting" note dated 5/17/19, "Plan of care has been at from the patient and/or RP POA (power of parties." prehensive care plan 5/16/19 for "Demonstrates ctivities of daily living) (urinary tract infection), OA bdomyolysis, Parkinson's and e plan included the 5/29/19, for "1/2 (half) side to sides) as needed for bed hing." As the above developed until 5/29/19, it at the resident and family the use of, risks and benefits of, he side rails at the 5/17/19	F 7	000		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495038		(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109			06/20/2019	
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 700	reveal a physician' Further review of t reveal any evidence entrapment for the #75 was complete evidence documer for the use of side resident and family informed consent Resident #75. On 6/20/19 at appl (administrative stadirector of risk matassurance & performance of the perfo	he clinical record failed to be of an assessment for risk of a use of side rails with Resident d. The clinical record failed to notation that the risk and benefits rails were discussed with the gor any evidence of an for the use of the side rails for roximately 4:00 PM, ASM ff member) 1, ASM #3 (the nagement and quality rmance improvement), and nember) #3 (the regional) were made aware of the	F 700				
	#32 for risk of entr benefits and obtain use of bed rails. Resident #32 was 4/11/19 with the dia pneumonitis, dysp intellectual disabilid dependent, trache blood pressure. T Data Set) was an a with an ARD (Asse	aff failed to assess Resident apment, review risks and in informed consent prior to the admitted to the facility on agnoses of but not limited to hagia, Parkinson's disease, ties, depression, oxygen ostomy, dementia, and high he most recent MDS (Minimum admission/5-day assessment essment Reference Date) of dent was coded as being					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING		E SURVEY MPLETED
		495038	B. WING		- 1	C /20/2019
	PROVIDER OR SUPPLIER SAS HEALTH AND RE	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 8575 RIXLEW LANE MANASSAS, VA 20109		20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	4	HOULD BE	(X5) COMPLETION DATE
F 700	decisions. The resitotal care for bathin eating, dressing, and On 6/18/19 at 11:30 9:33 AM revealed the lowest position, with sides. On 6/19/19 and in bed but the sithe up position. A review of the clinic readmission from the "Nursing Admission (and) Interim POC (four)" form was come a section identified and Mobility/Safety." The for "Side rails." New for marking "Yes" on yes:1. Left, line in the above set the document, for sapplied). Under tha2. Full" (Each line in the above set the document, for sapplied). Under tha2. Full" (Each line in the selecting which answas, "c. Are side rail independence with No." (Each line in the represented a circle selecting which answas, this document half-length side rails promote independente.	a ability to make daily life dent was coded as requiring g; extensive care for transfers, id hygiene. AM, 5:15 PM, and 6/19/19 at the resident to be in bed, in the at 1/2 side rails up on both at 1:44 PM, the resident was de rails were still observed in the hospital on 4/11/19, a readmission Assessment & plan of care) - V4 (version as "Section K. is section contained as as "Section K. is section contained an area at to "Side Rails" was a circle on electing which answer t, was "b. If yes:1. Half, was "a to promote on the document, for wer applied). Under that, Is used to promote oped mobility1 Yes,2.	F7	000		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
	PROVIDER OR SUPPLIER		B. WING _	STREET ADDRESS, CITY, STATE, ZIP C 8575 RIXLEW LANE MANASSAS, VA 20109		06/20/2019 E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 700	which documented developed with ingoresponsible party attorney)/Interested	d, "Plan of care has been out from the patient and/or RP) / POA (power of ed parties."	F 70	00	N		
	revealed one date need for ADL (acti secondary to wea' decreased safety This care plan inc 4/28/19, for "1/2 (I mobility and trans was not developed stated that the rest of the use of, risks	mprehensive care plan d 4/11/19 for "Demonstrates the vities of daily living) assistance kness, altered balance, awareness, comorbidities." luded the intervention, dated naif) side rails to assist in bed fers." As the above intervention d until 4/28/19, it cannot be ident and family were informed and benefits of, and side rails at the 4/11/19 Safe d.					
		the clinical record failed to 's order for the use of side rails.					
	reveal any eviden- entrapment for the #32 was complete evidence docume for the use of side resident and famil	the clinical record failed to be of an assessment for risk of a use of side rails with Resident and the clinical record failed to notation that the risk and benefits a rails were discussed with the yor any evidence of an for the use of the side rails for					
	No further informathe survey.	tion was provided by the end of					
		aff failed to assess Resident rapment, review risks and		- e			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495038	B. WING	i i			C
	PROVIDER OR SUPPLIER	3		STR 857	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE NASSAS, VA 20109	1 06/	6/20/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 700	benefits and obtain use of bed rails. Resident #53 was 7/18/17 with the diapleural effusion, che failure, diabetes, produced and pleural effusion, che failure, diabetes, produced and pleural effusion and about most recent MDS (quarterly assessment of the failure of the failu	admitted to the facility on agnoses of but not limited to hronic kidney disease, heart peripheral vascular disease, depression, insomnia, cataracts, ove knee amputation. The (Minimum Data Set) was a pent with an ARD (Assessment of 5/19/19. The resident was agnitively intact in ability to make. The resident was coded as a care for bathing, toileting, sfers; limited assistance for envision for eating. 30 AM, 5:15 PM, on 6/19/19 at AM, and 1:44 PM, the resident er room, in her wheel chair next and was noted to have 2 als (one on each side) and the last each observation. Although ot seen in bed for any of the side rails were present, in the vailable for use by the resident l. anical record revealed that on the hospital on 5/5/19, a n/Readmission Assessment & (plan of care) - V4 (version mpleted. This form contained	F7	700			

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	COM	E SURVEY MPLETED
		495038	B. WING	m Straile In		C 20/2019
	PROVIDER OR SUPPLIE BAS HEALTH AND R		81 85	CODE		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 700	line in the above sethe document, for applied). Under the 2. Full" (Each represented a circ selecting which are was, "c. Are side independence wit No." (Each line in represented a circ selecting which are #53, this document half-length side rapromote independence which the care plawas also docume family did not attee there was no evid was discussed with Further review of reveal a physician Further review of reveal any evidence the use of side resident and familinformed consent Resident #53. A review of the control of the con	sentence represented a circle on selecting which answer nat, was "b. If yes:1. Half, line in the above sentence cle on the document, for nswer applied). Under that, rails used to promote h bed mobility1 Yes,2. In the above sentence cle on the document, for nswer applied). For Resident not identified she was to use cle on the document, for nswer applied). For Resident not identified she was to use cle on both sides of the bed to dence with bed mobility. The clinical record revealed a note in Note dated 6/4/19, during an was reviewed. However, it noted that the resident and her not the meeting. Therefore, ence that the use of side rails the clinical record failed to its order for the use of side rails. The clinical record failed to come of an assessment for risk of the use of side rails with Resident and that the risk and benefits a rails were discussed with the comprehensive care planted 4/3/19 for "(Resident #53) in more dated 4/3/19 for "(Resident #53)	F 700			
1		ce with ADLs (activities of daily				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	R/SUPPLIER/CLIA (X2) MULTI ATION NUMBER: A. BUILDIN		ULTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495038	495038 B. WING			C 06/20/2019		
	PROVIDER OR SUPPLIER	HAB CENTER	Tax	8575	ET ADDRESS, CITY, STATE, ZIP CODE RIXLEW LANE JASSAS, VA 20109		0/20/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 700	above knee amputa altered balance, de This care plan inclu	LLE AKA (left lower extremity ation), decreased mobility, conditioning, comorbidities." uded the intervention, dated f length) side rails to assist in	F	700		95.		
	the survey. 21. The facility staff for risk of entrapme	ion was provided by the end of f failed to assess Resident #94 ent, review risks and benefits d consent prior to the use of						
	5/23/16 with the dia unspecified demendisturbance, type 2 depressive disorder disease. The most Set), a quarterly assement references dent as scoring (Brief Interview for disease), and cating the Resident required subtransfers, and eating dressing, hygiene, a	admitted to the facility on agnoses of but not limited to tia with behavioral diabetes mellitus, major r, and peripheral vascular recent MDS (Minimum Data sessment, with an ARD ence date) of 6/2/19, coded the a 15 out of 15 on the BIMS Mental Status) score, lent had no cognitive r decision making. The appervision for bathing, g; limited assistance for and toileting; was occasionally ler and always continent of						
	PM, the resident wa	PM and on 6/19/19 at 2:17 as observed in his room, in his his bed. His bed was noted to						

	OF DEFICIENCIES OF CORRECTION	(X1) PHOVIDEN/SUPPLIEN/CLIA IDENTIFICATION NUMBER:	Charles to the Control	NG		TE SURVEY MPLETED	
		495038	B. WING		ne	C 5/20/2019	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109			10/20/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 700	and the side rails Although the resident of the observation	n side rails (one on each side) were up at each observation. dent was not seen in bed for any ns, the side rails were present, in nd available for potential use by	F 7	00			
	readmission from "Nursing Admissi (and) Interim POG four)" form was ca section identified Mobility/Safety." for "Side rails." Nor marking "Yes" yes:1. Left, line in the above the document, for applied). Under the document, for applied). Under the gresented a circular selecting which a was, "c. Are side independence with No." (Each line in represented a circular selecting which a was, "t. Are side independence with No." (Each line in represented a circular selecting which a was, "t. Are side independence with the use half-length bed to promote in Further review of	inical record revealed that upon the hospital on 2/23/19, a con/Readmission Assessment & C (plan of care) - V4 (version ompleted. This form contained as "Section K. This section contained an area lext to "Side Rails" was a circle or "No." Under that, was "a. if2. Right,3. Both." (Each sentence represented a circle on reselecting which answer hat, was "b. If yes:1. Half, in line in the above sentence cle on the document, for inswer applied). Under that, rails used to promote the bed mobility1. Yes,2. In the above sentence cle on the document, for inswer applied). For Resident intidentified he did not require the side rails on both sides of the independence with bed mobility. The clinical record failed to in's order for the use of side rails.					
	reveal any evider of entrapment wit	the clinical record failed to ace of an assessment for the risk th the use of side rails for the record failed to evidence any					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495038	B. WING			C 6/20/2019	
	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP C 8575 RIXLEW LANE MANASSAS, VA 20109		0/20/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	· _ · _ ·	N SHOULD BE	(X5) COMPLETION DATE	
F 700	of risk and benefits discussed with the evidence of an info the side rails for Reference of the side rails for Reference of the conrevealed one dated demonstrates the reliving) assistance remobility and impair plan included the in "1/2 (half length) sineeded for bed more revealed for bed more review of the "Care Conference which the care plan documented that the meeting. There was versus benefits of some written consent On 6/20/19 at 1:20 Resident #94 was asked if the entrapment, review informed consent pstated, "No. No one of the following of the findings.	resident and family or any president #94. Imprehensive care planted 12/10/18 for "(Resident #94) need for ADL (activities of daily /t (related to) decreased red altered balance." This care intervention, dated 12/31/18, for de rails x (times) 1-2 as ability/positioning." The clinical record revealed a Note, "dated 6/18/19, during in was reviewed. It was ne resident attended the as no written evidence that risk side rails was discussed and obtained at this meeting. PM, an interview with conducted. When Resident he facility discussed risk of a risks and benefits, and obtain orior to the use of bed rails."	F7	700			
	the survey						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	G	CON	E SURVEY MPLETED	
		495038	B. WING _	IS NO ARTISE		/20/2019	
				STREET ADDRESS, CITY, STATE, ZIP O 8575 RIXLEW LANE MANASSAS, VA 20109		VIET THE VEHICLE OF THE	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 700	(1) End Stage Recondition in which functioning on a pneed for a regular a kidney transplar information was owebsite: https://www.cms.genefits-and-Record-Recovery-OverneSRD/ESRD.htm 22. The facility stafor risk of entrapnand obtain informbed rails. Resident #43 was 11/19/18 with the unspecified deme	nal Disease: is a medical a person's kidneys cease ermanent basis leading to the course of long-term dialysis or at to maintain life. This btained from the following gov/Medicare/Coordination-of-B very/Coordination-of-Benefits-an view/End-Stage-Renal-Disease- aff failed to assess Resident #43 nent, review risks and benefits ed consent prior to the use of admitted to the facility on diagnoses of but not limited to ntia without behavioral		0			
	acquired absence acquired absence blood pressure, a MDS (Minimum Dassessment, with date) of 4/29/19, of 12 out of 15 on the Mental Status) so moderate cognitive making. The resifor eating; extension dressing, and toiled transfers; was alw bowel.	of right leg above the knee, of left leg above the knee, high and anxiety. The most recent ata Set), a 14-day scheduled an ARD (Assessment reference coded the resident as scoring a e BIMS (Brief Interview for					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495038	B. WING			C 06/20/2019	
	PROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP C 8575 RIXLEW LANE MANASSAS, VA 20109	ODE	00/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 700	wheel chair next to have 2 half-length; and the side rails we Although the reside of the observations the up position, and the resident when he admission from the resident when he admission from the admission (and) Interim POC four)" form was corea section identified Mobility/Safety." The for marking "Yes" of yes:1. Left,line in the above set the document, for sapplied). Under the2. Full." (Each I represented a circle selecting which answas, "c. Are side raindependence with No." (Each line in the represented a circle selecting which answas, "the side rail promote independence with the feach line in the above selecting which answas, "the side rail promote independence with the feach line in the above selecting which answas, "the side rail promote independence with the feach line in the above selecting which answas, "the side rail promote independence with the feach line in the above selecting which answas, "the side rail promote independence with the feach line in the above selecting which answas, "the side rail promote independence with the feach line in the above selecting which answas, "the side rail promote independence with the feach line in the above selecting which answas, "the side rail promote independence with the feach line in the side rail promote independence with the feach line in the above selecting which are side rail promote independence with the side rail pro	as observed in his room, in his his bed. His bed was noted to side rails (one on each side) ere up at each observation. In the was not seen in bed for any the side rails were present, in a available for potential use by the is in bed. It cal record revealed that upon the hospital on 4/15/19, a nown of care) - V4 (version enclosed) - V4 (ve	F 7	00			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SI COMPLE	ETED
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109			
(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 CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE C	(X5) OMPLETION DATE
F 700	of entrapment wit Resident #43. The of risk and beneficial discussed with the evidence of an interest the side rails for FA review of the clicomprehensive of the comprehensive of the comprehensive of the Care Conference which the care play was also docume family did not attend there was no evidence was discussed with the facility of the facility review risks and become the findings. On 6/20/19 at 4:0 Administrator and Management and Performance Impathe findings. No further informathe survey	the use of side rails for the record failed to evidence any its for the use of side rails being the resident and family or any formed consent for the use of Resident #43. Inical record failed to reveal a faire plan for the use of bed rails the clinical record revealed a faire plan for the use of bed rails the clinical record revealed a faire plan for the use of bed rails the clinical record revealed a faire plan for the use of bed rails the master that the resident and his find the meeting. Therefore, thence that the use of side rails the the resident and family. In part of the use of side rails the resident and family. In part of the use of side rails the resident and family. In part of the use of side rails the resident #43 was y discussed risk of entrapment, benefits, and obtain informed the use of bed rails, he stated, In part of the use of side rails was y discussed risk of entrapment, benefits, and obtain informed the use of bed rails, he stated, In part of the use of side rails was y discussed risk of entrapment, benefits, and obtain informed the use of bed rails, he stated, In part of the use of side rails was y discussed risk of entrapment, benefits, and obtain informed the use of bed rails, he stated, In part of the use of side rails are plan to the use of side rails the resident was y discussed the use of side rails the use	F 700			
		ntrapment, review risks and		(4)		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			-		С	
		495038	B. WING		06/20/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3575 RIXLEW LANE MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 700	Continued From pa	age 92 ,	F 700			
	6/3/19 with the diag type 2 diabetes me major depressive of hyperplasia with low retention of urine, of fracture of right fer recent MDS (Minimassessment, with a date) of 6/10/19, con 11 out of 15 on the Mental Status) scon moderate cognitive making. The resid assistance for hygi transfers, and eating an indwelling urina frequently incontine	s admitted to the facility on gnoses of but not limited to ellitus, high blood pressure, disorder, benign prostatic wer urinary tract symptoms, displaced intertrochanteric nur (1), and anxiety. The most num Data Set), an admission an ARD (Assessment reference oded the resident as scoring an BIMS (Brief Interview for re, indicating the Resident had a impairment for daily decision ent required extensive ene, dressing, toileting, ag; total care for bathing; had ry catheter (2) and was ent of bowel.				
6	PM, the resident win his room, in his win his room, in his win his bed was noted (one on each side) each observation, seen in bed for any rails were present, available for potent he is in bed.	as the resident was observed wheel chair next to his bed. to have 2 half-length side rails and the side rails were up at Although the resident was not of the observations, the side in the up position, and tial use by the resident when				
	admission from the Admission/Readmi Interim POC (plan- form was complete	ical record revealed that upon hospital on 6/3/19, a "Nursing ssion Assessment & (and) of care) - V4 (version four)" d. This form contained a s "Section K. Mobility/Safety."		4 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION	COM	TE SURVEY MPLETED C /20/2019
	PROVIDER OR SUPPLIE		85	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE IANASSAS, VA 20109		20/2010
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 700	This section conton Next to "Side Rail or "No." Under the2. Right,3 sentence represe for selecting whice was "b. If yes: in the above sent document, for selection under that, was, promote independence,2. No." (represented a circum selecting which a #105, this docum half-length side rapromote independence.	page 93 ained an area for "Side rails." Is" was a circle for marking "Yes" Ist, was "a. if yes:1. Left, Is. Both." (Each line in the above nted a circle on the document, In answer applied). Under that, I. Half,2. Full." (Each line ence represented a circle on the ecting which answer applied). In a circle on the deciment which answer applied in the above sentence cle on the document, for answer applied. For Resident ent identified he was to use alls on both sides of the bed to dence with bed mobility. The clinical record failed to its order for the use of side rails.	F 700			
	reveal any eviden of entrapment wit Resident #105. T of risk and benefi discussed with th evidence of an int the side rails for F Further review of "Safe Transitions which the care pladocumented that attended the mee	the clinical record revealed a Meeting," dated 6/4/19, during an was reviewed. It was also the resident and his family sting. There was no evidence the rails was discussed with the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION			E SURVEY MPLETED
		495038	B. WING				C 20/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 8575 RIXLEW LANE MANASSAS, VA 20109	CODE	1 00/	20/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD E APPROPE	BE	(X5) COMPLETION DATE
F 700	revealed one dated need for ADL (active d/t (due to) decreased balance r/t (related care plan included 6/14/19, for "1/2 (h. 1-2 as needed for intervention was not cannot be stated the were informed of the and consented to, Transition Meeting On 6/20/19 at 1:24 #105 was conducted asked if the facility review risks and be consent prior to the "No." On 6/20/19 at 4:07 Administrator and Management and Operformance Improvement in the findings. No further information was decided as the survey (1) Displaced interference in the survey (1) Displaced interference in the survey (1) Displaced interference in the survey (2) The survey (3) Displaced interference in the survey (4) Displaced interference in the survey (5) Displaced interference in the survey (6) Displaced interference in the survey (7) Displaced interference in the survey (8) Displaced interference in the survey (9) Displaced interference in the survey (1) Displaced inte	mprehensive care pland 6/4/19. "Demonstrates the vities of daily living) assistance sed mobility and impaired I to) recent hip fracture." This the intervention, dated alf length) side rails x (times) bed mobility." As the above of developed until 6/14/19, it nat the resident and family ne use of, risks and benefits of, the side rails at the 6/4/19 Safe pm, an interview with Resident ed. When Resident #105 was discussed risk of entrapment, enefits, and obtain informed e use of bed rails, he stated,	F 7	00			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION G	CON	E SURVEY IPLETED
	ALVALUE -	495038	B. WING_	William William	. 06	20/2019
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		
PREFI	X (EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 70	00166.htm. (2) An indwelling urine from the blabody. This informwebsite: https://medlineplu00140.htm 24. The facility st for risk of entraprand obtain inform	catheter is a tube that drains adder to a bag outside of the nation was obtained from the us.gov/ency/patientinstructions/0 aff failed to assess Resident #40 nent, review risks and benefits	F 70	0		
	12/12/18 with the bipolar disorder, blood pressure, a (1). The most re a quarterly asses (Assessment referesident as scorii (Brief Interview for indicating the Reimpairment for daresident required assistance for hytoileting; independent of the control of the co	diagnoses of but not limited to major depressive disorder, high and unspecified cirrhosis of liver cent MDS (Minimum Data Set), sment, with an ARD erence date) of 5/2/19, coded theng a 15 out of 15 on the BIMS or Mental Status) score, sident had no cognitive aily decision making. The supervision for transfers; limited giene, bathing, dressing, and dent for eating; was always				
	at 2:17 PM, the room. His bed we side rails (one or were up at each resident was not	45 PM, 4:53 PM, and on 6/19/19 esident was not observed in his as noted to have 2 half-length each side) and the side rails observation. Although the seen in bed for any of the side rails were present, in the		V II		38

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING (X2) MULTIPLE CONSTRUCTION A. BUILDING (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X7			(X3) DATE SURVEY COMPLETED		
		495038	B. WING		06	C / 20/2019
	PROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 8575 RIXLEW LANE MANASSAS, VA 20109		12012013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 700	resident when he is A review of the clini admission from the "Nursing Admission (and) Interim POC (four)" form was con a section identified Mobility/Safety." The for "Side rails." New for marking "Yes" or yes:1. Left, line in the above se the document, for s applied). Under tha2. Full." (Each li represented a circle selecting which ans was, "c. Are side ra independence with No." (Each line in the represented a circle selecting which ans #40, this document half-length side rails promote independe Further review of the reveal a physician's Further review of the reveal any evidence of entrapment with the Resident #40. The of risk and benefits discussed with the re-	cal record revealed that upon hospital on 12/12/18, a l/Readmission Assessment & (plan of care) - V4 (version npleted. This form contained as "Section K. his section contained an area at to "Side Rails" was a circle or "No." Under that, was "a. if _2. Right,3. Both." (Each ntence represented a circle on electing which answer at, was "b. If yes:1. Half, the in the above sentence on the document, for twer applied). Under that, ils used to promote bed mobility1. Yes,2.	F 76			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495038	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION		C C	
	PROVIDER OR SUPPLIES		S1 85	REET ADDRESS, CITY, ST 675 RIXLEW LANE ANASSAS, VA 20109		06/20/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
F 700	Continued From p	page 97	F 700		=		
	revealed one date completes all ADL self but is able to times with ADLs s Level of assistance to fatigue, comorb the intervention, clength) side rails t transfers."	emprehensive care plan ed 4/3/19 for "(Resident #40) as (activities of daily living) by ask for requires assistance at secondary to decreased mobility. be needed may vary secondary bidities." This care plan included lated 1/21/19, for "1/2 (half to assist in bed mobility and				II ×	
	"Care Conference which the care plated documented that attended the meethat the use of side resident and family evidence that risk	the clinical record revealed a e Note," dated 5/14/19, during an was reviewed. It was also the resident and his family ting. There was no evidence the rails was discussed with the ly. There was no written as benefits of side rails was written consent obtained at this					
		5 pm, an interview with Resident d. Resident #40 was not in his	*11				
	Administrator and Management and	7 PM, ASM #1, the I ASM #3, the Director of Risk Quality Assurance & rovement were made aware of					
	No further informathe survey	ation was provided by the end of					
		hosis is scarring of the liver and it is the last stage of chronic					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF CORRECTION	IDENTIFICATION NUMBER:	1 1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495038	B. WING	_	C 06/20/2019
	PROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	00/20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 700 F 812 SS=D	the following websit https://medlineplus. Food Procurement,	nformation was obtained from ee: gov/ency/article/000255.htm Store/Prepare/Serve-Sanitary	F 70		7/23/19
33=0	§483.60(i) Food sat The facility must -				
	approved or considerate or local authors (i) This may include from local producer and local laws or respective from using gardens, subject to safe growing and for (iii) This provision describing the safe growing and for (iiii) This provision describerate authors are growing and for (iiii) This provision describerate authors are growing and for (iiii) This provision describerate authors are growing and for (iiii) This provision describerate authors are growing and for (iiii) This provision describerate authors are provision describerate authors are provision and authors are provision and authors are provision and are provision	food items obtained directly s, subject to applicable State			
	serve food in accordant standards for food so This REQUIREMEN by: Based on observat	IT is not met as evidenced ion, staff interview, and facility e facility staff failed to store,		The expired bottle of salsa was removed from the walk-in refrigera negative outcome was identified.	tor. No
	ten ounce bottle of a on the top shelf of the	ed to remove an eight pound- salsa available for use, sitting he walk-in refrigerator with an 19 and a use-by-date of		 2) Any resident has the potential affected if facility staff fail to follow protocol or food storage guidelines 3) Dietary staff will be educated regarding facility protocol for food s 4) Food storage areas will be aud daily (M-F) x 5 days, weekly x 3 we then monthly x 2 months to verify a 	facility storage. ited eks,

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING B. WING	PLE CONSTRUCTION	COM	E SURVEY PLETED C 20/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 8575 RIXLEW LANE MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 812	On 06/18/19 at approbate of the with OSM (other standards) walk-in responds to on the outside of the date of 05/15/19 at On 06/19/19 at 7:4 conducted with OSW when asked to de expired food is not stated, "We date the when it was opened check items on a cuse-by date, we dimissed that one." The "(Name of Conserving of the conducted with OSW when it was opened check items on a cuse-by date, we dimissed that one." The "(Name of Conserving of Conser	proximately 11:50 a.m., an facility's kitchen was conducted aff member) # 4, dietary ation of the inside of the frigerator revealed an eight pottle of salsa sitting on the top of salsa had two dates written he bottle. The dates were open and a use-by-date of 6/15/19. 6 a.m., an interview was side # 4, dietary manager. Socribe the process of ensuring available for use OSM # 4 he item when we receive it, and the use by date. We laily basis and if it is at the scard it. I don't know how we report to possible for the process of the process of ensuring available for use OSM # 4 he item when we receive it, and the use by date. We laily basis and if it is at the scard it. I don't know how we report to possible for the process of the proc	F 812	items are within the use-by will be reported to the QAPI for further recommendation	Committee	
F 880 SS=D		tion was provided prior to exit.	F 880		8	7/23/19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495038	B. WING _			C /20/2019	
	PROVIDER OR SUPPLIER SAS HEALTH AND RE	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	1 00,	20,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 880	§483.80 Infection C The facility must es infection prevention designed to provide comfortable enviror development and tradiseases and infect §483.80(a) Infectior program. The facility must estand control program a minimum, the following services and communicable staff, volunteers, vistoroviding services arrangement based conducted accordinaccepted national staff. (i) A system of survey possible communication of survey possibl	ontrol tablish and maintain an and control program a safe, sanitary and ament and to help prevent the ansmission of communicable ions. In prevention and control tablish an infection prevention of (IPCP) that must include, at awing elements: Item for preventing, identifying, ing, and controlling infections diseases for all residents, sitors, and other individuals upon the facility assessment g to §483.70(e) and following tandards; In standards, policies, and program, which must include, or elillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a	F 88				

		IDENTIFICATION NUMBER:	A. BUILDII B. WING	TIPLE CONSTRUCTION NG	СОМЕ	
NAME OF PROVIDER OR SUPPLIER MANASSAS HEALTH AND REHAB CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 101 depending upon the infectious agent or organisminvolved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (V) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	06/20/2019 DE			
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	depending upon the involved, and (B) A requirement least restrictive pocircumstances. (v) The circumstar must prohibit emploisease or infected contact with reside contact will transm (vi)The hand hygie by staff involved in §483.80(a)(4) A syidentified under the corrective actions §483.80(e) Linens Personnel must hat transport linens so	that the isolation should be the ssible for the resident under the aces under which the facility to easy with a communicable of skin lesions from direct ents or their food, if direct ent	F 8	80		
	The facility will cor IPCP and update to This REQUIREME by: Based on observation record review and determined that the implement infection residents in the surand # 56. 1. The facility staff control practices detracheostomy care	duct an annual review of its heir program, as necessary. NT is not met as evidenced ation, staff interview, clinical facility document review, it was a facility staff failed to n control practices for two of 44 rvey sample, Residents # 21 failed to implement infection uring Resident # 21's		1) Facility staff failed to impler infection control practices durin tracheostomy care for Resident for the placement of the cathete collection bag for Resident #56 catheter collection bag was ren the floor immediately. Staff was educational coaching on infecti protocol for tracheostomy care catheter collection bag placeme 2) Any resident requiring track care or the use of a catheter collection.	t #21 and er . The noved from s provided on control and ent.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
3		495038	B. WING _		- 1	C	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	1 06/	20/2019	
(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 CORRECT (EACH CORRECTIVE ACTION SHOUNDS) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 880	control practices for 56's catheter collect The findings included 1. The facility staff control practices distracheostomy care Resident # 21 was 12/24/18 and a resident # 21's moset), a quarterly asset), a quarterly asset (assessment refers Resident # 21 as so interview for mentality - 15, 15 - being coordinates of the conducted of trached as "D. Suctionare." On 06/19/19 at 10:2 conducted of trached 10 performed by LF 6. LPN #6 entered up packaged trach clean barrier. LPN and put on a clean sterile "Suction Kit".	e: failed to implement infection uring Resident # 21's admitted to the facility on admission on 04/18/19 with uded but were not limited to: failure (1), old myocardial	F 88		ection N) or If on ling glove collection N) or Atheter riate weekly x The beserve (M-F), 2 months ontrol		
	the kit. LPN #6 ther sterile suction tubin from the suction ma	o opened the package with the g, connected it to the tubing achine, and turned on the th her left sterile gloved hand.					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	COM	E SURVEY APLETED C 20/2019
	PROVIDER OR SUPPLIE		8:	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE IANASSAS, VA 20109	1 00/	20/2019
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 880	the sterile tubing a Resident #21's tra Upon completing suction machine, removed the glove then donned a pa sterile "Tracheostitems and placed included "Powder wearing the regularemoved the canrelated it in the tra and peroxide, placed it using the wearing the same another bottle of scleaned it using the wearing the same another bottle of scleaned the area opening. LPN #6 from the "Trached the strap on the ricuff. She then attover-the-bed table gloves, went to the left then removed #6 then removed."	ed both sterile gloved hands on and placed it the tubing into ach to suction out secretions. This task, LPN # 6 turned off the disconnected the tubing, and es she was wearing. LPN #6 ir of plastic gloves, opened a comy Care Tray", removed the them on the clean barrier that free Nitrate Gloves." While ar plastic gloves LPN # 6 mula from Resident # 21's trach, by, opened the bottle of saline ced the cannula in the tray and the enclosed brush. While a gloves LPN # 6 opened saline and using a cotton swab around Resident #21's trach then removed a clean strap ostomy Care Tray" and removed ght side of Resident #21's trach ached the new strap, moved the while wearing the same e left side of the bed, removed the trach cuff and attached the left side of the trach cuff. LPN a new cannula, opened the led a new, clean cannula into	F 880			
	21 dated "June 19	an's order sheet) for Resident # 9, 2019" documented, "Trach ire q (every) shift and PRN (as ate: 04/18/19."				
	dated 01/18/2019 # 21) is at risk for	ve care plan for Resident # 21 documented, "Focus: (Resident respiratory problem(s) related on DX (diagnosis) of chronic				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495038	B. WING				С
	PROVIDER OR SUPPLIER			STR 857	REET ADDRESS, CITY, STATE, ZIP CODE 5 RIXLEW LANE NASSAS, VA 20109	06/	20/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST 8E PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	respiratory failure vacute exacerbation Under "Intervention" "Provide Trach Car 02/08/2019." On 06/19/19 at 1:2 conducted with LPI regarding the trach Resident # 21. Why procedure for using sanitize or wash my LPN #6 was then in observations of not hands between chaitems while wearing Resident # 21's transhould have only to sterilized field. I tou same gloved hand on with." When as her hands between trach care for Resident # 21's policy documented, "PRO hands (keep procedure) facility's policy documented, "PRO hands (keep procedure) facility assurance of the facility assurance of th	with hypoxia with periods of a. Date Initiated: 01/18/2019." ins/Tasks" it documented, e as ordered. Date Initiated: 1 p.m., an interview was N (licensed practical nurse) # 6 eostomy care provided to den asked to describe the gloves, LPN # 6 stated, "I y hands between glove use." Informed of the above changing gloves, washing her anging gloves and touching gloves when providing the care. LPN # 6 stated, "I suched the items in the ched the suction tubing with I turned the suction machine ked if she washed or sanitized changing gloves during the dent LPN stated, "No." "Tracheostomy Care" (CEDURE: A. 2. Wash your dure as aseptic as possible)."."	F8	80			

		IDENTIFICATION NUMBER: A. BUI		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER		data see	STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	06/20/2019 DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	obtained from the https://www.nlm.n ilure.html. (2) Heart attack. Iby a blood clot tha arteries. The coro oxygen to the heat the heart is starve This information whittps://medlineplus. (3) Fear. This information.	od. This information was	F 880				
	control practices f 56's catheter colle Resident # 56 was 07/29/14 and a re- diagnoses that independent of urine, disorder (2), and re- Resident # 56's m set), a significant of ARD (assessment coded Resident # the brief interview score of 0 - 15, 7 impaired of cognit Resident # 56 was	if failed to implement infection or the placement of Resident # ction bag. s admitted to the facility on admission on 11/30/18 with cluded but were not limited to: hypertension (1), depressive multiple sclerosis (3). ost recent MDS (minimum data change assessment with an areference date) of 05/16/19, 56 as scoring a 7 (seven) on for mental status (BIMS) of a (seven) - being severely ion for making daily decisions. It is coded as being totally staff member for activities of		×			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405020					С
NAME OF	SPOVIDED OF CURRILIES	495038	B. WING			06/	/20/2019
NAME OF PROVIDER OR SUPPLIER MANASSAS HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZI 8575 RIXLEW LANE MANASSAS, VA 20109	P CODE		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
F 880	daily living. Section Resident # 56 was	n H "Bladder and Bowel" coded as "A. Indwelling suprapubic catheter and	F8	80			(0)
	Resident # 56 rever lying in her bed wat of the bed revealed the observation of t	1 p.m., an observation of aled she was in her room, ching television. Observation it was low to the ground and he catheter collection bag sched to the side of the bed loor.					
	56 dated "June 19, pubic catheter 20F centimeters) balloo	n's order sheet) for Resident # 2019" documented, "Supra (French) with 20cc (cubic n for neurogenic bladder. eeded) for facility protocol. 17."					
	dated 06/08/2015 d resident has an Ind	e care plan for Resident # 56 ocumented, "Focus: The welling (Suprapubic) Catheter: r. At risk for chronic UTIs ons) date Initiated:					
	conduct with CNA (When asked to des resident's catheter of "The collection bag	32 a.m., an interview was certified nursing assistant) # 7. cribe the placement of a collection bag, CNA # 7 stated, is put on the side of the bed. It should not be on the floor					
	conduct with LPN (I When asked to des	p.m., an interview was icensed practical nurse) # 4. cribe the placement of a collection bag, LPN # 4 stated.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ORRECTION IDENTIFICATION NUMBER:		A. BUILDING		CX3) DATE SURVEY COMPLETED C	
			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	06/20/2019 DE			
(X4) ID PREFIX TAG	(EACH DEFICIENT	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	(X5) COMPLETION DATE		
F 880	"The collection bashould not be on a contamination." The facility's polic "PROCEDURE: Heladder level but a company of the policity of the bladder level but a company of the bladder level bladder level but a company of the bladder level bladder level but a contamination of the bladder level blad	g is put on the side of the bed it the floor to avoid infection or y "Catheter Care" documented, 14. Collection container is below not touching the floor." proximately 5:30 p.m., ASM # 1 aff member), administrator, and of risk management and QAPI and performance are made aware of the findings. Ation was provided prior to exit.	F 880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495038	B. WING _		06	C /20/2019
NAME OF PROVIDER OR SUPPLIER MANASSAS HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	<u> </u>	20/2019
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	(X5) COMPLETION DATE
F 880	such as numbness needles" and think This information wa	age 108 nation and balance, sensations , prickling, or "pins and ting and memory problems. as obtained from the website: .gov/multiplesclerosis.html.	F 88			
1 m						,