PRINTED: 07/18/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		405017				С	
	5501/1551 G. S.	495217	B. WING		07	7/11/2019	
	CARE HEALTH SERV	ICES-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
E 000	Initial Comments		E 00				
F 000	survey was conducted on the fact of the fa	Medicare/Medicaid} Survey was conducted 7/11/19. Two complaints were the survey. Corrections are unce with 42 CFR Part 483 Care requirements. The Life	F 00	The statements made on this Pl Correction (PoC) are not an adress to and do not constitute an agree with the alleged deficiencies here remain in compliance with all Fe and State regulations, the facility taken or will take the actions set the following PoC. This PoC constitutes the facility's allegatic compliance such that all alleged deficiencies cited during the sur have been or will be corrected by compliance date indicated.	nission ement rein. To oderal y has forth in n of		
SS=D	113 at the time of the consisted of 50 currelosed record review Resident Rights/Exec CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a resulf-determination, a access to persons a outside the facility, in this section. §483.10(a)(1) A facility with respect and digresident in a manner promotes maintenar her quality of life, recindividuality. The facility of the resident the rights of the consistency of the resident the rights of the	ercise of Rights)(2)(b)(1)(2) It Rights. ight to a dignified existence, and communication with and and services inside and including those specified in the resident and ity must treat each resident and in an environment that are or enhancement of his or cognizing each resident's ility must protect and it the resident.	F 55	F550 1. Resident #46 was referred to Occupational Therapy and ar assessment completed speciresident's ability to activate cabell/light system. Resident un activate using touch-pad; a haplint was ordered to provide resident with enhanced ability activate standard unit. 2. All residents have the potential affected. 3. Unit Managers/designee will a ten (10) LTC residents daily x then weekly x4 weeks, to ensany decline in activation of the	fic to fill-	·	
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	TITLE		(X6) DATE	

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495217	B. WING			C /11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWA FAIRFAX, VA 22033		11/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	§483.10(a)(2) The faccess to quality caseverity of condition must establish and practices regarding provision of service residents regardles. §483.10(b) Exercise The resident has the rights as a resident or resident of the United Service from the facility. §483.10(b)(1) The fresident can exercise interference, coercife from the facility. §483.10(b)(2) The resident can exercise of interference, reprisal from the facility. §483.10(b)(2) The resident free of interference, reprisal from the facility. The facility document review is and to be sup exercise of his or he subpart. This REQUIREMENT by: Based on resident if facility document review, it was determ to maintain a resident review, it was determ to maintain a resident residents in the survice of the facility staff failed call bell for Resident Resident #46 was of the nouth so she cound then pushed it a bell. When asked hell.	racility must provide equal are regardless of diagnosis, and or payment source. A facility maintain identical policies and transfer, discharge, and the sounder the State plan for all sof payment source. The of Rights is or her of the facility and as a citizen	F 550	2. All residents have the potential affected. 3. Unit Managers/designee will ten (10) LTC residents daily with then weekly x4 weeks, to ensure any decline in activation of the bell/light system is identified a resolved in a timely manner. New admissions to the facility evaluated upon arrival with restolability to activate the call be system. Licensed nurses & CNAs will educated on reporting function decline in residents' status wiregards to the use of call light. 4. Director of Nursing/designee report the results of audits at monthly QAPI Committee mex3 months for its review and recommendations. 5. Compliance Date: August 13	audit 5 days, ure that e call and will be gards ell/light be re- nal th s. will the etings		

								. 0000 0001	
		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
I			40-04-					C	
ŀ	MANIFOR	2001/10/00 62 64 64	495217	B. WING			07	/11/2019	
١	NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
l	MANOR	CARE HEALTH SERVI	CES-FAIR OAKS			12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	*		
İ	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N!	(VE)	
	PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
	F 550	Continued From pa angry."	ge 2	F 5	50				
		The findings include	: :						
		7/8/2017 with a read Resident #46's diag limited to Parkinson	dmitted to the facility on dmission on 7/2/2019. noses included but were not 's disease (1), multiple herosclerotic heart disease						
		Resident #46's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/11/19, coded the resident's cognition as cognitively intact. Section G coded Resident #46 as requiring total dependence of two+ (or more) staff with bed mobility and transfers, total dependence of one staff with dressing and personal hygiene. Under section "G0400 Functional Limitation in Range of Motion" Resident #46 was coded as "2 (two) Impairment on both sides" for 'Upper extremity (shoulder, elbow, wrist, hand)."							
		7/08/2017 document	orehensive care plan dated ted, "Keep call lights and w/in (within) reach" and all for assistance."						
		observed in her roon bell was lying across asked to ring the cal was able to access t Resident #46 stated completely" paralyze weak with limited modemonstrated the us	a.m., Resident #46 was in in a wheelchair. The call is her lap. Resident #46 was is bell to ensure the resident the device effectively. The right arm is, "almost d and the left arm is very evement in the fingers. She te of the call bell by grasping ther fingers on her left hand						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7 30123			С	
		495217	B. WING			07/11/2019	
	PROVIDER OR SUPPLIEF CARE HEALTH SERV			STREET ADDRESS, CITY, STATE, ZIP (12475 LEE JACKSON MEMORIAL I FAIRFAX, VA 22033	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 550	and bringing the cocord in her mouth, to the end of the cagainst her chin to how she felt about stated, "It makes not conducted with CN #2. CNA #2 was a residents who have motion to ensure a bell. CNA #2 stated who is paralyzed we can touch with any on." When asked #46 access and ac stated, "I have never the call bell, for her not see how she is was informed of the accessing the call bell by putting it in the pad call light would will tell my supervise pad." On 7/11/19 at 8:16 conducted with RN was asked what the have limited or decreases to a stated, "I don't have press the light, but strong side so they informed of the obsaccessing the call be accessing the call be acces	ord to her mouth. Placing the she maneuvered her left hand all bell to grasp it and pushed it activate the bell. When asked this process, Resident #46	F	550			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING				C 11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD I	BE	(X5) COMPLETION DATE	
F 550	hand." RN #2 was witnessed Resident Call light. RN #2 sta a dignified manner mouth." The facility's reside Resident Rights" do must treat each resand care for each reenvironment that prenhancement of his recognizing each resulting the properties of the facility policy, "opart, "Purpose: To usystem to alert staff Bedside call light willight equipment is a cannot use standard On 07/11/19 at approperties of the facility policy, and administrative staff Bedside call light willight equipment is a cannot use standard On 07/11/19 at approperties of the facility policy. The facility policy is system to alert staff Bedside call light willight equipment is a cannot use standard Con 07/11/19 at approperties of the facility of the faci	asked if he has ever t #46 access and activate her ated, "No." RN#2 stated, "Not to access call light to put in "It's rights entitled "Your ocumented in part, "A facility ident with respect and dignity esident in a manner and in an romotes maintenance or s or her quality of life, esident's individuality." Call Light" documented in use a light and/or sound to patient needs. Equipment: th cord. NOTE: Adaptive call vailable for those patients who d call light cord." roximately 12:05 p.m., ASM # aff member), administrator, istrative director of nursing y assurance consultant, were findings. on was provided prior to exit. ase disorder. This information he website: gov/medlineplus/parkinsonsdi	F 5	50				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495217	B. WING _		C 07/11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 COMPLÉTION	
SS=D	and spinal cord. It of the material that su nerve cells. This da messages between leading to the symp visual disturbances, with coordination are as numbness, prick and thinking and me information was obthetys://medlineplus. 3. atherosclerosis A disease in which parteries. Plaque is a fat, cholesterol, calc found in the blood. (and narrows your are oxygen-rich blood to was obtained from the https://medlineplus.greasonable Accommediated from the https://medlineplus.greasonable Accommediation of references except endanger the health other residents. This REQUIREMEN by: Based on observation interview and facility determined that the reasonable accommediate accom	lamages the myelin sheath, rrounds and protects your mage slows down or blocks your brain and your body, toms of MS. They can include muscle weakness, trouble ad balance, sensations such ling, or "pins and needles" emory problems. This ained from the website: gov/multiplesclerosis.html. Dlaque builds up inside your sticky substance made up of sium, and other substances over time, plaque hardens teries. That limits the flow of your body. This information he website: gov/atherosclerosis.html. modations Needs/Preferences by with reasonable esident needs and when to do so would or safety of the resident or T is not met as evidenced on, resident interview, staff document review, it was facility staff failed to ensure odation of resident needs for in the survey sample,	F 558	F558	h n by for all to to hold to h	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495217	B. WING		07	C 7/11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-FAIR OAKS		IWAY	711/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		
	1. The facility staff if #61's call bell within resident up in her w. 2. The facility staff if call bell was within resident was in bed. 3. The facility staff if appropriate call bell ensure that the call reach while the resi. The findings include 1. The facility staff if #61's call bell within resident up in her w. Resident #61 was a 10/26/19 with diagnot limited to: high be breath, gastroesoph [backflow of the conesophagus, usually sphincter muscle be symptoms include be commonly known as falls, and osteoporotissue, causing fragi (2)]. The most recent Mc assessment, a quart assessment referencesident as having be memory difficulties.	ailed to place the Resident reach after getting the heelchair. ailed to ensure Resident #93's the resident's reach while the on 7/9/19. ailed to provide an for Resident #46 and failed to bell was within the resident's dent was in bed on 7/10/19.	F 55	3. Unit Managers/designee wrandom audits of each unit resident rooms, daily x5 daweekly x4 weeks, to ensure residents have their call lig reach, with appropriate intelinitiated as needed. Director of Nursing (DON) conduct random audits to ecompliance. Licensed nurses & CNAs reducated on expectation the light cords are within reach residents at all times. 4. Unit Managers and DON withe results of audits at the QAPI Committee meetings months for its review and recommendations. 5. Compliance Date: August	and ys then ht within ervention will also ensure at call- of the ill report monthly x3	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495217	B. WING		07	C 7/11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERV			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER CROSS-REFERENCED TO THE APPROPRIES OF THE	ILD BE	(X5) COMPLETION DATE	
F 558	decisions. Resident extensive assistant of her activities of of the comprehensive resident. Gathered room. The call bell between the wheelin reach of the resident for approximate the room for approximate the room for approximate the room for falls due balance/pro (problegait." The "Intervent" Reinforce need to An interview was confident of the reach. The "Intervent" asked where the call the comprehensive revised on 1/17/19, at 9:48 a.m. bell should be placed reach. The "Intervent" CNA #7 was if it is on the floor between the call the cal	t #61 was coded as requiring ce of one staff member for all	F 5	58			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	_	495217	B. WING				C 11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD	BE	(X5) COMPLETION DATE
F 558	Bedside call light wi light equipment is a cannot use standard position all light conreach." Administrative staff administrator, ASM of nursing, and ASM consultant, were maconcern on 7/11/19 No further information (1) Barron's Dictional Non-Medical Reade Chapman, page 243 (2) Barron's Dictional Non-Medical Reade Chapman, page 424 (2) Barron's Dictional Non-Medical Reade Chapman, page 424 (2) Barron's Dictional Non-Medical Reade Chapman, page 424 (3) Barron's Dictional Non-Medical Reade Chapman, page 424 (4) Barron's Dictional Non-Medical Reade Chapman, page 424 (5) Barron's Dictional Non-Medical Reade Chapman, page 424 (6) Barron's Dictional Non-Medical Reade Chapman, page 424 (7) Barron's Dictional Non-Medical Reade Chapman, page 424 (th cord. NOTE: Adaptive call vailable for those patients who dicall light cord6. Always veniently for use and within member (ASM) #1, the #2, the administrative director I #3, the quality assurance and aware of the above at 10:50 a.m. On was provided prior to exit. Any of Medical Terms for the r, 5th edition, Rothenberg and B. ary of Medical Terms for the r, 5th edition, Rothenberg and Rothenberg and Rothenberg and Rothenberg and Rothenberg and Rothenberg and Rot	F 5	558			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495217	B. WING				C
	PROVIDER OR SUPPLIER	ICES-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		BE	(X5) COMPLETION DATE
F 558	On 7/9/19 at 11:37 observed lying in be was observed on the a half feet from the call bell to ensure the resident's bed. On 7/9/19 at 4:43 pobserved lying in be the bed. Resident bell to ensure the rethe device. Resider asked. When asked Resident #93 stated. On 7/10/19 at 3:02 conducted with CN/#1. CNA #1 was as resident's call bell is resident is in bed. Obell somewhere on asked if every call betted, "Yes." When "So that it will not factonfirmed Resident and confirmed the reach or obtain the capproximately one asked. On 7/10/19 at 5:49 petals from the device of the administrative of #3 (the quality assurance of the above in the ab	a.m., Resident #93 was ed. The resident's call bell he floor approximately one and bed. There was no clip on the he device could be attached to he.m., Resident #93 was ed. The call bell was lying on #93 was asked to ring the call esident understood how to use ht #93 rang the call bell when d if she uses the call bell, d she does. p.m., an interview was A (certified nursing assistant) ked how staff ensures a kept within reach when a CNA #1 stated, "Clip the call the bed or the sheet." When hell should have a clip, CNA #1 h asked why, CNA #1 stated, ll on the floor." CNA #1 #93 does use the call bell esident would not be able to call bell if it was on the floor and a half feet away from the D.m., ASM (administrative he administrator), ASM #2 lirector of nursing) and ASM rance consultant) were made concern. On was presented prior to exit.	F5	58			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY MPLETED	
		405047					С
		495217	B. WING			07/	11/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADI	DRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-FAIR OAKS			JACKSON MEMORIAL HIGHWAY VA 22033	r	
(V4) ID	STIMMADV STA	TEMENT OF DEFICIENCIES					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD ISS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 558	Continued From pag	ge 10	F 5	58			
	ensure that the call	for Resident #46 and failed to bell was within the resident's dent was in bed on 7/10/19.					
	7/8/2017. Resident were not limited to F	dmitted to the facility on #46's diagnoses included but Parkinson's disease1, multiple rosclerotic heart disease3.					
	set), a quarterly ass (assessment referent the resident's cognit Section G coded Redependence of two- mobility and transfer staff with dressing a section "G0400 Fundation" Resident # 4	t recent MDS (minimum data essment with an ARD nee date) of 5/11/19, coded ion as cognitively intact. Isident #46 as requiring total (or more) staff with bed res, total dependence of one and personal hygiene. Under ctional Limitation in Range of 16 was coded as "2 (two) sides" for 'Upper extremity ist, hand)."					
	7/08/2017 document	orehensive care plan dated ted, "Keep call lights and w/in (within) reach" and all for assistance."					
	observed lying in bed was observed drape mattress in the bed the the resident's left up was able to use her that it was in the bed have to hunt for it. F arm is, "almost comp	a.m., Resident #46 was d. The resident's call bell d across the back of the beside the upper portion of per arm. When asked if she call bell, Resident #46 stated I somewhere and she would Resident #46 stated her right bletely" paralyzed and the left h limited movement in the edical condition.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING			1	С	
NAME OF	PROVIDER OR SUPPLIER	495217	b. WING	STREET ADDRESS, CITY, STATE, ZIF	2 CODE	07/	11/2019	
	CARE HEALTH SERV	ICES-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
	On 7/10/19 at 3:00 observed in room in was lying across he asked to ring the cawas able to access Resident #46 again "almost completely' very weak with limit She demonstrated grasping the call be bringing the cord to in her mouth, she may the end of the call be against her chin to a how she felt about the makes me angry." On 7/11/19 at 08:04 conducted with CNA#2. CNA#2 was as resident has access stated, "We put it will CNA#2. CNA#2 was asked who have limited or ensure access to the "For instance, one phave call light that pof their hand and it is specifically about reher call light, CNA#1 light and she holds in push the call light ard daughter. Resident call light on her lap a her. They are suppoplace it in the middle it." CNA#2 was ask Resident #46 access.	ge 11 p.m., Resident #46 was a wheelchair. The call bell er lap. Resident #46 was all bell to ensure the resident the device effectively. stated her right arm is paralyzed and the left arm is ed movement in the fingers. the use of the call bell by ll cord with her fingers and her mouth. Placing the cord naneuvered her left hand to well to grasp it and pushed it activate the bell. When asked his process she stated, "It a.m., an interview was a (certified nursing assistant) ked how staff ensures a to the call bell. CNA #2 here the patient can reach." what staff do with residents decreased range of motion to e call bell. CNA #2 stated, watient who is paralyzed we atient can touch with any part cuts it on." When asked sident #46's ability to access 2 stated, "We give her call t with her hand. She can and dial phone to call her (name of Resident #46), has and in bed she has it beside posed to put it in front of her, I are of her lap and she can reach ted if she has witnessed using and activating her call to that a side of the call that have never seen her	F 5	558				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495217	B. WING		07	C //11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW FAIRFAX, VA 22033		711/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 558	struggle to activate see a problem, I do though." CNA #2 w observation noted bp.m. CNA #2 stated activate the call bell Maybe the touch pa option for her; I will needs a touch pad." On 7/11/19 at 8:16 a conducted with RN was asked how staf access to the call be process is we try to possible, it has to be able to press when what staff do with redecreased range of the call bell. RN #2 sresidents who cannow put light on the s When asked specifi #2 stated, "She has times last week, did being informed of the 46 accessing the castated, "This is new, her hand." RN #2 w witnessed Resident call light. RN #2 staft a dignified manner to mouth." On 07/11/19 at approximately a	the call bell, for her I never not see how she is pressing it as informed of the above by surveyor on 7/10/19 at 3:00 l, "It is not a dignified way to by putting it in the mouth. It call light would be a better tell my supervisor that she tell my supervisor that she tell my supervisor that she tell. RN #2 stated, "The keep the call light as close as e close to them so they are needed." RN #2 was asked esidents who have limited or motion to ensure access to stated, "I don't have any of press the light but usually strong side so they can use it." cally about Resident #46, RN used the call light multiple not have any difficulty." After e observation of Resident # Il bell on 7/10/19, RN # 2 I have seen the call light in ras asked if he has ever #46 access and activate her ted, "No." RN#2 stated, "Not o access call light to put in oximately 12:05 p.m., ASM # fff member), administrator, istrative director of nursing assurance consultant, were	F 5	58		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495217	B. WING			С	
NAME OF	PROVIDER OR SUPPLIER	433217	D. WING	STREET ADDRESS, CITY, STATE, ZIP C		07/11/2019	
	CARE HEALTH SERV	ICES-FAIR OAKS		12475 LEE JACKSON MEMORIAL H FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 558	Continued From pa	ge 13	F 5	58			
	No further informati	on was provided prior to exit.					
	References:	*	9				
	was obtained from	t disorder. This information					
	and spinal cord. It depends that support the material that support cells. This day messages between leading to the sympth visual disturbances, with coordination are as numbness, prick and thinking and meinformation was obtined.	isease that affects your brain lamages the myelin sheath, rrounds and protects your mage slows down or blocks your brain and your body, toms of MS. They can include muscle weakness, trouble and balance, sensations such ling, or "pins and needles" emory problems. This ained from the website: gov/multiplesclerosis.html.					
F 577 SS=C	arteries. Plaque is a fat, cholesterol, calc found in the blood. Cand narrows your ar oxygen-rich blood to was obtained from thttps://medlineplus.cRight to Survey Res CFR(s): 483.10(g)(1)	gov/atherosclerosis.html. ults/Advocate Agency Info	F 57	77 F577 1. An orange & white binde "Survey Results and Pla Correction for Past 3 Ye	ins of		

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION G		E SURVEY IPLETED
		495217	B. WING		1	C 11/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		11/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	(i) Examine the rest of the facility condusurveyors and any prespect to the facilities (ii) Receive information advocates, are to contact these ages §483.10(g)(11) The (i) Post in a place reand family members residents, the result the facility. (ii) Have reports with certifications, and correspecting the facility to review upon requivers, and any plan respect to the facility of accessible to the put (iv) The facility shall information about contact the survey. Based on observations and contact of the survey. The findings include On 7/10/19 at 11:00 conducted with five of the survey.	sults of the most recent survey ucted by Federal or State plan of correction in effect with ty; and ation from agencies acting as nd be afforded the opportunity rencies. If facility must-eadily accessible to residents, rs and legal representatives of its of the most recent survey of the respect to any surveys, complaint investigations made ity during the 3 preceding nof correction in effect with ty, available for any individual uest; and ne availability of such reports in that are prominent and ublic. If not make available identifying omplainants or residents. Note in the facility ethe survey results were or residents and failed to post or results. The census in the cility was 113 at the time of the	F 577	been placed in the lobby area facility, that is now readily access to all residents and/or their representatives to review 24/7. All residents have the potential affected. Administrative and Manageme Staff were educated on the requirement specific to access to survey results and plans of correction. Administrator or designee in their absence will monitor daily to determine ong compliance with this requirementall times. Results of this ongoing monitor and related audits will be present the monthly QAPI Committe meetings x3 months for its revisand recommendations. Compliance date: August 13, 25	to be ent sibility oing ent at ring ented se iew	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495217	B. WING		C 07/11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
	they were not aware results. On 7/10/19 at 11:27 observations of the posting regarding the observed. The survivinder labeled, "VIRHEALTH INSPECTI was located on a dein the front lobby. On 7/10/19 at 4:06 pconducted with OSM (the general clerk be during the day) and coordinator behind the evening). OSM #11 residents are permit desk. OSM #11 and On 7/10/19 at 5:49 pstaff member) #1 (the administrative of the administrative of the during the day). On 7/11/19 at 9:47 afacility did not have a results and the facility.	32, 114, 44, and 83) stated of the location of the survey a.m. and 3:02 p.m., facility were conducted. No be survey results was vey results were observed in a lightly dependent of the survey results was vey results were observed in a lightly dependent of the sk behind the reception desk of the reception desk of the reception desk during the and OSM #12 (the business office the reception desk during the and OSM #12 were asked if the ted to go behind the reception dosk if the ted to go behind the reception of OSM #12 both stated, "No." of the administrator, ASM (administrative the administrator), ASM #2 lirector of nursing) and ASM rance consultant) were made concern.	F 57		
F 578 SS=E	Request/Refuse/Dsc CFR(s): 483.10(c)(6	on was presented prior to exit. continue Trmnt;FormIte Adv Dir)(8)(g)(12)(i)-(v) ght to request, refuse, and/or	F 578	F578 1. New evaluations were conducted the Social Workers for Resident #64, #66, #93 & #94 to determine the social was also be the social workers.	ts

			E SURVEY MPLETED			
		495217	B. WING_		1	C /11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW FAIRFAX, VA 22033		11/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	discontinue treatment to participate in exp formulate an advan §483.10(c)(8) Nothic construed as the right the provision of ments services deemed minappropriate. §483.10(g)(12) The requirements specificate subpart I (Advance (i) These requirements inform and provide residents concerning medical or surgical resident's option, for (ii) This includes a vigacility's policies to it and applicable State (iii) Facilities are perentities to furnish this legally responsible frequirements of this (iv) If an adult indivictime of admission an information or articulas executed an admay give advance dindividual's resident with State Law. (v) The facility is not provide this information or she is able to receive Follow-up procedure.	ent, to participate in or refuse erimental research, and to ce directive. Ing in this paragraph should be that of the resident to receive dical treatment or medical edically unnecessary or facility must comply with the ied in 42 CFR part 489, Directives). Into include provisions to written information to all adult go the right to accept or refuse treatment and, at the remulate an advance directive. Written description of the mplement advance directives a law. In information but are still or ensuring that the	F 57	any change in advance direction and, when/if applicable, to obtain related documents, e.g., DNF Power of Attorney, etc. 2. All residents have the potential affected. 3. Social Workers were re-educategarding requirement to perfective decisions regarding and directives for LTC residents. Social Workers will audit all of LTC residents to identify any additional residents that requivered overdue, periodic review of a directive, initiating the necess action to complete in a timely manner if any identified. Social Workers will randomly LTC residents to ensure committee with periodic review of advantificatives. 4. Results of all audits will be proby the Social Workers at the QAPI Committee meetings x3 months for its review and recommendations. 5. Compliance Date: August 13	etain R, al to be ated iodically dvance current ire an dvance ssary audit pliance ce esented monthly B	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		ATE SURVEY OMPLETED
		495217	B. WING		07	C 7/11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033		711/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ULD BE	(X5) COMPLETION DATE
	by: Based on resident clinical record reviet facility staff failed to advance directives if survey sample, Res The facility staff faile Resident #64's, #66 representative's) de directives. The findings include 1. The facility staff fa Resident #64's (or the regarding advance of the regarding advance of the regarding advance dispressive disorder. MDS (minimum data with an ARD (assess 5/26/19, coded the resident a social service assessment address documented the residing not have advance directives) information on advar.	interview, staff interview and w, it was determined that the conduct follow-up reviews of for four of 57 residents in the idents #64, #66, #93 and #94. ed to periodically review 's, #93's and #94's (or their cisions regarding advance 's'. ailed to review periodically ne representative's) decisions directives. dmitted to the facility on 64's diagnoses included but ough, chronic pain and major. Resident #64's most recent a set), a quarterly assessment sment reference date) of esident as being cognitively #64's clinical record revealed essment dated 12/29/17. The sed advance directives and ident and/or representative ed care planning (including in place and did not want	F 5	78		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		495217	B. WING		07	C 7/11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW FAIRFAX, VA 22033		711/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRICE DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	service assessment Resident #64's com 11/17/17 failed to do advance directives. On 7/10/19 at 1:49 p conducted with OSM OSM #3 (both social OSM #3 was asked regarding advance of social service assess admission and advance directives in residents have advance directives in residents have advance directives in residents have advanced in the clinical residents do not have admission then the sinformation regardin periodic reviews and directives are conduct meetings. At this tin were asked to provide #64's advance direct reviewed since 12/29 On 7/10/19 at 5:25 p conducted with Resistated the facility sta and updated her cod be resuscitated) but has not periodically re-	prehensive care plan dated ocument information regarding o.m., an interview was a look (other staff member) #2 and look workers). OSM #2 and about the facility process directives. OSM #2 stated a sment is completed upon note directives is a part of the #2 stated the social workers representatives if they have a place. OSM #2 stated if note directives in place then sk for a copy and the copy is record. OSM #2 stated if the advance directives upon social workers offer to provide g this. When asked if the follow up of advance cted, OSM #2 stated periodic the dat the quarterly care plan note, OSM #2 and OSM #3 the evidence that Resident this had been periodically 19/17. I.m., an interview was dent #64. Resident #64 ff has periodically reviewed the status (whether or not to confirmed the facility staff eviewed full advance the decision to appoint a	F 5	78		

		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		NSTRUCTION		E SURVEY MPLETED
			495217	B. WING				C
l		PROVIDER OR SUPPLIER	CES-FAIR OAKS			T ADDRESS, CITY, STATE, ZIP CODE LEE JACKSON MEMORIAL HIGHWAY		/11/2019
ŀ					FAIRF	FAX, VA 22033		
	(X4) ID PREFIX TAG				(X5) COMPLETION DATE			
		confirmed they had provide. On 7/10/19 at 5:49 pataff member) #1 (the administrative of #3 (the quality assuratives of the above) The facility document directives failed to dregarding periodic receives failed to dregarding periodic receives failed to dregarding periodic receives failed to dregarding advance of the facility staff faresident #66's (or the facility staff faresident facility staff facilit	p.m., OSM #2 and OSM #3 no further information to p.m., ASM (administrative ne administrator), ASM #2 director of nursing) and ASM rance consultant) were made concern. Int regarding advance locument information eviews. In was presented prior to exit. In ailed to periodically review the representative's) decisions directives. Idmitted to the facility on 166's diagnoses included but the art disease and chronic is most recent MDS (minimum of assessment with an ARD ince date) of 5/26/19, coded ion as severely impaired. #66's clinical record revealed the sed advance directives and ident and/or representative ed care planning (including in place and did not want	F	78			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495217	B. WING			1	C /11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		12	TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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
	service assessment Resident #66's com 11/5/18 failed to do advance directives. On 7/10/19 at 1:49 conducted with OSM OSM #3 (both social OSM #3 was asked regarding advance of social service assess admission and adva assessment. OSM ask residents and/or advance directives is residents have adva the social workers at placed in the clinical residents do not have admission then the sinformation regardin periodic reviews of a conducted, OSM #2 conducted at the qua this time, OSM #2 a provide evidence that directives had been 12/29/17. On 7/10/19 at 5:49 p staff member) #1 (th (the administrative di	prehensive care plan dated current information regarding o.m., an interview was M (other staff member) #2 and I workers). OSM #2 and to explain the facility process directives. OSM #2 stated a sment is completed upon note directives is a part of the #2 stated the social workers or representatives if they have in place. OSM #2 stated if note directives in place then sk for a copy and the copy is record. OSM #2 stated if note directives upon social workers offer to provide gothis. When asked if advance directives are stated periodic reviews are stated periodic reviews are stated periodic reviews are arterly care plan meetings. At and OSM #3 were asked to at Resident #66's advance periodically reviewed since of the information to incomplete the information the incomplete the inc	F 5	78			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495217	B. WING		07	C 7/11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033		71112010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 578	No further informati 3. The facility staff of Resident #93's (or the regarding advance of Resident #93 was an 9/6/06. Resident #93 were not limited to provide an ARD (assessment advance) an ARD (assessment as ocial service assessessment addressed ocumented the resident and the	on was presented prior to exit. ailed to review periodically he representative's) decisions directives. dmitted to the facility on 33's diagnoses included but bain, chronic kidney disease ident #93's most recent MDS, a quarterly assessment with not reference date) of 6/14/19, a cognition as severely #93's clinical record revealed essment dated 12/12/17. The sed advance directives and ident and/or representative sed care planning (including in place and did not want	F 5			
	Resident #93's com 12/4/17 failed to doc advance directives.	orehensive care plan dated ument information regarding				
	conducted with OSM OSM #3 (both social OSM #3 was asked regarding advance of	o.m., an interview was I (other staff member) #2 and workers). OSM #2 and to explain the facility process lirectives. OSM #2 stated a sment is completed upon				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		E CONSTRUCTION		E SURVEY MPLETED
		495217	B. WING			l	С
NAMEOE	PROVIDER OR SUPPLIER		B. WING		TREET ADDRESS OF STATE OF STAT	07/	/11/2019
	CARE HEALTH SERV			1	TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROFILE OF CORRECTION SHOULD THE APPROPROPROFILE OF CROSS-REFERENCED TO THE APPROPROPROFILE OF CROSS-REFERENCED TO THE APPROPROFILE OF CROSS-R		BE	(X5) COMPLETION DATE
	assessment. OSN ask residents and/a advance directives residents have adv the social workers placed in the clinical residents do not have admission then the information regarding periodic reviews of conducted, OSM #1 conducted at the quadrice that time, OSM #2 a provide evidence the directives had been 12/12/17. On 7/10/19 at 5:31 confirmed they had provide. On 7/10/19 at 5:49 staff member) #1 (the administrative #3 (the quality assurance of the above No further information 4. The facility staff for Resident #94's (or the decisions regarding Resident #94's diagolimited to type 2 diagolimited 2 diagolimited 2 diagolimited 3 diagolimited 3 diagolimited 4 diagoli	rance directives is a part of the I #2 stated the social workers or representatives if they have in place. OSM #2 stated if rance directives in place then ask for a copy and the copy is all record. OSM #2 stated if two advance directives upon social workers offer to provide ng this. When asked if advance directives are 2 stated periodic reviews are uarterly care plan meetings. At and OSM #3 were asked to nat Resident #93's advance in periodically reviewed since p.m., OSM #2 and OSM #3 no further information to	F	578			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING			1	C /11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		12475 LE	ADDRESS, CITY, STATE, ZIP CODE EE JACKSON MEMORIAL HIGHWAY X, VA 22033		11/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE		
F 578	data set), a quarterl (assessment refere the resident's cogni: Review of Resident a social service ass assessment addres documented the residid not want informated. Further review of Refailed to reveal a peadvance directives a service assessment. On 7/10/19 at 1:49 pronducted with OSM OSM #3 (both social periodic reviews of a conducted, OSM #2 conducted at the quarthis time, OSM #2 a provide evidence the directives had been 2/13/18. On 7/10/19 at 4:00 propy of Resident #9 resuscitate) and Virg Scope of Treatment of periodic review was directives. On 07/11/19 at approx 1 (administrative states ASM # 2, the administrative states and was a conducted at the quarthis time.	y assessment with an ARD nce date) of 6/15/19, coded tion as cognitively intact. #94's clinical record revealed essment dated 2/13/18. The sed advance directives and ident and/or representative ation on advance directives. esident #94's clinical record riodic review regarding since the 2/13/18 social comm., an interview was for advance directives are stated periodic reviews are arterly care plan meetings. At and OSM #3 were asked to at Resident #94's advance periodically reviewed since for idated 2/27/18. No evidence as noted for advanced for meetings are noted for advanced for interview and the communication of the communication	F5	78				

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		PLE CONSTRUCTION G	CON	(X3) DATE SURVEY COMPLETED	
		495217	B. WING			C /11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	1. diabetes mellitus A chronic disease in regulate the amoun information was obth https://www.nlm.nih 001214.htm. 2. atrial fibrillation A problem with the sheartbeat. This information website: https://www.nlm.nih on.html. 3. hemodialysis Dialysis treats enderemoves waste from kidneys can no long (and other types of of the kidneys when information was obth https://medlineplus.go/0707.htm. Safe/Clean/Comfort CFR(s): 483.10(i)(1) §483.10(i) Safe Env The resident has a recomfortable and hor	on was provided prior to exit. In which the body cannot to of sugar in the blood. This ained from the website: I.gov/medlineplus/ency/article/ Ispeed or rhythm of the primation was obtained from the primation was obtained from the gov/medlineplus/atrialfibrillati Istage kidney failure. It is a your blood when your er do their job. Hemodialysis dialysis) does some of the job they stop working well. This ained from the website: I.gov/ency/patientinstructions/0 able/Homelike Environment (-(7)) Ironment. Iight to a safe, clean, nelike environment, including the environment, including the environment and ing safely.	F 578	F584	om 219, resolved. n floor esolved. ial to be re re-		
homelike enviro		nt, allowing the resident to nal belongings to the extent		on the TELS computer syste timely manner for any identifi			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495217	B. WING		C 07/11/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	receive care and so physical layout of the independence and (ii) The facility shall the protection of the or theft. §483.10(i)(2) Hous services necessary and comfortable into §483.10(i)(3) Clear in good condition; §483.10(i)(4) Private resident room, as so §483.10(i)(5) Adequevels in all areas; §483.10(i)(6) Comfortable into 1990 must maintain 1990 m	suring that the resident can ervices safely and that the feacility maximizes resident does not pose a safety risk. I exercise reasonable care for e resident's property from loss ekeeping and maintenance to maintain a sanitary, orderly, terior; I bed and bath linens that are see closet space in each pecified in §483.90 (e)(2)(iv); uate and comfortable lighting ortable and safe temperature ially certified after October 1, in a temperature range of 71 to the maintenance of comfortable light in staff interview, and facility was determined the facility e a homelike environment in the Arcadia (dementia) unit,	F 584	repair issues toward timely resolution. An inspection was completed or resident rooms to identify any routstanding repair issues, and TELS system to determine if a needed repairs were reflected repair completed. Any missing orders were added at that time Regular, assigned room round management staff will include identifying and addressing towaresolution any repair needs. 4. Results of completed room round will be shared and discussed a morning stand-up meeting, and results of all inspections and any will be presented at the monthl QAPI Committee meetings x3 months for its review and recommendations. 5. Compliance Date: August 13, 13, 15, 15, 15, 15, 15, 15, 15, 15, 15, 15	new or of the il until g work s by ard inds t dudits y

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495217	B. WING		C 07/11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 584	hanging by one scree 2. The facility staff of tiles in resident room The findings include 1. On 7/9/19 at 11:2 conducted of the Ard pull handle on the nidrawer with only one hanging down by the In Room 222, a pull was fastened to the and was observed hanging down by the In Room 223, a pull fastened to the draw observed hanging down by the In Room 227, there is bottom drawer of the A walk through the unadministrative staff of administrative staff of administrative staff of the director of environ at 3:55 p.m. ASM #1 with the missing or hasked if this was hor it's not." An interview was consuring assistant) #1 regarding the processomething broken, m	failed to maintain the floor in 218 in good repair. 8 a.m., observation was cadia unit. In Room 219, a ightstand was fastened to the excrew, and was observed exone screw. handle on the nightstand that drawer with only one screw, anging down by the one handle on the nightstand was ever with one screw, and was own by the one screw. was no pull handle on the exightstand. Init was conducted with member (ASM) #1, the SM (other staff member) #7, onmental services, on 7/10/19 was shown the above rooms anging pull handles, and was melike. ASM #1 stated, "No, and was melike. ASM #1 stated, "No, is followed if she observes hissing or in need of repair. put it in (name of computer of the maintenance	F 5	84		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION, NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		40004					С
		495217	B. WING			07/	11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP 12475 LEE JACKSON MEMORIAL FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD TE APPROPE	SHOULD BE CO	
	practical nurse) #2, asked about the prosomething in need LPN #2 stated, "We program) or page in away." On 7/11/19 at 9:11 aconducted with OSI reports of broken the repair are reported. (name of computer staff has access to #7 stated, "No, my stated, "N	onducted with LPN (licensed on 7/11/19 at 9:00 a.m. When ocess staff follows if they see of repair, broken or missing. e put it in (name of computer naintenance to fix it right a.m., an interview was M #7. OSM #7 was asked how nings or things in need of OSM #7 stated, "We put it in program)." When asked if his put it in the computer, OSM staff tell me and I put it in program) or tell maintenance member (ASM) #1, the #2, the administrative director M #3, the quality assurance ade aware of the above at 10:50 a.m. a.m., ASM #3 informed this did not have a policy on	F	584			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495217	B. WING _		C 07/11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	
(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)	DBE COMPLETION
F 607 SS=D	2. The facility staff tiles in resident roor On 07/09/19 at 4:15 9:14 a.m., observatirevealed three floor room, to the left of tile with an opening meinches long and one second tile with an opening measurihalf inches long and On 07/10/19 at approximately three one and a half inches an opening measurihalf inches long and On 07/10/19 at approximately three one and a half inches an opening measurihalf inches long and on 07/10/19 at approximately three one and a half inches long and I check it every maintenance assistathe process for identicality, OSM # 4 stathat are in need of rein the 'Tels', a compand I check it every through every morni When asked if he was resident room 218, On 07/11/19 at approximately ap	and a half inches long and as wide, and the third tiles with an approximately two and a two and a half inches wide. Toximately 3:30 p.m., a was conducted with OSM # 4, ant. When asked to describe tifying needed repairs in the ted, "If the staff finds things epair they put the work order uterized work order system, day. We also do a walk ng to identify any problems." as aware of the broken tiles in DSM # 4 stated no. Toximately 12:05 p.m., ASM # ff member), administrator, strative director of nursing assurance consultant, were indings.	F 607		by the
				The state of the s	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495217	B. WING _		C 07/11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 607	§483.12(b)(1) Prohneglect, and exploit misappropriation of §483.12(b)(2) Estal to investigate any s §483.12(b)(3) Incluparagraph §483.95. This REQUIREMENT by: Based on staff intered and clinical record of facility staff failed to and procedures for survey sample, Resulter and procedures for survey sample, Resulter and procedure allegation of abuse immediately and or Agency. The allegation of abuse immediately and or Agency. The facility staff failed abuse policy after Facility staff failed to accompany the facility staff failed to acc	policies and procedures that: ibit and prevent abuse, tation of residents and resident property, plish policies and procedures uch allegations, and de training as required at into is not met as evidenced rview, facility document review review, it was determined the implement the abuse policies one of 57 residents in the sident #39. ed to implement the abuse re to report Resident # 39's verbalized to staff on 5/15/19, within 2 hours to the State tion was not reported until	F 60	required timeframe per current Federal regulations. However actions including an investigat were initiated timely toward a determination and resolution for well-being of the resident. No other residents were affect Staff across departments were educated on the requirements report any allegation or suspic abuse immediately to the facility Administrator, or Director of Normality in their absence. Administrator ensure that allegations of abuse reported to the appropriate State entities consistent with current Federal regulations. Facility Administrator will share information pertaining to FRIs daily management meetings, a results of related audits at the monthly QAPI Committee mee 3 months for its review and recommendations. Compliance date: August 13, 2	in timely ion or the ed. e re- to ion of ty ursing r will se are at and tings x

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		(X3) DATE SURVEY COMPLETED	
		495217	B. WING		0.	C 7/11/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW FAIRFAX, VA 22033		71172019	
(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)	LD BE	(X5) COMPLETION DATE	
F 607	Resident # 39 as s assessment for me of 0 - 15, four - bein cognition for making. The Facility Report # 39, documented date: May 17, 2019 documented, "Alleg FRI further docume including location a stated to various st girls came into her threw things all over She said to the writt nights ago, to other employee 'about twassessment by nur shoulder."	ence date) of 05/06/19, coded coring a four on the staff ental status (BIMS) of a score ng severely impaired of g daily decisions. ed Incident (FRI) for Resident "Indeterminable" and "Report at a "Indeterminable" and "Report a "Incident Type" it gation of abuse/mistreat." The ented, "Describe incident, and action taken: Resident aff members that two teenage room at night, hit her and ar her room before leaving. The enter that it happened a couple of its a few days ago', and to one to weeks ago'. Skin see only identified a rash on	F 6	07			
	witness statement of member) # 7, direct dated "5-15-19." To documented, "Time Residents report to two young females, stated they [sic] ent Slapped her in the freported it to the nut follow up with the readminister and the The facility's "Program Resident # 39 documes ponsive able to responsive able to responsive able to responsive ables."	written by OSM (other staff tor of environmental services he witness statement 11:15 am (a.m.) [sic] me that she got beat up by about two weeks ago. She er her room and beat her up. face and kept hitting her. I arse on private hall. I her to esident and talk to the DON (director of nursing)." ess Notes" dated 5/15/19 for mented, "Resident alert and make her needs known. All ons administered and					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING			1	С
NAME OF	PROVIDER OR SUPPLIER	T33217	D. WING	STREET ADDRESS, CITY, STATE, ZIF	P CODE	07/	/11/2019
MANOR	CARE HEALTH SERVI	CES-FAIR OAKS		12475 LEE JACKSON MEMORIAL FAIRFAX, VA 22033		•	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		ON SHOULD TE APPROPI	BE	(X5) COMPLETION DATE
F 607	daily living) care as for meals. Residen two teenage female Skin assessment warash on the RUE (rig (nurse practitioner) skin and prescribed the issue to (Name administrator whom Resident is currently nurse's station. No noted. Nursing will Review of the facility receipt for the FRI of documented, "DATE (number)/NAME: (FOffice of Licensure and Con 07/10/19 at 2:33 conducted with OSM director of houseked confirmed the witnes 5/15/19. When asked statement, OSM # 7 informed me of bein then, I followed up w DON (director of nurresident told me and DON) advised me to Con 07/10/19 at 4:05 (administrative staff regarding the FRI in abuse for Resident # describe the facility's reporting an allegatic	sted with ADL (activities of needed. Resident ate 75% treported beeb beting [sic] by two days ago in the night. as done and resident has a ght upper extremity), NP FE assessed the resident's Nystatin cream. Reported of Administrator), the interviewed the resident. In the sitting on hallway next to complain of pain voiced or keep monitor." y's facsimile confirmation lated May 17, 2019 E/TIME: 05/17 10:56. FAX NO ax Number for the State	F	607			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495217	B. WING			07	C /11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		111/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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
	the facsimile of the and the witness starmember) # 7, direct was asked if the alle # 39 was reported to hours of receiving to "No." The facility's policy of Neglect, Exploitation Misappropriation Progression (c) (1): (c) In response Allegation (c) (1): (c) In response and misappropriation and to exploit the analysis of the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events the analysis of the events that cause the result in serious both hours if the events the analysis of the events that cause the result in serious both hours if the events the analysis of the events that cause the result in serious both hours if the events the events that cause the result in serious both hours if the events the events that cause the result in serious both hours if the events the events that cause the result in serious both hours if the events the events that cause the result in serious both hours if the events the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause the result in serious both hours if the events that cause	FRI dated 05/17/19, the FRI tement by OSM (other staff for of housekeeping, ASM # 1 egation of abuse for Resident to the state agency within two the allegation. ASM # 1 stated, "Patient Protection. Abuse, in, Mistreatment & evention" documented, ins of Abuse. §42CFR 483.12 is to allegations of abuse, in, or mistreatment, the facility at all alleged violations glect, exploitation or ding injuries of unknown ropriation of resident property, iately, but not later than two illegation is made, if the ine allegation involve abuse or dily injury, or not later than 24 hat cause the allegation do ind do not result in serious administrator of the facility including to the State adult protective services wides for jurisdiction in ties) in accordance with State hed procedures." Oximately 12:05 p.m., ASM # off member), administrator, istrative director of nursing assurance consultant, were	F6	607			
	No further information	on was provided prior to exit.					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495217	B. WING		C 07/11/2019
	PROVIDER OR SUPPLIER	ICES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 608 SS=C	References: (1) A loss of brain f diseases. It affects judgment, and beha obtained from the whttps://medlineplus. (2) Low iron. This in the website: https://www.nlm.nih. (3) High blood pres obtained from the whttps://www.nlm.nih. Reporting of Reaso CFR(s): 483.12(b)(s) §483.12(b) The fact implement written poccurring in federal facilities in accordance. The policies at but are not limited to (i) Annually notifying defined at section 1 individual's obligation reporting requirement (A) Each covered in State Agency and o entities for the politifacility is located an crime against any iron is receiving care	unction that occurs with certain memory, thinking, language, avior. This information was vebsite: gov/ency/article/000739.htm. Information was obtained from a gov/medlineplus/anemia.html Issure. This information was vebsite: gov/medlineplus/highbloodpr Inable Suspicion of a Crime of (i)-(iii) Ity must develop and olicies and procedures that: Iter reporting of crimes by-funded long-term care nee with section 1150B of the need procedures must include the following elements. In covered individuals, as 150B(a)(3) of the Act, of that the need to comply with the following ints. It will be a government to the need or more law enforcement call subdivision in which the y reasonable suspicion of a dividual who is a resident of,	F 608		on of a cility ne vo HR o be II be s and able will stice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENŢIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		405047			1	С	
		495217	B. WING		07/	11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERV		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPA DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 608	Continued From paimmediately, but not forming the suspicion result in slater than 24 hours suspicion do not result. Posting a consprights, as defined at Act. (iii) Prohibiting and defined at section 1 This REQUIREMENT by: Based on observat document review, it facility staff failed to rights regarding the crimes. The findings included On 7/11/19 at approact the facility was concountice of employee of suspicious crimes. On 7/11/19 at approact the facility was concountice of employee of suspicious crimes of suspicious crimes of stated she would characteristic was not postewith a copy of the "EReasonable Suspicious crimes with a copy of the "EReasonable Suspicious crimes continued the posting."	eximately 9:00 a.m., a tour of flucted to locate a posted rights regarding the reporting s. No notice could be located.	F 608	employee break room, at the to time clocks and in front of the knotfice at all times. 4. Administrator will report finding these inspections at the month QAPI Committee meetings x3 months for its review and consideration. 5. Compliance date: August 13, 2	is from ly		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495217	B. WING		1	C 11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 608	Continued From pa	ge 35	F 608			
F 609	Neglect, Exploitation Misappropriation Practical (B)(ii) Posting a confights, as defined at Act"	evention" documented, "(5) spicuous notice of employee section 1150B (d)(3) of the	F 609	F609 1. The allegation of abuse by resi		
SS=D	CFR(s): 483.12(c)(1) §483.12(c) In respondent, exploitation must: §483.12(c)(1) Ensurinvolving abuse, negmistreatment, include source and misapporare reported immed hours after the allegath that cause the allegate serious bodily injury the events that cause and do not rethe administrator of officials (including to adult protective service for jurisdiction in lon accordance with Staprocedures. §483.12(c)(4) Report investigations to the designated represervaccordance with Staprocedures with Staprocedures.	nse to allegations of abuse, or mistreatment, the facility of that all alleged violations glect, exploitation or ling injuries of unknown opriation of resident property, iately, but not later than 2 ation is made, if the events ation involve abuse or result in, or not later than 24 hours if the allegation do not involve sult in serious bodily injury, to the facility and to other the State Survey Agency and ices where state law provides g-term care facilities) in the law through established		#39 was reported to the State I Administrator, albeit not within required timeframe per current Federal regulations. However, actions including an investigative were initiated timely toward a determination and resolution for well-being of the resident. 2. No other residents were affects. 3. Staff across departments were educated on the requirements report any allegation or suspicical abuse immediately to the facility Administrator, or Director of Nurin his absence. Administrator wensure that allegations of abus reported to the appropriate Statentities consistent with current Federal regulations. 4. Facility Administrator will share information pertaining to FRIs adaily management meetings, as results of related audits at the monthly QAPI Committee meet x3 months for its review and consideration. 5. Compliance date: August 13, 25.	timely on the ed. re-to on of y irsing will e are te at at at ind ings	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495217	B. WING		07/1) 1/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWA FÁIRFAX, VA 22033		172013
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 609	incident, and if the appropriate correct This REQUIREMENT by: Based on staff intered and clinical record of a facility staff failed to immediately and or residents in the sum 05/15/19, when Residents in the sum 05/15/19, when Resident and or Agency and other of State law through eallegation was not resident #39 was a 07/26/2010 and a rediagnoses that includementia (1), anem Resident #39 is most a set), a quarterly asset), a quarterly asset), a quarterly asset (assessment for mer of 0 - 15, four - bein cognition for making 39 was coded as recone staff member for the Facility Reporter #39, documented "Incomparison for the Facility Reporter	alleged violation is verified ive action must be taken. NT is not met as evidenced rview, facility document review review, it was determined the report an allegation of abuse within 2 hours, for one of 57 vey sample, Resident #39. On sident # 39 verbalized an to facility staff, the facility staff allegation of abuse within 2 hours to the State fficials in accordance with stablished procedures. The eported until 5/17/19.	F 60	0.9		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495217	B. WING		1	C 11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	including location as stated to various stated to various stated to various stated into her of threw things all over threw things all over She said to the writenights ago, to others employee 'about two assessment by nurse shoulder." The facility's "Invest witness statement witness statement witness statement witness statement witness stated "5-15-19." The documented, "Time Residents report to two young females, stated they [sic] enter Slapped her in the fareported it to the nurfollow up with the readminister and the Employer and the Employer as a stated well. Assisted they located well. Assisted in assessment warash on the RUE (rig (nurse practitioner) is skin and prescribed the issue to (Name of the RUE).	nted, "Describe incident, and action taken: Resident aff members that two teenage room at night, hit her and r her room before leaving. er that it happened a couple of s 'a few days ago', and to one	F 6	29		

	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495217	B. WING			1	C /11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		1	TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033	-	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	Resident is currentl nurse's station. No noted. Nursing will Review of the facility receipt for the FRI of documented, "DATE (number)/NAME: (FOffice of Licensure) On 07/10/19 at 2:33 conducted with OSM director of houseked confirmed the witne 5/15/19. When ask statement, OSM # 7 informed me of beint then, I followed up v DON (director of nuresident told me and DON) advised me to On 07/10/19 at 4:05 (administrative staff regarding the FRI in abuse for Resident describe the facility's reporting an allegatime with the witness statement of the I and I as a sked if the allegation of the I and I as a sked if the allegation of the I and I as a sked if the allegation of the I as a sked if th	y sitting on hallway next to complain of pain voiced or keep monitor." y's facsimile confirmation lated May 17, 2019 E/TIME: 05/17 10:56. FAX NO ax Number for the State and Certification)." 5 p.m., an interview was M (other staff member) # 7, eping. OSM # 7 reviewed and se statement he wrote dated ed to elaborate on his witness stated, "The resident ag abused. I told the nurse with the administrator and rising) on the same day the difference with the statement." p.m., an interview with ASM member) # 1, administrator volving the allegation of # 39. When asked to so policy and procedure for on of abuse, ASM # 1 stated, discovery." After reviewing FRI dated 05/17/19, the FRI ement by OSM (other staff or of housekeeping, ASM # 1 signation of abuse for Resident of the state agency according regulatory requirements, "" Patient Protection. Abuse,	F	609			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495217	B. WING			I	C	
NAME OF	PROVIDER OR SUPPLIER	100211	1	STR	EET ADDRESS, CITY, STATE, ZIP CODE	07/	11/2019	
MANOR	CARE HEALTH SERVI	CES-FAIR OAKS		1247	75 LEE JACKSON MEMORIAL HIGHWAY RFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
	Misappropriation Pr "Reporting Allegatio (c) (1): (c) In resporting Allegatio (c) (1): (c) In resporting Allegatio (c) (1): (c) In resporting Allegatio (d) In resporting Allegation must: (1) Ensure that involving abuse, near mistreatment, include source and misappropriate reported immed (2) hours after the attention events that cause the result in serious book hours if the events the notinvolve abuse and bodily injury, to the attention and to other officials. Survey Agency and where state law proviong-term care facilitate through establis. On 07/11/19 at approximate 1 (administrative states ASM # 2, director of assurance consultary findings. No further information. References: (1) A loss of brain further diseases. It affects rejudgment, and behavior of the weather through established from the weather through es	revention" documented, ons of Abuse. §42CFR 483.12 ase to allegations of abuse, or mistreatment, the facility at all alleged violations glect, exploitation or ding injuries of unknown repriation of resident property, liately, but not later than two allegation is made, if the ne allegation involve abuse or dily injury, or not later than 24 hat cause the allegation do not result in serious administrator of the facility including to the State adult protective services wides for jurisdiction in ties) in accordance with State hed procedures." Toximately 12:05 p.m., ASM # aff member), administrator, nursing and ASM # 3, quality nt, were made aware of the on was provided prior to exit. Inction that occurs with certain memory, thinking, language, vior. This information was	F6	09				
		gov/medlineplus/anemia.html						

02.11.4.	CO TOTAL MEDICATION	WILDION ND OCH WIOLO				CIVID INC	7. 0930-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(c	
		495217	B. WING			07/	11/2019	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
MANORC	ARE HEALTH SERVICES	-FAIR OAKS			475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUTH FOR CROSS-REFERENCED TO THE APPRINT DEFICIENCY)			(X5) COMPLETION DATE	
F 609	Continued From page	40	F	609				
F 622 SS=E	obtained from the well https://www.nlm.nih.g essure.html. Transfer and Discharg CFR(s): 483.15(c)(1)(§483.15(c) Transfer a §483.15(c)(1) Facility (i) The facility must peremain in the facility, a discharge the resident (A) The transfer or disresident's welfare and cannot be met in the f (B) The transfer or disbecause the resident's sufficiently so the resident (C) The safety of indivendangered due to the status of the resident; (D) The health of indivotherwise be endange (E) The resident has fappropriate notice, to under Medicare or Me Nonpayment applies it submit the necessary payment or after the the Medicare or Medicaid, resident refuses to pay resident who becomes admission to a facility,	ov/medlineplus/highbloodpr ge Requirements i)(ii)(2)(i)-(iii) and discharge- requirements- emit each resident to and not transfer or t from the facility unless- charge is necessary for the the resident's needs acility; charge is appropriate s health has improved dent no longer needs the he facility; riduals in the facility is e clinical or behavioral riduals in the facility would ered; ailed, after reasonable and pay for (or to have paid dicaid) a stay at the facility. If the resident does not paperwork for third party	F	622	 Resident #56 returned to the on 5/15/19. Resident #52 ref to the facility on 5/28/19. Resident returned to the facility on 5/10/19. All residents experiencing a finitiated transfer to the hospit the potential to be affected. Unit Managers/Shift Supervis audit facility-initiated discharge the hospital, daily x 5 days ar weekly x4 weeks, to ensure compliance with the requirement information provided to the hospital provided to the	turned sident acident		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI		(X3) DATE SURVEY COMPLETED	
		495217	B. WING		C 07/11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	3111112010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
	(F) The facility ceas (ii) The facility may resident while the al § 431.230 of this chexercises his or her discharge notice fro 431.220(a)(3) of this discharge or transfe or safety of the resident interest facility. The facility is that failure to transfe §483.15(c)(2) Document the facility resident under any concept in paragraphs (c)(1) section, the facility nor discharge is documedical record and communicated to the institution or provide (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of pasection, the specific be met, facility atterneeds, and the servifacility to meet the ne (ii) The documentation (2)(i) of this section in (A) The resident's prodischarge is necessar (A) or (B) of this section (B) A physician where	es to operate. not transfer or discharge the opeal is pending, pursuant to apter, when a resident right to appeal a transfer or m the facility pursuant to § schapter, unless the failure to rewould endanger the health dent or other individuals in the must document the danger er or discharge would pose. mentation. nsfers or discharges a of the circumstances specified (i)(A) through (F) of this nust ensure that the transfer mented in the resident's appropriate information is a receiving health care r. the resident's medical record e transfer per paragraph (c)(1) ragraph (c)(1)(i)(A) of this resident need(s) that cannot upts to meet the resident ce available at the receiving eed(s). on required by paragraph (c) must be made by- nysician when transfer or ary under paragraph (c) (1)	F 62	22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3	(X3) DATE SURVEY COMPLETED	
		495217	B. WING			С	
NAME OF I	PROVIDER OR SUPPLIER	453211	D. WING	STREET ADDRESS, CITY, STATE, ZIP COD		07/11/2019	
	CARE HEALTH SERVI	CES-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	,	DULD BE	(X5) COMPLETION E DATE	
	must include a minii (A) Contact informa responsible for the of (B) Resident repression contact information (C) Advance Directii (D) All special instruongoing care, as ap (E) Comprehensive (F) All other necession copy of the resident consistent with §483 any other document a safe and effective This REQUIREMEN by: Based on staff internand clinical record rethe facility staff failed information was profacility-initiated trans	vided to the receiving provider mum of the following: tion of the practitioner care of the resident. entative information including ve information actions or precautions for propriate. care plan goals; eary information, including a discharge summary, 3.21(c)(2) as applicable, and ation, as applicable, to ensure	F6	622			
	The findings include	:					
	comprehensive care	ailed to evidence that plan goals were provided to Resident #56 was transferred 11/19.					
	7/12/17. Resident #. were not limited to p asthma. Resident #. (minimum data set),	dmitted to the facility on 56's diagnoses included but neumonia, heart disease and 56's most recent MDS an annual assessment with it reference date) of 5/20/19,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING			l .	C	
NAME OF	PROVIDER OR SUPPLIER	430211	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	07	/11/2019	
MANOR	CARE HEALTH SERVI	CES-FAIR OAKS		1:	2475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE	
F 622	coded the resident's impaired. Review of Resident the resident was tra 5/11/19 due to a low of Resident #56's cl acute care transfer to reveal evidence t comprehensive care the hospital staff. On 7/10/19 at 3:08 p conducted with LPN LPN #1 was asked that is provided to h is transferred to the evidences that infor stated the nurses promedication list, proghours, history and p tests], an acute care plan and the best the nurses have a club the nurses have a club do not physically previous in-services they need to docum plan and the bed ho #1 stated this inform in nurses' notes. On 7/10/19 at 5:49 p staff member) #1 (the administrative of #3 (the quality assuraware of the above of The facility documents)	#56's clinical record revealed insferred to the hospital on voxygen level. Further review inical record (including an form and nurses' notes) failed hat the resident's e plan goals were provided to p.m., an interview was I (licensed practical nurse) #1. to describe the information ospital staff when a resident hospital and how staff mation was provided. LPN #1 rovide a face sheet, press notes for the last 72 hysical, labs [laboratory e transfer form, a copy of the ed hold policy. LPN #1 stated hecklist that they reference v use. LPN #1 stated due to the nurses have learned that ent that a copy of the care ld policy was provided. LPN nation should be documented on, ASM (administrative ne administrator), ASM #2 lirector of nursing) and ASM rance consultant) were made concern.	F	522				

	PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495217	B. WING			07	C //11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	CHECKLISTS" doc FROM SKILLED NU ACUTE CARE: Cor Documentation Chedocuments includin Record and copy of care plan goals from and place in envelo top copy and place No further information of the facility staff of goals to the hospita for Resident #52 was a 5/22/16 with diagnoral limited to: dementia and glaucoma [a dispressure in the eye, outflow of aqueous nerve and causes with the most recent ME assessment, a quarrassessment references ident as scoring a interview for mental severely impaired to decisions. The physician order "Send resident to the total causes with the physician order resident to the physician order resident to the control of the physician order resident to the physician order resident physician order resident physician order resident physician order resident physician ord	umented, "TRANSITION JRSING FACILITY TO mplete Acute Care Transfer ecklist. Collect necessary g a Transfer/Discharge the patient's comprehensive in (name of computer system) pe. Seal envelope. Remove in patient's clinical record" on was presented prior to exit. ailed to provide the care plan I for a facility initiated transfer 5/27/19. dmitted to the facility on ses that included but were not anxiety disorder, agitation, sease in which elevated due to obstruction of the humor, damages the optic isual defects (1)]. DS (minimum data set) terly assessment, with an ce date of 4/9/9, coded the a "6" on the BIMS (brief status) score, indicating he is make daily cognitive dated, 5/27/19, documented, ame of hospital) for the RE (regarding) pushed	Fe	\$22			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495217	B. WING				С
NAME OF I	PROVIDER OR SUPPLIER	493217	b. Willia	_	STREET ADDRESS, CITY, STATE, ZIP CODE	07/	11/2019
	CARE HEALTH SERVI	CES-FAIR OAKS		1	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES '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
	documented in part doctor). New order hospital) for evaluate Review of the clinical documentation of the plan goals were sen hospital. On 7/10/19 at 3:08 planted with LPN LPN #1 stated due to nurses have learned that a copy of the capolicy was provided information should be notes. Administrative staff administrator, ASM of nursing, and ASM consultant, were made concern on 7/11/19 On 7/11/19 at 11:00 ASM #2 for any doc goals were sent with the hospital on 5/27/stated that if she did this surveyor, she did this surveyor, she did No further information (1) Barron's Dictional Non-Medical Reade Chapman, page 247	"Call placed to (name of received to send to (Name of tion." all record failed to evidence that the comprehensive care it with the resident to the p.m., an interview was a comprehensive was and the bed hold. LPN #1 stated this was a comprehensive was a comprehensive was a comprehensive was a comprehensive was made of the was a comprehensive was made of the was a comprehensive was made of the resident when he went to comprehensive was made of the resident when he went to comprehensive was made of the resident when he went to comprehensive was provided prior to exit. The was provided prior to exit.	Fé	622			
	o. The facility Stall la	aned to provide the care plan					- 1

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION ING	C	(X3) DATE SURVEY COMPLETED	
		495217	B. WING			07/1) 1/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
	goals to the hospita for Resident #61 on Resident #61 was a 10/26/19 with diagnous limited to: high beath, gastroesoph [backflow of the conesophagus, usually sphincter muscle be symptoms include be commonly known as falls, and osteoporotissue, causing fragi (2)]. The most recent Massessment, a quart assessment referen resident as having be memory difficulties, being severely impadecisions. The nurse's note dat documented in part, paged the building secome front desk, all front desk area, upo was observed sitting daughter holding her happened and the dawas entering the buil on the front desk coland was bleeding. A medical services) had came after about 5 medical services and was bleeding.	for a facility initiated transfer	F 6	22			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING			С	
NAMEOF	DOOMDED OF SUPPLIED	495217	D. WING			07	/11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI			1	STREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	Continued From page	ge 47	F 6	522			
	documentation evid	al record failed to evidence encing the comprehensive e sent with the resident to the					
	conducted with LPN LPN #1 stated due to nurses have learned that a copy of the ca policy was provided.	o.m., an interview was I (licensed practical nurse) #1. Io previous in-services, the Id that they need to document Interpolar and the bed hold I LPN #1 stated this I be documented in nurses					
	administrator, ASM of nursing, and ASM	member (ASM) #1, the #2, the administrative director #3, the quality assurance de aware of the above at 10:50 a.m.					
	ASM #2 for any doct goals were sent with the hospital on 5/27/	a.m., a request was made of umentation that the care plan the resident when he went to 19. At 11:45 a.m., ASM #2 n't give this information to dn't have it.)3		
	No further information	on was provided prior to exit.					
	Non-Medical Reader Chapman, page 243 (2) Barron's Dictiona Non-Medical Reader Chapman, page 424 4. The facility staff fa comprehensive care	ary of Medical Terms for the ;, 5th edition, Rothenberg and .					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING				C 11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, Z 12475 LEE JACKSON MEMORIA FAIRFAX, VA 22033			11/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD THE APPROPR	BE	(X5) COMPLETION DATE	
	6/9/19. Resident #70 was a 4/27/19. Resident # were not limited to led disease and anxiety most recent MDS (nadmission assessm reference date) of 4, cognition as cognitive. The nurse note date documented in part, x 2. Nurse checked around 6:00 p.m. is blood pressure aroune elevated patient's lepressure. MD (medialeft. Supervisor award Order received from patient to acute care sent to Fairfax Hosp emergency room nu Patient's sister notific transfer to hospital. Review of the clinical documentation of the goals being sent with On 7/10/19 at 3:08 p conducted with LPN #1 stated due to nurses have learned that a copy of the carpolicy was provided.	dmitted to the facility on 70's diagnoses included but egal blindness, kidney disorder. Resident #70's ninimum data set), an ent with an ARD (assessment /24/19, coded the resident's rely intact. 10, 6/9/19 at 11:38 p.m. 11 Patient is alert and oriented patients blood pressure 104/46. Then nurse checked and 8:10 p.m. is 72/37. Nurse gs to increase patient blood cal director) called, message re of it. Supervisor notified. 11 MD to call 911 and transfer thospital. Patient has been ital via 911. Report given to rese and paramedic staff. ed for patient's condition and 1. I record failed to evidence to comprehensive care plan in the resident to the hospital. 12 I record failed to evidence to comprehensive care plan in the resident to the hospital. 13 I record failed to evidence to comprehensive care plan in the resident to the hospital. 14 I record failed to evidence to comprehensive care plan in the resident to the hospital.	F 63	22				

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		495217	B. WING		07/11	/2019
	PROVIDER OR SUPPLIER CARE HEALTH SER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETION DATE
F 623 SS=E	On 07/11/2019 at a #1 (administrative administrator), ASI director of nursing) assurance consultatindings. No further informat Notice Requirement CFR(s): 483.15(c)(3) Notice Before a facility transident, the facility (i) Notify the resident representative(s) of the reasons for the language and man facility must send a representative of the Long-Term Care Of (ii) Record the reasons discharge in the reaccordance with paragraph (c)(5) of \$483.15(c)(4) Timing (i) Except as specification (c)(8) of this section discharge required made by the facility resident is transferring (ii) Notice must be before transfer or discharge of the safety of in the sa	approximately 2:00 p.m., ASM staff member) (the M #2 (the administrative and ASM #3 (the quality ant) were made aware of the made aware of the staff member of the sta	F 623	RINUEL	the that of a ge. copy nan. nitor	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495217	B. WING		1	C
	PROVIDER OR SUPPLIER CARE HEALTH SERVI			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY		11/2019
	OUR MADV OTA			FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	this section; (B) The health of incibe endangered, under 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 pure must include the foll (i) The reason for the fill (ii) The location to we transferred or dischart (ivi) A statement of the including the name, and telephone number of the completing the form hearing request; (v) The name, addressed to be a completed to be a completed to be a complete to be a complete to be a complete to be a complete to the protection and according to the protection and according to the developmental disabilities, the mailing telephone number of the protection and according the developmental disabilities of the Developmental contents of the Developmental disabilities of the Developmental disabilitie	dividuals in the facility would der paragraph (c)(1)(i)(D) of lealth improves sufficiently to diate transfer or discharge, i(1)(i)(B) of this section; ansfer or discharge is dent's urgent medical needs, i(1)(i)(A) of this section; or ot resided in the facility for 30 ents of the notice. The written aragraph (c)(3) of this section lowing: ansfer or discharge; e of transfer or discharge; which the resident is arged; he resident's appeal rights, address (mailing and email), ber of the entity which ests; and information on how form and assistance in and submitting the appeal less (mailing and email) and if the Office of the State inbudsman; ity residents with intellectual	F 623	the hospital to ensure complian with this requirement. 4. Administrator will present finding these audits at the monthly QA Committee meetings x3 month its review and recommendations. Compliance Date: August 13,	ngs of VPI s for	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/SUIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495217	B. WING			C 7/11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 623	(vii) For nursing fact disorder or related email address and agency responsible advocacy of individe established under the for Mentally III Individes and III Individed and III Individes and II	cility residents with a mental disabilities, the mailing and telephone number of the for the protection and uals with a mental disorder the Protection and Advocacy riduals Act. Inges to the notice. In the notice changes prior to per or discharge, the facility cipients of the notice as soon the updated information The facility must provide prior to the facility must provide prior to the impending closure are Ombudsman, residents of resident representatives, as the transfer and adequate sidents, as required at § NT is not met as evidenced rview, facility document review review, it was determined that and to provide written lity-initiated transfer to the expresentative and/or of 57 residents in the survey #25, #56, #52, #61, #70 and	F 63	23		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI	NG	COMPLETED		
		495217	B. WING		C 07/11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	1	
(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 COMPLÉTIC)N
F 623	1. The facility staff frontification of transf resident's represent when the resident won 6/16/19. Resident #25 was a 2/19/19. Resident # were not limited to durinary retention. Remarked to make the resident was transfer. Review of Resident # reveal evidence that representative and the provided written notion transfer. On 7/10/19 at 1:49 producted with OSM OSM #3 (both social OSM #3 were asked notification of hospital and/or their representative and the conducted with OSM OSM #3 were asked notification of hospital and/or their representative and the conducted with OSM OSM #3 were asked notification of hospital and/or their representative and osmotify the ombudsmattansfers. OSM #2 sombudsman twice a were asked to provide	ailed to provide written er to Resident #25, the ative and the ombudsman ras transferred to the hospital dmitted to the facility on f25's diagnoses included but liabetes, prostate cancer and esident #25's most recent a set), a quarterly assessment sment reference date) of resident as being cognitively #25's clinical record revealed resident as being cognitively #25's clinical record failed to the resident, the resident's the ombudsman were fication regarding the o.m., an interview was for (other staff member) #2 and workers). OSM #2 and for the transfers to residents and transfers to residents of the transfers to residents o	F 6.	23		

	IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495217	B. WING		C 07/11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	
(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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	conducted with LPN LPN #1 was asked in notification of hospit and/or their represe but we do put in our unable to manage spatient and rp (responded understand." On 7/10/19 at 5:31 pconfirmed they had provide. On 7/10/19 at 5:49 pstaff member) #1 (the administrative did the administrative did the administrative did the quality assur aware of the above of the facility documer "INTERDISCIPLINA CHECKLISTS" documer "INTERDISCIPLINA CHECKLISTS" documer "INTERDISCIPLINA CHECKLISTS" documer "INTERDISCIPLINA CHECKLISTS" documer "INTERDISCIPLINA" (The CARE: Notifice presentative. Issu specific guidelines; of the legal department ombudsman" No further information.	o.m., an interview was a light (licensed practical nurse) #1. If nurses provide written ital transfers to residents intatives. LPN #1 stated, "No documentation that we were ymptoms in-house and the consible party) were notified on the consible party) were notified on. If the consible party were notified on. If the considering the considering it is a consultant on the consultant of the co	F 62	23	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	ILTIPLE CONSTRUCTION DING	(X	(X3) DATE SURVEY COMPLETED	
		495217	B. WING			С	
		495217	B. WING			07/11/2019	
	RCARE HEALTH SERV	ICES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP COI 12475 LEE JACKSON MEMORIAL HIG FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	l · · · · ·	HOULD BE		
F 623	Resident #56 was a 7/12/17. Resident were not limited to pasthma. Resident (minimum data set) an ARD (assessme coded the resident's impaired. Review of Resident the resident was tra 2/7/19 due to bloody low oxygen level. F #56's clinical record the resident, the resombudsman were pregarding the transf On 7/10/19 at 1:49 conducted with OSM OSM #3 (both social OSM #3 were asked notification of hospit and/or their represe social workers do not of the order o	admitted to the facility on #56's diagnoses included but oneumonia, heart disease and #56's most recent MDS, an annual assessment with nt reference date) of 5/20/19, a cognition as severely #56's clinical record revealed insterred to the hospital on y urine and 5/11/19 due to a further review of Resident failed to reveal evidence that sident's representative and the provided written notification	F	623			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		495217	B. WING		C 07/11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWA FAIRFAX, VA 22033	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION
F 623	but we do put in our unable to manage spatient and rp (respand understand." On 7/10/19 at 5:31 confirmed they had provide. On 7/10/19 at 5:49 staff member) #1 (ti (the administrative of the above) No further information and for resident reproductive for the reason for a fact hospital, for Resident #52 was a 5/22/16 with diagnor limited to: dementia and glaucoma [a dispressure in the eye, outflow of aqueous nerve and causes with the most recent ME assessment, a quarrassessment references interview for mental severely impaired to decisions.	r documentation that we were symptoms in-house and the consible party) were notified p.m., OSM #2 and OSM #3 no further information to p.m., ASM (administrative he administrator), ASM #2 director of nursing) and ASM rance consultant) were made concern. on was presented prior to exit. ailed to provide the resident resentative a written notice, of ility initiated transfer to the nt #52 on 5/27/19. dmitted to the facility on ses that included but were not anxiety disorder, agitation, sease in which elevated due to obstruction of the humor, damages the optic isual defects (1)]. OS (minimum data set) terly assessment, with an ce date of 4/9/9, coded the a "6" on the BIMS (brief status) score, indicating he is make daily cognitive	F 6.	23	

		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
		495217	B. WING			07	C /11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		1	TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		711/2013	
(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	(X5) COMPLETION DATE	
F 623	psychiatric evaluation another resident to another resident in part doctor). New order is hospital) for evaluation Review of the clinicathat a written notificathat a written notification. On 7/10/19 at 1:49 pconducted with OSM OSM #3 (both social OSM #3 were asked notification of hospit and/or their represensult workers do not do. On 7/10/19 at 3:08 pconducted with LPN LPN #1 was asked in notification of hospit and/or their represensult we do put in our unable to manage sepatient and rp (responsand understand." Administrative staff in administrator, ASM is of nursing, and ASM consultant, were maconcern on 7/11/19 and concern on 7/11/19 and conc	the floor." Ited, 5/27/19 at 8:57 p.m. "Call placed to (name of received to send to (Name of ion." Itel record failed to evidence ation of the transfer was dent and/or resident Itel workers). OSM #2 and I workers). OSM #2 and I transfers to residents at transfers to residents at transfers to residents of and she thought the nurses of and she thought the nurses (licensed practical nurse) #1. If nurses provide written al transfers to residents at transfers to residents of and she thought the nurses (licensed practical nurse) #1. If nurses provide written al transfers to residents of tatives. LPN #1 stated, "No documentation that we were ymptoms in-house and the pursible party) were notified the member (ASM) #1, the insible party) were notified the above the above	F 6	23				

PRINTED: 07/18/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495217	B. WING			C	
NAME OF	PROVIDER OR SUPPLIER	100217	J. 111110		STREET ADDRESS, CITY, STATE, ZIP CODE	07/	11/2019
MANOR	CARE HEALTH SERV	CES-FAIR OAKS			2475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROFILE OF CORRECTION OF		BE	(X5) COMPLETION DATE
F 623	and/or the resident written notification won 5/27/19. At 11:45 she didn't give the ishe didn't have it. No further informati (1) Barron's Dictional Non-Medical Reader Chapman, page 24 4. The facility staff fand/or resident represent represent for a fact hospital, for Resident #61 was a 10/26/19 with diagrant limited to: high be breath, gastroesoph [backflow of the cone esophagus, usually sphincter muscle be symptoms include be commonly known as falls, and osteoporotissue, causing fraging (2)]. The most recent ME assessment, a quarassessment reference resident as having be memory difficulties, being severely imparations.	representation that the resident representative was provided when he went to the hospital 5 a.m., ASM #2 stated that if information to this surveyor, on was provided prior to exit. Tary of Medical Terms for the er, 5th edition, Rothenberg and 7. Tailed to provide the resident esentative a written notice, of illity initiated transfer to the	F	623			

	AND BLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495217	B. WING		0.	C 7/11/2019	
	PROVIDER OR SUPPLIER	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033		71172019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPLICATION OF THE APPLICA	OULD BE	(X5) COMPLETION DATE	
	of her activities of did The nurse's note dadocumented in part, paged the building some front desk, all front desk area, upon was observed sitting daughter holding he happened and the dwas entering the building he happened and the dwas entering the building he happened and the dwas entering the building her holding. A medical services) had came after about 5 medical services had a written notificated and notified. The clinical that a written notificated provided to the residence representative. On 7/10/19 at 1:49 producted with OSM OSM #3 (both sociated of hospital and/or their representations of hospital workers do not document. On 7/10/19 at 3:08 producted with LPN LPN #1 was asked it notification of hospital to the producted with LPN LPN #1 was asked it notification of hospital documents.	e on one staff member for all aily living. Ited, 5/10/19 at 12:49 a.m. "At about 10 pm, a nurse saying 2nd floor nurses to 2nd floor nurses rushed to on getting there, PT (Patient) g on the floor with her r head. When asked what aughter said that pt (patient) ilding and fall hitting her head unter resulting in head injury and that EMS (emergency as been called and EMS min (minutes) and take the pt medical doctor) was called all record failed to evidence ation of the transfer was	F 6	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495217	B. WING	-		ı	C 11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP (12475 LEE JACKSON MEMORIAL I FAIRFAX, VA 22033			11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	_ 1.	N SHOULD	BE	(X5) COMPLETION DATE
	unable to manage spatient and rp (respand understand." Administrative staff administrator, ASM of nursing, and ASN consultant, were maconcern on 7/11/19 On 7/11/19 at 11:00 ASM #2 for any doc and/or the resident written notification won 5/10/19. At 11:45 she didn't give the inshe didn't have it. No further information. (1) Barron's Dictional Non-Medical Reade Chapman, page 243 (2) Barron's Dictional Non-Medical Reade Chapman, page 4245. Resident #70 was 6/9/19. The facility swritten notification reprovided to the resident representation. Resident #70 was all 4/27/19.	symptoms in-house and the consible party) were notified member (ASM) #1, the #2, the administrative director #3, the quality assurance ade aware of the above at 10:50 a.m. a.m., a request was made of sumentation that the resident representative was provided when she went to the hospital 5 a.m., ASM #2 stated that if information to this surveyor, on was provided prior to exit. ary of Medical Terms for the r, 5th edition, Rothenberg and 8. ary of Medical Terms for the r, 5th edition, Rothenberg and 4. stransferred to the hospital on taff failed to evidence that egarding the transfer was dent, resident and/or the	F 6	23			

1	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		E SURVEY IPLETED
		495217	B. WING				C
NAME OF I	PROVIDER OR SUPPLIER	133211		-	STREET ADDRESS, CITY, STATE, ZIP CODE	077	11/2019
					12475 LEE JACKSON MEMORIAL HIGHWAY		
MANOR	CARE HEALTH SERVI	CES-FAIR OAKS		1	FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPERTY)	BE	(X5) COMPLETION DATE
	cognition as cognitive Review of Resident the resident was trace 6/9/19 for low blood Further review of Refailed to reveal door resident and/or the received written not the hospital on 6/9/10 On 7/10/19 at 1:49 producted with OSM OSM #3 (both social OSM #3 were asked notification of hospital and/or their represe social workers do not do. On 7/10/19 at 3:08 producted with LPN LPN #1 was asked in notification of hospital and/or their represe but we do put in our unable to manage sepatient and RP (respand understand." On 07/11/2019 at ap #1 (administrator), ASM director of nursing),	wely intact. #70's clinical record revealed insferred to the hospital on pressure. esident #70's clinical record amentation to evidence the resident representative ification regarding transfer to 19. o.m., an interview was of (other staff member) #2 and of they provide written real transfers to residents intatives. OSM #3 stated the ot and she thought the nurses of the consideration that we were ymptoms in-house and the provide party) were notified opproximately 2:00 p.m., ASM	F6	;23	DEFICIENCY)		
	No further information	on was presented prior to exit.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY MPLETED
		495217	B. WING				C
NAME OF	PROVIDER OR SUPPLIER	450217	D. Willia		TREET ADDRESS, CITY, STATE, ZIP CODE	1 07/	/11/2019
	CARE HEALTH SERVI	CES-FAIR OAKS		12	2475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033	r	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 623	6. The facility staff of transfer to Reside party at the time of the Resident #87 was a 05/20/2019. Her dia general anxiety, and blood cells). Reside Minimum Data Set of Unscheduled Assess Reference Date (AF Interview for Mental Resident #87 at a 1 impairment. A review of Resident Progress Note dated that documented Resident #87 at a 1 impairment. A review of Resident Progress Note dated that documented Resident #87 at a 1 impairment. Or are transfer form, tests], and bed hold [emergency room] and discussed with Patie party)." No document transfer was found. On 7/10/19 at 1:49 producted with OSM OSM #3 (both social OSM #3 were asked notification of hospitical party) was a set on the conducted with of the conducted with OSM OSM #3 were asked notification of hospitical party at the time of the conducted with OSM OSM #3 were asked notification of hospitical party at the time of the conducted with OSM OSM #3 were asked notification of hospitical party at the time of the conducted with OSM OSM #3 were asked notification of hospitical party at the time of the conducted with OSM OSM #3 were asked notification of hospitical party at the time of the conducted with OSM OSM #3 were asked notification of hospitical party at the time of the conducted with OSM OSM #3 were asked notification of hospitical party at the time of the conducted with OSM OSM #3 were asked notification of hospitical party at the conducted with OSM OSM #3 were asked notification of hospitical party at the conducted with OSM OSM #3 were asked notification of hospitical party at the conducted with OSM OSM #3 were asked notification of hospitical party at the conducted with OSM OSM #3 were asked notification of hospitical party at the conducted with OSM OSM #3 were asked notification of hospitical party at the conducted with OSM OSM #3 were asked notification of hospitical party at the conducted with OSM OSM #3 were asked notification of hospitical party at the conducted with OSM OSM #4 were asked notification of hospitical party at the conducted wi	ge 61 ailed to provide written notice ent #87 or their responsible transfer to the hospital. Idmitted to the facility on agnoses included hip fracture, dranemia (low levels of red nt #87's most recent (MDS) assessment was an assent with an Assessment and the facility of 06/19/2019. The Brief Status (BIMS) scored or indicating moderate It #87's record revealed a dropout of 05/23/2019 at 7:21 p.m., asident #87 was transferred to date, 05/23/2019, following a one documented in part "Acute care plan, labs [laboratory ing policy was send[sic] to ER and bed holding policy was ent and RP (responsible notation of a written notice of the factors of	F 6	23			
	do. On 7/10/19 at 3:08 p	ot and she thought the nurses o.m., an interview was (licensed practical nurse) #1.					

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	(X3) DATE SURVEY COMPLETED	
		495217	B. WING _		C 07/11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 623	LPN #1 was asked notification of hospi and/or their represe but we do put in our unable to manage spatient and rp (respand understand." On 7/10/19 at 5:31 confirmed they had provide.	ge 62 if nurses provide written tal transfers to residents ntatives. LPN #1 stated, "No documentation that we were symptoms in-house and the onsible party) were notified	F 623	3		
SS=D	Nursing, were informmorning of 07/11/20 was provided. Notice of Bed Hold CFR(s): 483.15(d) (1) §483.15(d) (1) Notice of §483.15(d) (1) Notice of §483.15(d) (1) Notice of §483.15(d) (1) Notice of second specifies of the resident or res	med of the findings on the of 9. No further documentation Policy Before/Upon Trnsfr (1)(2) If bed-hold policy and returnation before transfer. Before a fers a resident to a hospital or a therapeutic leave, the provide written information to tent representative that The state bed-hold policy, if the eresident is permitted to the esidence in the nursing payment policy in the state of this chapter, if any; lity's policies regarding thich must be consistent with this section, permitting a	F 625	F625 1. Residents #70 returned to the on 6/18/19. Resident #56 returned to the facility on 5/15/19. 2. All residents experiencing a facinitiated transfer to the hospital the potential to be affected. 3. Unit Managers/Shift Superviso audit facility-initiated discharge the hospital, daily x 5 days and weekly x4 weeks, to ensure compliance with the requireme information provided to the hospital acopy of the bed-holpolicy, and completion of the indocument Post Acute Care Transpocument Checklist. Licensed nurses on all shifts we re-educated on the requirement information provided to the hospital shifts were provided to the hospital s	cility- chave rs will s to nt of cpital, d aternal ansfer ill be at of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		495217	B. WING			C 11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWA FAIRFAX, VA 22033		11/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 625	(iv) The information of this section. §483.15(d)(2) Bedthe time of transfer hospitalization or the facility must provide resident represental specifies the duration described in paragrathis REQUIREMENT by: Based on staff intered and clinical record in the facility staff fails notice for a facility-investedents in the sum and #70. The findings included 1. The facility staff for the resident's report the bed hold policity discharged to the hold section of the bed hold policity of the bed hold policity of the bed hold policity. Resident #56 was a 7/12/17. Resident #were not limited to pasthma. Resident # (minimum data set) an ARD (assessment coded the resident's impaired. Review of Resident the resident was traffer the section of the section of the section of the resident was traffer the section.	hold notice upon transfer. At of a resident for erapeutic leave, a nursing to the resident and the tive written notice which on of the bed-hold policy aph (d)(1) of this section. To is not met as evidenced rview, facility document review eview, it was determined that to provide a written bed hold initiated transfer for two of 57 vey sample, Residents #56 eresentative written notification by when the resident was	F 62	to include a copy of the bed-h policy, and completion of the document Post Acute Care To Document Checklist. 4. Unit Managers or DON will re results of audits at the monthl Committee meetings x3 mont its review and recommendation 5. Compliance Date: August 13	internal ransfer port the y QAPI hs for ons.	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY MPLETED
		495217	B. WING			C	
NAME OF	DDOMINER OR OURDUIS		D. WING			07/	/11/2019
	PROVIDER OR SUPPLIEF			12	TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	to reveal evidence bed hold policy wa and/or the resident and/or the resident on 7/10/19 at 3:08 conducted with LP LPN #1 stated a consent with residents the hospital. LPN in-services, the nuneed to document provided. LPN #1 be documented in On 7/10/19 at 5:49 staff member) #1 ((the administrative #3 (the quality assurance of the above "INTERDISCIPLIN CHECKLISTS" docume t of the above "INTERDISCIPLIN CHECKLISTS" document of the abov	r form and nurses' notes) failed that written notification of the sprovided to the resident trepresentative. 8 p.m., an interview was N (licensed practical nurse) #1. Opy of the bed hold policy is when they are transferred to #1 stated due to previous rses have learned that they the bed hold policy was stated this information should nurses' notes. 9 p.m., ASM (administrative the administrator), ASM #2 director of nursing) and ASM urance consultant) were made expondent. ent titled, ARY CARE TRANSITIONS cumented, "TRANSITION URSING FACILITY TO ue copy of bed hold policy to expresentative" sion was presented prior to exit. If alled to provide Resident #70 presentative written notification cy when the resident was nospital on 6/9/19.	F6	:25			
	were not limited to	legal blindness, kidney y disorder. Resident #70's					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON IDENTIFICATION NUMBER: A. BUILDING				E SURVEY IPLETED			
		495217	B. WING			1	C 11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		1	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	most recent MDS (radmission assessm reference date) of 4 cognition as cognition. Review of Resident the resident was tra 6/9/19 due to a low review of Resident # nurses' notes) failed written notification oprovided to the resident representative. On 7/10/19 at 11:05 conducted with Resident anyone had of the bed hold policy to the hospital on 6/3 don't recall receiving bed hold policy." On 7/10/19 at 3:08 producted with LPN #1 stated a copsent with residents with the hospital. LPN #1 in-services, the nurs need to document the provided. LPN #1 stated a composent with residents with the document of the document of the documented in nursided. LPN #1 stated acomposent with residents with residents with residents with residents with a document the provided. LPN #1 stated acomposent with residents with residen	minimum data set), an ent with an ARD (assessment /24/19, coded the resident's /ely intact. #70's clinical record revealed insferred to the hospital on blood pressure. Further f70's clinical record (including to reveal evidence that if the bed hold policy was dent and/or the resident a.m., an interview was ident #70. Resident #70 was given her written notification by when she was transferred for the paperwork regarding the figure paperwork regarding the figure paperwork regarding the figure paperwork is suffered to the stated due to previous es have learned that they are transferred to the stated due to previous es have learned that they are bed hold policy was stated this information should curses' notes. proximately 2:00 p.m., ASM	F 6	25			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		E SURVEY PLETED
		495217	B. WING		L i	C 11/2019
	PROVIDER OR SUPPLIER	ICES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF THE PROPORTION OF THE PROPOR) BE	(X5) COMPLETION DATE
F 625 F 641 SS=D	No further informate Accuracy of Assess CFR(s): 483.20(g) §483.20(g) Accuracy The assessment meresident's status. This REQUIREMENT by: Based on staff intereview, and clinical determined the faci accurate MDS (minfor one of 57 reside Resident #61. The findings included The facility staff failed C - Cognition, on the an assessment reference Resident #61 was a 10/26/19 with diagon not limited to: high be breath, gastro-esop [backflow of the coresophagus, usually sphincter muscle be symptoms include be commonly known as falls, and osteoporo tissue, causing fragging (2)]. The most recent ME assessment, a quar	on was presented prior to exit. ments by of Assessments: ust accurately reflect the NT is not met as evidenced rview, facility document record review, it was lity staff failed to complete an imum data set) assessment nts in the survey sample,	F 625	22.7	under stion to 11, the nection has will nt. I to be ed the ts nt. dit 3 w and nts, esults as for	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495217	B. WING		C 07/11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	111	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION	٧
F 641	resident in Section I Vision, as sometimes understa cognition, the reside being completed durarely/never undersi section, C0500 BIM status) score, docur resident was unable The "Staff Interview completed and code and long-term memwas coded as being daily cognitive decis An interview was conurse) #3, the MDS 3:11 p.m. When ask of the MDS assessed does that section. We section C, RN #3 status to the social worsurveyor. On 7/10/19 at 3:18 pmember (OSM) #2, OSM #2 stated, "I at time. She was upset with me. She kept on I re-attempted the in response." When as have been coded as OSM #2 stated, "No reference the facility	B - Hearing, Speech and as being understood and anding others. In Section C - ent interview was coded as not e to the resident being tood. The bottom of this S (brief interview for mental ments, "Enter 99 if the to complete the interview." for Mental Status" was ed the resident with both short ory difficulties. The resident severely impaired to make ions. Inducted with RN (registered coordinator, on 7/10/19 at ed who completes Section B ment, RN #3 stated that she when asked who completes at the social workers do ove MDS assessment was B. RN #3 stated she wanted to refer and get back with this of the social worker, returned tempt the interview every that day and wouldn't talk in saying, 'my heart is broken.' the saying, 'my heart is broken.' the treview and I got the same ked if the resident should rarely/never understood, "When asked what uses to complete the MDS B stated, "The RAI (resident	F 6	41		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	(X3) DATE SURVEY COMPLETED		
		495217	B. WING_		C 07/11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 641	The RAI manual do Should Brief Intervie Conducted? Code 1 be conducted becausometimes underste using another methoneeded, one is avail complete the Staff A if the resident intervicenducted, but not conducted, but not conducted, but not of nursing, and ASM consultant, were maconcern on 7/11/19	ge 68 cumented in part, "C0100: ew for Mental Status be , yes; if the interview should use the resident is at least ood verbally, in writing, or od, and if an interpreter is lableCoding Tips: Do not assessment for Mental Status iew should have been done. member (ASM) #1, the #2, the administrative director 1 #3, the quality assurance ade aware of the above at 10:50 a.m.	F 64		
SS=D	Non-Medical Reade Chapman, page 243 (2) Barron's Diction Non-Medical Reade Chapman, page 424 Develop/Implement CFR(s): 483.21(b)(1) \$483.21(b)(1) The faimplement a compres care plan for each reresident rights set for \$483.10(c)(3), that is objectives and timef medical, nursing, an needs that are identical	Comprehensive Care Plan) nensive Care Plans acility must develop and chensive person-centered esident, consistent with the orth at §483.10(c)(2) and	F 65	F656 1. The oxygen-concentrator levels Residents #85, #61 & #110 wer corrected to be consistent with physician order and resident's respective care plan. 2. All residents on supplemental oxygen have the potential to be affected. 3. Unit Managers/Shift Supervisor audit all residents on suppleme oxygen, 3x/week x5 weeks and weekly x4 weeks, to ensure set	re s will ntal

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495217	B. WING		1	C 11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	TION 495217 B. WING 07 OR SUPPLIER ALTH SERVICES-FAIR OAKS SUMMARY STATEMENT OF DEFICIENCIES HOPERCY WIST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION) OR SUMMARY STATEMENT OF DEFICIENCIES HOPERCY WIST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION) OR From page 69 or the following - ervices that are to be furnished to attain ain the resident's highest practicable in mental, and psychosocial well-being as under §483.24, §483.25 or §483.40, and ervices that would otherwise be required the services that would otherwise be required the services the nursing facility will as a result of PASARR endations. If a facility disagrees with the of the PASARR, it must indicate its in the resident's exercise of resident and the services the nursing facility will as a result of PASARR endations. If a facility disagrees with the of the PASARR, it must indicate its in the resident's exercise of resident and the services the nursing facility will as a result of PASARR endations. If a facility disagrees with the of the PASARR, it must indicate its in the resident's exercise of resident and the services the nursing facility will as a result of PASARR endations. If a facility disagrees with the of the PASARR, it must indicate its in the resident's medical record. Insultation with the resident and the services the nursing facility will as a result of PASARR endations. If a facility disagrees with the of the PASARR, it must indicate its in the resident's preference and potential for scharge; Facilities must document the resident's desire to return to the ity was assessed and any referrals to tact agencies and/or other appropriate				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETION DATE
F 656	describe the followi (i) The services tha or maintain the resi physical, mental, ar required under §48: (ii) Any services tha under §483.24, §48 provided due to the under §483.10, incli treatment under §48 (iii) Any specialized rehabilitative service provide as a result of recommendations. findings of the PAS/ rationale in the resid (iv) In consultation were ident's represent (A) The resident's g desired outcomes. (B) The resident's p future discharge; Fa whether the residen community was ass local contact agenci entities, for this purp (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMEN by: Based on observati record review, it was staff failed to implen plan for three of 57.	t are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the fative(s)-oals for admission and reference and potential for acilities must document at's desire to return to the essed and any referrals to desire and/or other appropriate	F 65	care plan for each resident. Licensed nurses on all shifts w re-educated on the requiremer ensure O2 settings are consist with physician orders and care for each resident. 4. Unit Managers or DON will rep results of audits at the monthly Committee meetings x3 month its review and recommendation	vill be nt to ent plans ort the QAPI s for	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
						С
		495217	B. WING			07/11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORREX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION E DATE
	comprehensive care for Resident #85. Resident #85 was a 8/26/17. Resident # were not limited to horessure and chron recent MDS (minimassessment with an date) of 6/5/19, cod cognitive impairmer #85 as requiring ext two staff members for the connected to an oxy #85's oxygen conce flow meter ball sitting This reading was observed by television. Resident was being administed connected to an oxy #85's oxygen conce flow meter ball sitting This reading was observed by television. Resident was being administed connected to an oxy #85's oxygen conce flow meter ball sitting This surveyor observed by the connected to an oxy #85's oxygen conce flow meter ball sitting This surveyor observed by Resident a physician order data.	ailed to implement the e plan for the use of oxygen admitted to the facility on 85's diagnoses included but neart failure, high blood ic pain. Resident #85's most um data set), a quarterly ARD (assessment reference ed Resident #85 with no at Section G coded Resident rensive assistance with one to for activities of daily living. Simately 11:45 a.m., Resident regen concentrator. Resident resident ansal cannular regen concentrator. Resident regen to a teyer of the served at eye level by this simately 12:45 p.m., Resident regen to a teyer oxygen that regen concentrator. Resident regen and 2.5 liters. The served with the great of the served with the great oxygen that regen concentrator. Resident regen concentrator.	F6	556		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING			l	С
NAME OF	PROVIDER OR SUPPLIER	453217	D. WINC	,	GTREET ADDRESS, CITY, STATE, ZIP CODE	07/	/11/2019
MANOR	CARE HEALTH SERVI	CES-FAIR OAKS		1	2475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From parvia nasal cannula or Further review of Resident." On 7/11/19 at 8:48 at conducted with RN manager). RN #1 with the resident's care plan is what is what the resident rewind is responsible from the residents. RN #1 was plan interventions are made to interventions are in aware of Resident # incorrect. RN #1 stars should've been notion rounds. The facility document and implement a coare plan for each measurable objective patient's medical, no psychosocial needs comprehensive assecare plan must design consultation with the	ge 71 continuously." esident #85's care plan dated d, "Administer oxygen as a.m., an interview was #1 (registered nurse) (unit as asked what the purpose of plan is. RN #1 stated that the used to let nursing staff know eeds are. RN #1 was asked for developing and are plan. RN #1 stated that the whole is responsible for lementing the care plan for as asked how you ensure care re in place. RN #1 stated that ensure that care planned place. RN #1 was made 185's oxygen setting being ted that this is something that bed and corrected during that titled "Interdisciplinary Care and timeframes to meet a patient that includes and timeframes to meet a patient that includes are and timeframes to meet a patient that includes are sand timeframes to meet a patient that one comprehensive ensured that are identified in the easment. The comprehensive ensured that and the patient's		356	DEFICIENCY)	MAIL	
	preference and pote	ed outcomes, The patient's ntial for future discharge, - he comprehensive care plan,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495217	B. WING			1	С	
NAME OF	PROVIDER OR SUPPLIER	433217	B. WING	_	STREET ADDRESS, CITY, STATE, ZIP CODE	07/	11/2019	
MANOR	CARE HEALTH SERVI	ICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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	
	furnished to maintal practicable physical well-being, Any spe specialized rehabilit facility will provide a admission screening recommendations. Indings of the PASA rationale in the patien. On 07/11/2019 at ap #1 (administrative sadministrator), ASM director of nursing), assurance consultatindings. No further information. Resident #110 was a 6/14/19. Resident #110. Resident #110 was a 6/14/19. Resident #10 was a 6/14/19. Resident #110 was a 6/14/19. Resident #110 was a 6/14/19 assistance with one activities of daily living On 7/9/19 at approximation of 7/9/19 at approximation was observed.	in the patient's highest II, mental, and psychosocial cialized services or tative services the nursing as a result of PASARR (pregand annual resident review) If a facility disagrees with the ARR, it must indicate its ent's medical record." oproximately 2:00 p.m., ASM taff member) (the II #2 (the administrative and ASM #3 (the quality nt) were made aware of III was plan for the use of oxygen admitted to the facility on 110's diagnoses included but high blood pressure, heart tolesterol. Resident #110's ninimum data set), a 14-day ent with an ARD (assessment /28/19, coded Resident #110 e impairments. Section G of as requiring extensive to two staff members for	F	356				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495217	B. WING				C 11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CO 12475 LEE JACKSON MEMORIAL H FAIRFAX, VA 22033		017	11/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD B	BE	(X5) COMPLETION DATE
F 656	that was being adm connected to an ox #110's oxygen condithe flow meter ball liters. This surveyor level. On 7/9/19 at approx #110 was observed television. Resident that was being adm connected to an ox #110's oxygen condon with the flow me 2.5 liters. This surveye level. Review of Resident revealed a physicial documented, "Oxygvia nasal cannula conducted with RN manager). RN #1 withe resident's care plan is what is what the resident naw to is responsible the furnished as a wideveloping and impresidents. RN #1 was plan interventions a	ninistered via nasal cannula ygen concentrator. Resident centrator was observed on with sitting between 2 and 2.5 r observed this reading at eye ximately 12:55 p.m., Resident I lying in bed watching the #110 was wearing oxygen ninistered via nasal cannula ygen concentrator. Resident centrator was observed being ter ball sitting between 2 and eyor observed this reading at #110's clinical record in order dated 6/15/19 which gen at 2 lpm (liters per minute) continuously." esident #110's care plan dated did, "Administer oxygen as per a.m., an interview was #1 (registered nurse) (unit was asked what the purpose of colan is. RN #1 stated that the used to let nursing staff know eeds are. RN #1 was asked	F	656			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495217	B. WING			1	C /11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	к	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	aware of Resident # incorrect. RN #1 sta should've been notion room rounds. On 07/11/2019 at ap #1 (administrative sadministrator), ASM and ASM #3 (the quare made aware of the facility staff facomprehensive care oxygen to Resident #61 was a 10/26/19 with diagnous limited to: high be breath, gastroesoph [backflow of the confesophagus, usually sphincter muscle be symptoms include be commonly known as falls, and osteoporotissue, causing fraging). The most recent ME assessment, a quare assessment referencesident as having be memory difficulties. being severely impadecisions. Resident extensive assistance.	place. RN #1 was made #85's oxygen setting being ated that this is something that ced and corrected during proximately 2:00 p.m., ASM taff member) (the I #2 (the director of nursing), reality assurance consultant) of findings. on was presented prior to exitalled to implement the explan for the administration of	F 6	56			

AND PLAN OF CORRECTION (XT) PROVIDER/SOPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD	ING		COMPLETED		
		495217	B. WING		07	C /11/2019	
	PROVIDER OR SUPPLIER	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 656	Special Treatments coded the resident alook back period. The comprehensive documented in part respiratory impairmerspiratory failure as breath). The "Intention" administer oxygen order. The physician order "O2 (oxygen) at 4 lp (nasal cannula) for some cannula (a two-pronthe nose) connected the oxygen concern minute (LPM), the constituting on the 4.5 LP p.m., a second obsewas set at the same a.m., an observation the oxygen concentrof the ball sitting on ball resting just below their needs. It has to patient. When aske administered per the	A Procedures, and Programs, as using oxygen during the ecare plan dated, 12/3/18, "Focus: Has/At risk for ent related to chronic and SOB (shortness of ventions" documented in part, per MD (medical doctor) I dated, 5/11/19, documented, and (liters per minute) via NC SOB (shortness of breath)." I dated of Resident #61 on 7/9/19 sident was sitting in her oxygen on via the nasal ged tubing that inserts into a to an oxygen concentrator. Itrator was set at 4.5 liters per enter of the black ball was M line. On 7/9/19 at 5:13 ervation was made the oxygen or rate. On 7/10/19 at 9:18 in was made of Resident #61 rator was set with the bottom the 4.0 line and the top of the	F6	56			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495217	B. WING		1	C
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			/11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETION DATE
F.656		ge 76 bllowing the care plan, LPN #2	F6	556		
	nurse) #2 on 7/11/1 the purpose of the of the nursing commit do for these resider #2 was asked if the administer oxygen a not at the physician	onducted with RN (registered 9 at 9:13 a.m. When asked care plan, RN #2 stated, "It is ment of what we promise to its based on their needs." RN care plan documents to as ordered, and the oxygen is prescribed flowrate, are the and following the care plan,	· · · · · · · · · · · · · · · · · · ·		7	
F 658 SS=D	administrator, ASM of nursing, and ASM consultant, were ma concern on 7/11/19 No further information (1) Barron's Dictional Non-Medical Reader Chapman, page 243 Services Provided MCFR(s): 483.21(b)(3) Comparthe services provides outlined by the comustion (i) Meet professional This REQUIREMEN by: Based on observation	ary of Medical Terms for the r, 5th edition, Rothenberg and 3. Meet Professional Standards (1)(i) brehensive Care Plans (2) arranged by the facility, omprehensive care plan, I standards of quality. T is not met as evidenced on, staff interview and clinical addetermined the facility staff	F 6	58 1. Upon notification by the identified physician orde Resident #75 was clarifie 2. All residents on insulin h potential to be affected. 3. Unit Managers/designee complete an audit of all r currently on insulin, to de additional, physician orde clarification with regards coordination and accommith meal times.	r for ed. ave the will residents etermine any ers requiring to	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495217	B. WING _		0.	C 7/11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	ICES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP C 12475 LEE JACKSON MEMORIAL H FAIRFAX, VA 22033	ODE	71172010
(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 COME (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 658	professional standarthe survey sample, failed to clarify a ph #75's insulin to be go The findings included Resident #75 was a 5/29/19 with diagnol limited to: diabetes, [chronic obstructive term for chronic, no is usually a combinate chronic bronchitis (1). The most recent MI admission assessman reference date of 6/3 scoring a "7" on the mental status) score severely impaired to decisions. The resid limited to extensive member for her action. Observation was manurse) #2 on 7/10/19 proceeded to check The reading was 24 gets any (insulin) coshe does." LPN #2 poart and drew up two [short acting insulin to the resident's room administered the insinjection.	admitted to the facility on ses that included but were not dementia, and COPD pulmonary disease - general nreversible lung disease that ation of emphysema and [1]]. DS (minimum data set), an ent, with an assessment [5/19, coded the resident as BIMS (brief interview for e, indicting the resident was a make daily cognitive dent was coded as requiring assistance of one staff vities of daily living. ade of LPN (licensed practical 9 at 10:06 a.m. LPN #2 Resident #75's blood sugar. 7. When asked if the resident verage, LPN #2 stated, "Yes, proceeded to the medication of units of Humalog insulin a (2)]. LPN #2 then proceeded m at 10:18 a.m. and sulin to Resident #75 by	F 65	New Admissions on ins clarified at time of admi ensure coordination and accommodation with me Licensed nurses will be regarding need and expensure that meals are a time insulin is administr. Unit Managers/designer andomly audit resident daily x5 days then week to determine compliance and expectation to have readily available for resinsulin. 4. Unit Managers will repoor of monitoring and audits monthly QAPI Committe x3 months for its review recommendations. 5. Compliance Date: Augi	ssion to d eal times. re-educated pectation to evailable at ated. e will s on insulin kly x4 weeks, e with need e snacks idents on rt the results at the ee meetings and	

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
							С	
		495217	B. WING	-		07/	11/2019	
NAME OF PROVIDER OR SU		CES-FAIR OAKS		1	TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
PRÉFIX (EACH DE	FICIENCY	TEMENT OF DEFICIENCIES 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	
If (blood sug 70 - 200 - giv 201 - 250 = 2 251 - 300 = 4 301 - 350 = 6 351 - 400 = 8 401 - 450 = 6 16 BS (blood s Subcutaneou DM (diabetes The Medicati July 2019 do order. The tirand at bedtin 11:00 a.m. 4: The compreh documented insulin r/t (rel "Interventions resident/fami insulin. Monit results as ord The schedule documented Breakfast - (Non) - 9:00 a.m. Lunch - (Nam 1:05 p.m. Dinner - (Nam 6:05 a.m. Resident #75 7/10/19 and the Resident #75	ject as ar) < (le ve no ir 2 units a u	per sliding scale: ess than) 70 - call doctor issulin s > 450 call doctor fore meals and at bedtime for us)." ministration Record (MAR) for ted the above physicians heduled for the before meals documented as: 6:00 a.m., and 9:00 p.m. care plan dated, 5/30/19, "Focus: The resident is on diabetes." The mented in part, "Educate giver on administration of d sugar, lab (laboratory tests) y the physician." meal cart delivery	F6	558				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MÜİ A. BÜİLE		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405045		-			С
		495217	B. WING			07/	11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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 658	hour and 18 minute breakfast meal. An interview was converted to the asked what time Reaked what time Reaked what time Reaked what time Reaked breakfast. LPN #2 was asked breakfast. LPN #2 was asked breakfast. LPN #2 wreading she obtaine Resident #75 had how reading she was as for before meals she stated, "Depending resident actually eat above order for Hummeal times was revistated, "That order round interview was constaff member (ASM) director of nursing, of when asked what it documents to give bound in the potter and Pedition Potter and Pedition Potter and Pedition Potter and Pedition Potter and Pedition Potter and Pedition Potter and Pedition Potter and Pedition Potter and Pedition Potter and Pedition Potter and Pedition Potter and Pedition Potter and Pedition Potter and Pedition Potter and Pedition Potter and Pedition Potter and Pedition Potter and Pedition Potter and Pedition	onducted with LPN #2 on LPN #2 was asked when a ed as before meals should be #2 stated, "You follow the time ou can give it an hour before prescribed time." When esident #75 ate her lunch, LPN is come up around 1:00 p.m." when the resident ate stated they serve them around as asked if the blood sugar d was just an hour after er breakfast. LPN #2 stated, intact the doctor to get the inducted with RN (registered manager; on 7/11/19 at 9:13 ked when insulin prescribed ould be administered. RN #2 on the order, but before the is. I go by the order." The malog and the schedule of ewed with RN #2. RN #2 needs to be clarified." Inducted with administrative of #2, the administrative on 7/11/19 at 10:55 a.m. means when an order pefore meals, ASM #2 stated,	F	658			

AND PLAN OF CORRECTION (X1) PROVIDEN/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI	ING		COMPLETED		
		495217	B. WING			C 07/11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE ACTION SI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	be administered by order is incomplete prescriber and ensucarrying out any me Administrative staff administrator, ASM of nursing, and ASM consultant, were maconcern on 7/11/19 On 7/11/19 at 11:14 assurance consultated have a policy on classification Non-Medical Reader Chapman, page 12-4 (2) Humalog insulin treat elevated blood as a solution (liquid) particles that will sessible that will sessible that will sessible that minutes be after a meal. This in the following website https://medlineplus.gtml (2) Barron's Diction Non-Medical Reader Chapman, page 42-44-45.	a nurseIf the medication, the nurse should inform the ure completeness before edication order." member (ASM) #1, the #2, the administrative director #3, the quality assurance ade aware of the above at 10:50 a.m. a.m. ASM #3, the quality not, stated the facility did not rifying physician orders. on was provided prior to exit. asy of Medical Terms for the er, 5th edition, Rothenberg and 4. a short acting insulin used to sugars -Insulin lispro comes and a suspension (liquid with title on standing to inject der the skin). Insulin lispro Humalog) is usually injected fore a meal or immediately formation was obtained from estimatory of Medical Terms for the gov/druginfo/meds/a697021.h	F 69				
33-5	()()						

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495217	B. WING		C 07/11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERV		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			11/2013
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	§ 483.25(i) Respiratracheostomy care The facility must en needs respiratory care and tracheal scare, consistent wipractice, the compicare plan, the resident 483.65 of this This REQUIREME by: Based on observate record review, it wastaff failed to oxyg with professional state comprehensive per of 57 residents in the #85, #110 and #61. The findings included the physician order Resident #85 was a 8/26/17. Resident #were not limited to pressure and chromassessment with an date) of 6/5/19, code cognitive impairment #85 as requiring extended to the physician order factor of 6/5/19, code cognitive impairment #85 as requiring extended to the physician order factor of 6/5/19, and the physician order factor of 6/5/19, and the physician order factor of 6/5/19, and the physician order factor of 6/5/19, and the physician order factor of 6/5/19, and the physician order factor of 6/5/19 at approximate factor of 6/5/19 at appro	and tracheal suctioning. Insure that a resident who care, including tracheostomy suctioning, is provided such the professional standards of rehensive person-centered dents' goals and preferences, subpart. No is not met as evidenced tion, staff interview and clinical as determined that the facility en administration consistent tandards of practice, and the reson-centered care plan for 3 are survey sample, Residents	F 695	1. The oxygen-concentrator level Residents #85, #61 & #110 we corrected to be consistent with physician order and resident's respective care plan. 2. All residents on supplemental oxygen have the potential to be affected. 3. Unit Managers/Shift Superviso audit all residents on suppleme oxygen, 3x/week x5 weeks and weekly x4 weeks, to ensure se are consistent with physician o care plan for each resident. Licensed nurses on all shifts w re-educated on the requirement ensure O2 settings are consist with physician orders and care for each resident. 4. Unit Managers or DON will represults of audits at the monthly Committee meetings x3 monthists review and recommendation. 5. Compliance Date: August 13, 15.	ers will ental distrings rder ill be ent plans ort the QAPI s for is.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495217	B. WING		07/1	1/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	ball sitting between observed this readir On 7/9/19 at approx #85 was wearing ox administered via na oxygen concentrator concentrator was observed to the surveyor observed	cimately 12:45 p.m., Resident cygen that was being sal cannula connected to an r. Resident #85's oxygen oserved being on with the flow tween 2 and 2.5 liters. This his reading at eye level. #85's clinical record revealed ated 12/5/17 which en at 2 lpm (liters per minute) ontinuously." esident #85's care plan dated d, "Administer oxygen as a.m., an interview was #1 (registered nurse) (unit as asked the process for soxygen was on the correct d, "You review the physician he oxygen should be set at. resident's room and get front of the oxygen ure the setting is correct. The end in the middle of the line on onlysician has ordered. RN #1 at Resident #85's oxygen was	F 69	95		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						I	С
		495217	B. WING	=		07/	11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		1	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	Continued From pa	ge 83	F	895			
	#1 (administrative s administrator), ASM director of nursing),	pproximately 2:00 p.m., ASM taff member) (the 1 #2 (the administrative and ASM #3 (the quality nt) were made aware of					
	No further information	on was presented prior to exit.					
	2. The facility staff failed to implement the comprehensive care plan for the use of oxygen for Resident #110.						
	The findings include	ed:					
	6/14/19. Resident # were not limited to h disease and high ch most recent MDS (n scheduled assessm reference date) of 6 with severe cognitive coded Resident #11	admitted to the facility on 110's diagnoses included but high blood pressure, heart holesterol. Resident #110's minimum data set), a 14-day lent with an ARD (assessment 1/28/19, coded Resident #110 e impairments. Section G 0 as requiring extensive to two staff members for ng.					
	#110 was observed being administered to an oxygen concer oxygen concentrator flow meter ball sittin	imately 11:55 a.m., Resident wearing oxygen that was via nasal cannula connected ntrator. Resident #110's r was observed on with the g between 2 and 2.5 liters. ved this reading at eye level.					
	#110 was observed	imately 12:55 p.m., Resident wearing oxygen that was via nasal cannula connected					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
	495217		B. WING		C 07/11/2019		
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		12475	T ADDRESS, CITY, STATE, ZIP CODE LEE JACKSON MEMORIAL HIGHWAY FAX, VA 22033		11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 695	to an oxygen conce oxygen concentrator the flow meter ball soliters. This surveyor level. Review of Resident revealed a physician documented, "Oxygvia nasal cannula conformation of the flow meter physician order." On 7/11/19 at 8:48 a conducted with RN amanager). RN #1 we ensuring a resident's setting. RN #1 state orders to see what the You then go into the down at eye level in concentrator to ensuball should be located the setting that the pwas made aware the was being administed. The user manual titl documented, "Flow to the setting prescriberapist. On 07/11/2019 at ap #1 (administrator), ASM director of nursing),	mtrator. Resident #110's ir was observed being on with sitting between 2 and 2.5 observed this reading at eye #110's clinical record in order dated 6/15/19 which en at 2 lpm (liters per minute) ontinuously." esident #110's care plan dated d, "Administer oxygen as per a.m., an interview was #1 (registered nurse) (unit as asked the process for s oxygen was on the correct d, "You review the physician he oxygen should be set at. resident's room and get front of the oxygen ure the setting is correct. The ed in the middle of the line on ohysician has ordered. RN #1 at Resident #110's oxygen ered at the wrong rate. ed "Perfecto O2 Series" ate 1. Turn the flowrate knob ibed by your physician or opproximately 2:00 p.m., ASM	F6	95			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495217	B. WING		0.	C 07/11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERV	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG			ULD BE	(X5) COMPLETION DATE			
F 695	3. The facility staff of the physician orders. Resident #61 was a 10/26/19 with diagn not limited to: high beath, gastroesoph [backflow of the coresophagus, usually sphincter muscle be symptoms include be commonly known as falls, and osteoporotissue, causing frag (2)]. The most recent ME assessment, a quarassessment referencesident as having being severely impadecisions. Resident extensive assistance of her activities of despecial Treatments, coded the resident a look back period. Observation was mad 3:44 p.m. The resident with her cannula (a two pronothe nose), connected The oxygen concentrations.	on was presented prior to exit. ailed to administer oxygen per	F 69	95			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		495217	B. WING	-		07/	11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		1	STREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
F 695	sitting on the 4.5 LF p.m., a second observation was set at the same an observation was oxygen concentrated the ball sitting on the ball resting just below the ball sitting on the ball resting just below the physician order "O2 (oxygen) at 4 lp (nasal cannula) for 3 the comprehensive documented in part, respiratory impairments respiratory failure and documented in part, (medical doctor) order the part of the pa	PM line. On 7/9/19 at 5:13 ervation was made the oxygen erate. on 7/10/19 at 9:18 a.m., made of Resident #61 the was set with the bottom of e 4.0 line and the top of the ow the 4.5 line. I dated, 5/11/19, documented, om (liters per minute) via NC SOB (shortness of breath)." I care plan dated, 12/3/18, "Focus: Has/At risk for ent related to chronic and SOB." The "Interventions", "administer oxygen per MD der." Inducted with LPN (licensed on 7/11/19 at 8:56 a.m. When an oxygen concentrator, LPN has to go directly through the mucted with RN (registered erat 9:13 a.m. RN #2 was es read an oxygen flowmeter. you get at eye level. Then butting the prescribed dose dle of the ball." I member (ASM) #1, the #2, the administrative director if #3, the quality assurance ade aware of the above	F6	695			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495217	B. WING_		C 07/11/2019
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS		<i>(</i>	
(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 COMPLÉTION
F 761 SS=E	CFR(s): 483.45(g)(last square) S483.45(g) Labeling Drugs and biological labeled in accordant professional princip appropriate accessed instructions, and the applicable. §483.45(h) Storage S483.45(h)(1) In accepted laws, the fabiologicals in locked temperature control personnel to have a S483.45(h)(2) The foliocked, permanently storage of controlled the Comprehensive Control Act of 1976 abuse, except when package drug distrikt quantity stored is midble readily detected. This REQUIREMEN by: Based on observation determined that the store controlled medication rooms), medications were stored in acceptance of the composition of the composition of the controlled medication rooms).	of Drugs and Biologicals als used in the facility must be ce with currently accepted les, and include the pry and cautionary expiration date when of Drugs and Biologicals cordance with State and cility must store all drugs and compartments under propers, and permit only authorized coess to the keys. Accility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the nimal and a missing dose can and staff interview, it was facility staff failed to securely lications in two of three facility first and second floor Refrigerated controlled ored in containers not to the refrigerator in the first m.	F 76	1. The refrigerator shelves on the nursing units, with the secured lockboxes attached to them for controlled medications, are attato the frames of the refrigerato. 2. No residents were affected. 3. Unit Managers/designees will monitor and audit to ensure all controlled medications are kep the lockboxes, all lockboxes are secured to a refrigerator shelf, all of those shelves are attached the inside frame of the refrigerator. 4. Unit Managers or DON will represults of audits at the monthly Committee meetings x3 month its review and recommendation. 5. Compliance Date: August 13,	ached r. at in e and ed to ator ort the QAPI s for

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT! A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		495217	B. WING		C 07/11/0010		
NAMEOE	PROVIDER OR SUPPLIER	430217	07/11/201				
I NAME OF	FROVIDER OR SUFFLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MANOR	CARE HEALTH SERV	ICES-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHWAY			
				FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT 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 APPROPF DEFICIENCY)	BE COMPLETION		
			1.	JEN IOLENOTY			
E 761	O						
F 761	Continued From pa	ge 88	F 76	1			
		cility medication, storage					
		ted on the afternoon of					
		p.m., the first floor					
		as inspected. During	- i	pr			
		rvation was made of the					
	secured lockbox ins						
	refrigerator used fo						
		ckbox was clear plastic, and					
		f of the refrigerator. However,					
		not attached to the frame of					
	the refrigerator. Thi	s surveyor was able to lift the					
	shelf out of the refri	gerator.					
		pection of the second floor					
	medication room wa	as conducted with Registered					
	Nurse (RN) #2, the	Unit Manager. During the					
	inspection, an obse	rvation was made of the					
	secured lockbox ins	side the medication					
	refrigerator used for	r storing controlled					
		ckbox was the same clear					
	plastic, and secured	to the shelf of the	ĺ				
		er, again the shelf itself was					
	not attached to the	frame of the refrigerator. This					
		o lift the shelf out of the					
		stated that the shelf should be					
	secured.						
	Administrative Staff	Member (ASM) #1, the facility					
		ASM #2, the Administrative					
		were informed of the findings					
	on the morning of 0	7/11/2019. The Administrator					
		e to fix that", but no further					
	documentation was			F040			
F 812		Store/Prepare/Serve-Sanitary	F 812	F812			
	CFR(s): 483.60(i)(1)		1 012	1. All lood items identified during			
33=E	○. 11(0). →00.00(1)(1,	/\ - /		survey as not being properly sto	ored		
	§483.60(i) Food safe	ety requirements		were discarded.			
	3 .55.55(i) i 554 54i	ory roquironionio.					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495217	B. WING _		C 07/11/2019	
	PROVIDER OR SUPPLIER CARE HEALTH SERV	ICES-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	approved or considerate or local author (i) This may include from local produce and local laws or reference (ii) This provision of facilities from using gardens, subject to safe growing and for (iii) This provision of from consuming for from consuming for \$483.60(i)(2) - Storn serve food in according standards for food This REQUIREMENT by: Based on observed document review it facility staff failed to sanitary manner. 1. The facility staff date on an open gallalian dressing in the available for use. In ensure a quart carte walk-in refrigerator air. 2. The facility staff fixes not stored inside	cure food from sources lered satisfactory by federal, rities. If food items obtained directly rs, subject to applicable State egulations. If oes not prohibit or prevent a produce grown in facility compliance with applicable pod-handling practices. If oes not preclude residents ods not preclude residents ods not procured by the facility. If alled to document an open lon of coleslaw dressing and the walk-in refrigerator and addition, the staff failed to on of pre-thickened milk in the was covered and not open to failed to ensure a flour scoop de the flour bin. If alled to ensure clean shallow failed to ensure clean shallow	F 81:	2 2. All residents have the potential affected. 3. All Food-Services Staff were reducated by Food Services Di (FSD) on proper Food Storage Labeling, Scoop Usage, Pan 8 Small-wares Drying, Cleaning Mixer and Meat Slicer and Use Hair Restraints. Related Polic and Procedures reviewed as we posted for quick reference by serson or Assistant FSD will more and audit these practices to ercompliance. These audits will completed 3x/week for 4 week 4. FSD or Assistant FSD will present results of all kitchen audits and inspections at the monthly QAI Committee meetings x 3 month its review and recommendation 5. Compliance Date: August 13,	e- rector e & c of e of ies vell as staff nitor nsure be es. sent d PI hs for ns.	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD		E CONSTRUCTION	COMPLETED		
		495217	B. WING	B. WING		C 07/11/2010	
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	4. The facility staff formeat slicer that wer and free from food of the facility staff for preparing and serving the findings included the findings included the findings included the facility staff for the findings included the finding included the facility staff for the finding in the finding in the finding included the finding included the finding included the finding included the finding included the finding included the finding included the finding included the finding included the finding included including included including	ailed to ensure a mixer and e ready for use, were cleaned debris. failed to cover facial hair while ng food. failed to document an open lon of coleslaw dressing and addition, the staff failed to on of pre-thickened milk in the was covered and not open to 5 a.m., an observation of the conducted with OSM (other assistant dietary manager. An ralk-in refrigerator revealed a rof coleslaw dressing and a talian dressing sitting on the ack of the walk-in ation of the gallon container of and the Italian dressing open and approximately eslaw dressing remained in	F8	12			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI	TIPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
		495217	B. WING			C 07/11/2019
	PROVIDER OR SUPPLIER	CES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	there was approxim remaining in the car on 07/10/19 at 4:45 conducted with OSN When asked to descopened food OSM # when it is opened. Note that it should have be 2. The facility staff f was not stored inside Observation of the facility's kitchen clear plastic dry stora a food storage-shelved dry storage bin revealed flour in the bin. For storage bin revealed flour on the inside of On 07/10/19 at 4:45 conducted with OSN When informed of the stored in the flour OS have been stored secould be an infection. The facility's policy "I "Guidelines. 6. Store foods in air tight control scoops out of the foods."	cher observation revealed ately half a quart of milk ton. p.m., an interview was M # 10, dietary manager. Cribe the process of storing 10 stated it should be dated When informed of the opened ened milk stated OSM # 10 ween covered. Tailed to ensure a flour scoop to the flour bin. Tacility's dry storage room of revealed a twenty-two quart, age bin on the bottom self of ring unit. Observation of the aled approximately six cups wither observation of the dry I a plastic scoop resting in the the storage bin. The p.m., an interview was I # 10, dietary manager. We scoop observed being SM # 10 stated that it should parately from the flour and it issue. Food Storage documented, the flour, sugar and similar tainers with the handle of od product."	F 8'	312		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495217 B. WING			С			
	PROVIDER OR SUPPLIER			s 1	TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	•	/11/2019
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	Observation of the of three compartment revealed three, four stacked together, experiment of the conducted with OSM when informed of the dried before being some and ready for use, OSM 8 removed, the plas observation of the material of the	of the drying rack next to the sink in the facility's kitchen inch deep shallow pans ach one inside the other. of the pans revealed they SM # 8 stated that they ried before being stacked i. p.m., an interview was M # 10, dietary manager. The wet nesting pans flour at they should have been stacked together. Cleaning Procedure - Pots at they should have been stacked together. Cleaning Procedure - Pots at they are defined. "Guidelines. 7. Remove Invert to drain. Air dry. and once completely dry." alled to ensure a mixer and the ready for use, were cleaned debris. Inixer revealed it was sitting on table covered with a plastic of the mixer was clean and # 8 stated yes. After OSM # tic bag from the mixer an anixer revealed food debris ck of mixer, behind and wl. When asked if the mixer	F	312			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495217	B. WING		C 07/11/2019		
	NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 812	meat slicer. An observe aled food debriattached to the sled fingers across the mare sidue on his finger un her fingers acroasked if the meat slistated no. On 07/10/19 at 4:45 conducted with OSM When informed of for and meat slicer afterwere clean and react that they should have clean them after every documented, "Guide parts of the mixer us special attention to: cord, handles, under and walls around and take removable Wash in hot water, round the cook, prior to the 9 had been observed, setting up the temperatures of elevery served, setting up the temperatures of elevery served, setting up the results of the served served, setting up the served	ervation of the meat slicer is on the meat grip, which was in the tribing and it left a greasy res. OSM # 8 was asked to see the meat grip and when icer was clean, OSM # 8 in p.m., an interview was p.m., and that they p.m., and they p.m., and	F8	12			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495217	B. WING		C C	
NAME OF	PROVIDER OR SUPPLIER	100211		STREET ADDRESS, CITY, STATE, ZIP CODE	07/11/2019	
MANOR	MANORCARE HEALTH SERVICES-FAIR OAKS			12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT 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 APPROPE DEFICIENCY)	BE COMPLÉTION	
F 814 SS=C	covered. On 07/11/19 at 11:4 conducted with OSI When informed of 0 mustache covered food OSM # 13 stat should be covered, The facility's policy "1. Hair restraints a kitchen. 5. Hair reshair coverings." On 07/11/19 at apput 1 (administrative states ASM # 2, director of assurance consultate findings. No further information Dispose Garbage at CFR(s): 483.60(i)(4)- Dispose Garbage at CFR(s): 483.60(i)(a mustache and it was not 5 a.m., an interview was M # 13, food service director. DSM # 9 not having his while preparing and serving ed, 'Beard and mustaches it's out policy." "Hair Restraints" documented, re worn by anyone in the traints include: beard or facial roximately 12:05 p.m., ASM # aff member), administrator, f nursing and ASM # 3, quality nt, were made aware of the on was provided prior to exit. nd Refuse Properly) pse of garbage and refuse IT is not met as evidenced ion and staff interview, it was facility staff failed to maintain in a sanitary manner.	F 812	*4.:T	e trash ff ment rbage eir ster all	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		495217	B. WING		C 07/11/2019		
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	,	fi (m)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE		
F 814	Continued From pa	ge 95 in front of one of the trash	F 814	garbage on the ground, initiatin			
		ont of the cardboard recycling		manner. 4. Housekeeping Supervisor will r findings of these inspections at	eport		
	observation of the fa	roximately 12:00 p.m., an acility dumpsters was W (other staff member) # 8, anager.		monthly QAPI Committee meet x3 months for its review and recommendations. 5. Compliance Date: August 13, 2	tings	3	
	dumpster's and one dumpster located be Observations of the dumpsters revealed wet cardboard lying of the trash dumpster cardboard recycling was responsible for	area around the three several large pieces of used, on the ground in front of one ers and in front of the dumpster. When asked who ensuring the dumpster area ##8 stated that it was the					
	On 07/10/19 at appr telephone interview maintenance assista responsible for mair OSM # 4 stated that	roximately 3:30 p.m., a was conducted with OSM # 4, ant. When asked who was ntaining the dumpster area the maintenance department mpster area should be					
	(administrative staff ASM # 2, director of	oximately 2:30 p.m., ASM # 1 member), administrator, nursing and ASM # 3, quality nt, were made aware of the					
	No further information Infection Prevention CFR(s): 483.80(a)(1		F 880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 07/11/2019	
		495217				
MANORCARE HEALTH SERVICES-FAIR OAKS				STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		11/2010
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	§483.80 Infection of The facility must exinfection prevention designed to provid comfortable environdevelopment and the diseases and infection of the facility must exand control program. The facility must exand control program a minimum, the foll §483.80(a)(1) A syreporting, investigation and communicable staff, volunteers, viproviding services arrangement based conducted accordinaccepted national system of survivial procedures for the but are not limited (i) A system of survivial possible communication of the facility when and to whom the facility of	Control stablish and maintain an and control program e a safe, sanitary and anment and to help prevent the transmission of communicable stions. In prevention and control stablish an infection prevention m (IPCP) that must include, at lowing elements: Item for preventing, identifying, ating, and controlling infections ediseases for all residents, sitors, and other individuals under a contractual dupon the facility assessmenting to §483.70(e) and following standards; Item standards, policies, and program, which must include, to: Ireillance designed to identify table diseases or ley can spread to other lifty; hom possible incidents of lease or infections should be ransmission-based precautions event spread of infections; isolation should be used for a	F 88	 Upon notification by surveyor, oxygen tubing for Resident #6 replaced. All residents have the potential be affected. Unit Managers/Shift Supervisor conduct room rounds to detern any issues with oxygen tubing being properly maintained in a sanitary manner. Licenses nurses and CNAs reeducated on the requirement to ensure oxygen tubing is maintain a sanitary and safe manner times. Unit Managers/Shift Supervisor conduct random audits of residenceiving supplemental oxygen determine ongoing compliance maintaining tubing in a sanitary safe manner. Unit Managers will report the reof audits at the monthly QAPI Committee meetings x3 month its review and recommendations. Compliance Date: August 13, 	I was I for to Irs will nine not If will lent I to I with I and I was I sesults I sesu	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
2.95	495217		B. WING		1	С
						11/2019
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORCARE HEALTH SERVICES-FAIR OAKS				12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLETION	
F 880	(A) The type and dudepending upon the involved, and (B) A requirement the least restrictive posticircumstances. (v) The circumstancemust prohibit emploidisease or infected contact with residen contact will transmit (vi)The hand hygien by staff involved in contact with the corrective actions ta §483.80(a) (4) A systidentified under the corrective actions ta §483.80(e) Linens. Personnel must hand	ration of the isolation, infectious agent or organism hat the isolation should be the sible for the resident under the ses under which the facility yees with a communicable skin lesions from direct the disease; and e procedures to be followed direct resident contact.	F 88			
	IPCP and update the This REQUIREMEN by: Based on observati document review, as was determined the administer oxygen in 57 residents in the s	uct an annual review of its eir program, as necessary. IT is not met as evidenced on, staff interview, facility and clinical record review, it facility staff failed to a sanitary manner for one of urvey sample, Resident #61. The determinant of the resident intering oxygen to Resident intering oxygen to Resident				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED			
495217 B. W		B. WING		C 07/11/2019			
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE COMPLETION	1	
F 880	10/26/19 with diagn not limited to: high to breath, gastroesoph [backflow of the coresophagus, usually sphincter muscle be symptoms include to commonly known as falls, and osteoporotissue, causing frag (2)]. The most recent MI assessment, a quarassessment, a quarassessment referent resident as having to memory difficulties. being severely impadecisions. Resident extensive assistance of her activities of despecial Treatments, coded the resident a look back period. An observation was 7/10/19 at 9:18 a.m. assistant) had just gwheelchair. The Oxycannula, was observation the floor and place the floor a	dmitted to the facility on oses that included but were blood pressure, shortness of nageal reflux disease atents of the stomach into the caused by malfunction of the etween the two organs; purning pain in the esophagus, is heartburn. (1)], history of sis [abnormal loss of bony die bones that fracture easily OS (minimum data set) terly assessment, with an oce date of 5/17/19, coded the both short and long-term. The resident was coded as irred to make daily cognitive #61 was coded as requiring e on one staff member for all aily living. In Section O - Procedures, and Programs, as using oxygen during the made of Resident #61 on The CNA (certified nursing otten the resident up into her gen tubing, with the nasal and on the floor behind the A picked the oxygen tubing up the dit on Resident #61. She on the oxygen tubing falls on when oxygen tubing falls on the oxygen tubing tubing falls on the oxygen tubing tubing tubing tubing tu	F 8	80			

		IDENTIFICATION NUMBER:	A. BUILDIN	G	(X3) DATE SURVEY COMPLETED		
		495217	B. WING _		C 07/11/2019		
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS				STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(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)	LD BE COMPLÉTION		
F 880	the floor, CNA #2 s have to get another another one." An interview was condition 7/11/19 at 8:59 a.m.	age 99 tated, "If it's on the floor we r one or tell the nurse to get anducted with LPN #2 on . When asked if is acceptable to apply oxygen tubing to a	F 880				
	resident that has be stated, "No, it has t That's an infection The facility policy, " to evidence guidant	een on the floor, LPN #2 o be changed immediately. control issue." Oxygen Administration" failed ce as to what to do if the					
	administrator, ASM of nursing, and ASM consultant, were maconcern on 7/11/19	he floor. member (ASM) #1, the #2, the administrative director #3, the quality assurance ade aware of the above at 10:50 a.m. on was provided prior to exit.					
F 947 SS=E	Non-Medical Reade Chapman, page 24 (2) Barron's Diction Non-Medical Reade Chapman, page 42	nary of Medical Terms for the er, 5th edition, Rothenberg and 4. Training for Nurse Aides	F 947	F947 1. The required 12 hours of ann	ual		
	aides. In-service training n §483.95(g)(1) Be su	d in-service training for nurse nust- officient to ensure the nce of nurse aides, but must		training will be completed by 5, 2019, for the four (4) CNAs identified during the survey a deficient in one or more areas training. 2. All residents have the potential affected.	August s s being s of		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495217	B. WING			C 07/11/2019		
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-FAIR OAKS	1	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFILE OF THE APPROPROPROFILE OF THE APPROPROFILE OF TH	D BE	(X5) COMPLETION DATE		
F 947	\$483.95(g)(2) Include training and resident \$483.95(g)(3) Address the special determined in nurse and facility assessmaddress the special determined by the factorial state of the second determined by the factorial state of the second determined by the factorial state of the second determined by the factorial state of the second determined by the factorial state of the second determined by the factorial state of the second determined by the factorial state of the second determined by the factorial state of the second determined factorial state of the second determi	de dementia management tabuse prevention training. ess areas of weakness as aides' performance reviews nent at § 483.70(e) and may needs of residents as acility staff. urse aides providing services ognitive impairments, also the cognitively impaired. It is not met as evidenced view and employee record nined that the facility staff four of six, CNA (certified cords reviewed received the fannual training's.	F 947	3. The balance of CNA employe will be reviewed, to determine need for additional hours of reannual training. Failure by any identified CNA to complete all required training by the completed will result in being remove from the work schedule until a required training has been completed. Human Resources Director (Hwill communicate this requirer newly-hired CNAs during initial orientation, will conduct a qual review of CNA files to determing service status and ensure that required training and in-service completed by the employees' anniversary date-of-hire. 4. Along with other employee-relating reports and data, HRD will prefind and recommendations. 5. Compliance date: August 13,	equired, / iance ed ill IRD) ment to al rterly ne in- t all es are ated esent I QAPI review			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495217		B. WING	B. WING			C 11/2019	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS				STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 947	(CNAs) are assigned	ed mandatory training on the nd it is reviewed quarterly to ing is done."	F	947				

If continuation sheet 1 of 2

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495217		B. WING	-	07/11/2019		
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY	STATE, ZIP CODE			
MANORCARE HEALTH SERVICES-FAIR OAKS 12475 LEE FAIRFAX,				N MEMORIAL HIGHWAY			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE		
F 000	Initial Comments			F 000			
	An unannounced biennial State Licensure Inspection was conducted 7/9/19 through 7/11/19. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities.						
	113 at the time of the	155 certified bed fac ne survey. The surve rent Resident review ws.	ey sample				
F 001	Non Compliance		1	F 001			
	The facility was out following state licen	of compliance with t sure requirements:	he				
	This RULE: is not a 12 VAC 5 - 371 - 25 Federal deficiency !	met as evidenced by 60 G Cross reference 558	: es to		See PoC for F 558 on CMS-2567	1	
	12 VAC 5 - 371 - 37 Federal Deficiency	'0 A, G Cross referei 584	nces to		See PoC for F 584 on CMS-2567	,	
	12 VAC 5 - 371 - 250 A - 3 Cross references to Federal Deficiency 641				See PoC for F 641 on CMS-2567		
*** A decare	12 VAC 5 - 371 - 20 Federal Deficiency	00 B 1 Cross referend 658	ces to		See PoC for F 658 on CMS-2567		
14 12	12 VAC 5 - 371 - 18 Federal Defciency 8 Management & Adr		s to		See PoC for F 880 on CMS-2567		
the season of th	12VAC5-371-110 B2,3,C cross reference to F609				See PoC for F 609 on CMS-2567		
1	Staff Developement and Inservice Training 12VAC5-371-260 F cross reference to F947 12 VAC 5-371-220 (D), Cross reference to F695						
				See PoC for F 947 on CMS-2567			
			10 ⊢695		See PoC for F 695 on CMS-2567		
	12 VAC 5-371-250 (G), Cross reference	to F656		See PoC for F 656 on CMS-2567		
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESEN	TATIVE'S SIGN	ATURE	I: TITLE	(X6) DATE	
	trock	•			Administrator	July 31, 2019	

021199

UVOJ11